St Joseph's Intellectual Disability Service

ID Number: AC0052

2018 Approved Centre Inspection Report (Mental Health Act 2001)

St Joseph's Intellectual Disability Service
St Ita's Hospital
Portrane
Donabate
Co. Dublin

Approved Centre Type:
Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
17 May 2016

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Angela Walsh, Head of Mental Health Services, CHO9

Inspection Team:
Martin McMenamin, Lead Inspector
Carol Brennan- Forsyth
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Dr Enda Dooley, MCRN004155

Inspection Date:
10 – 13 April 2018

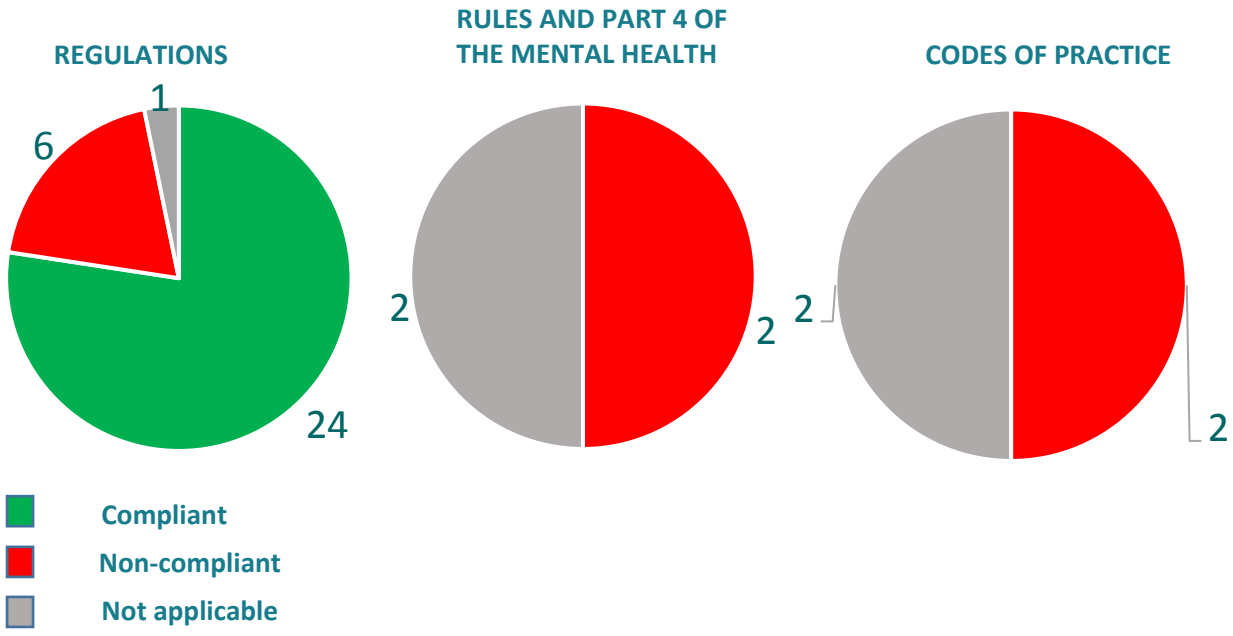
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
13 – 16 June 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
25 October 2018

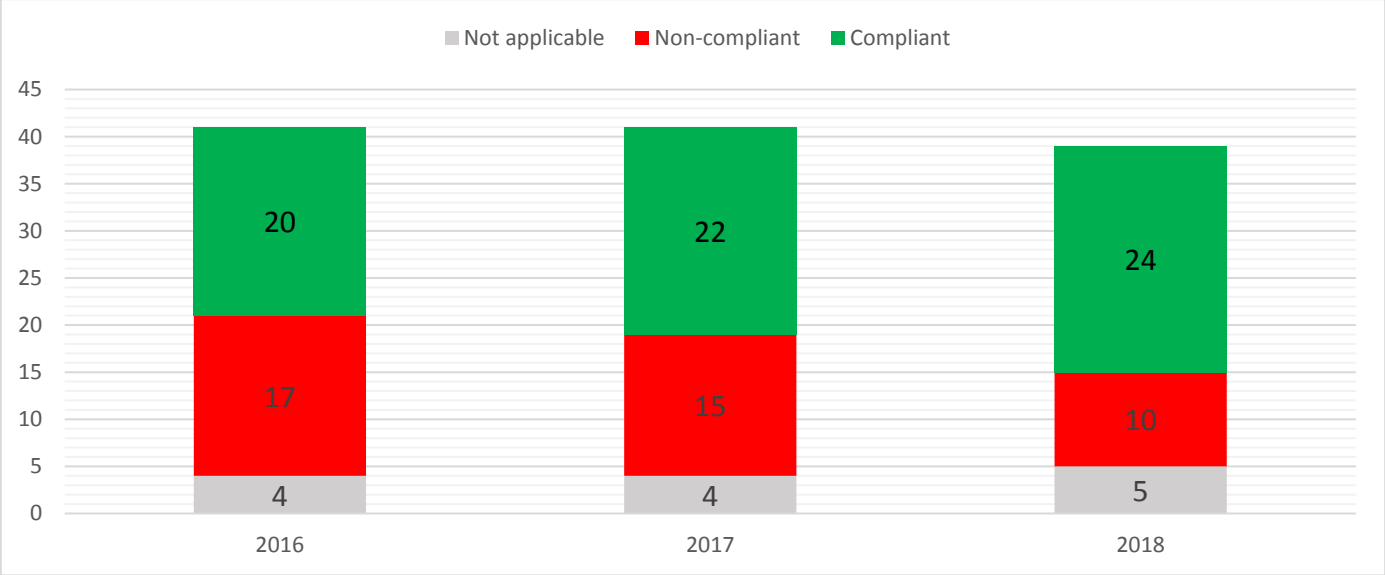
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

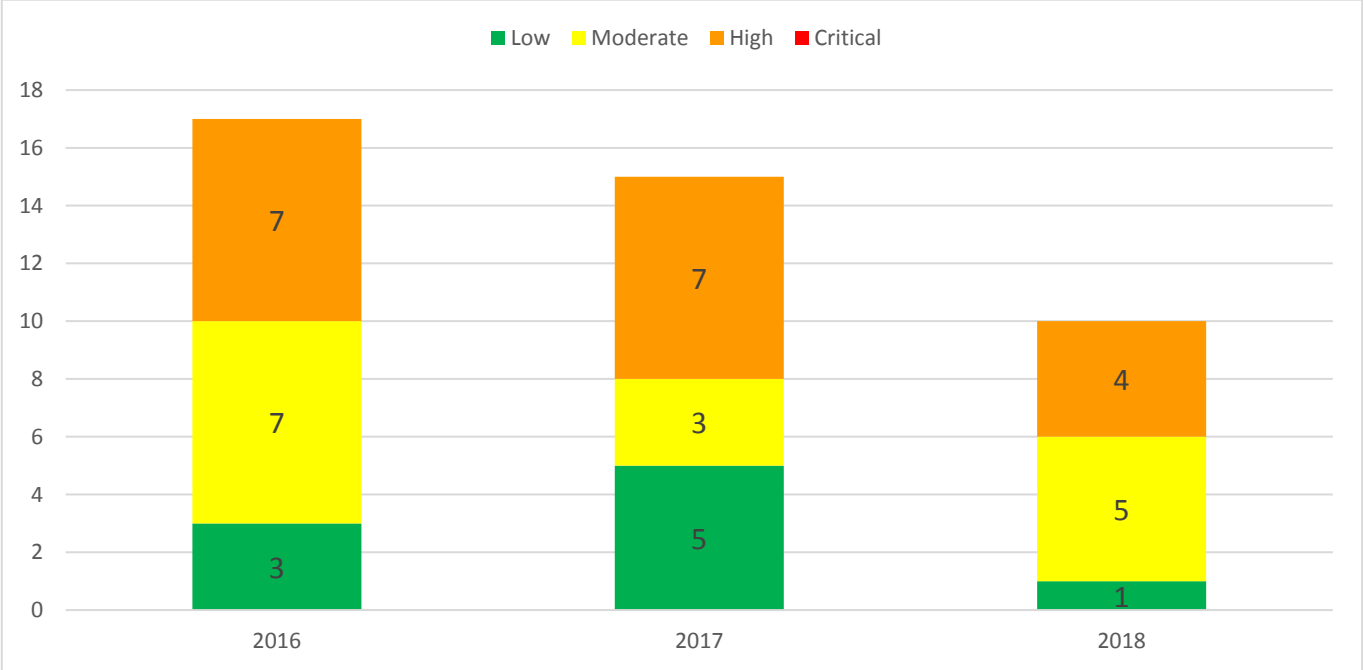
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018



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1.0 Introduction to the Inspection Process

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

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

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

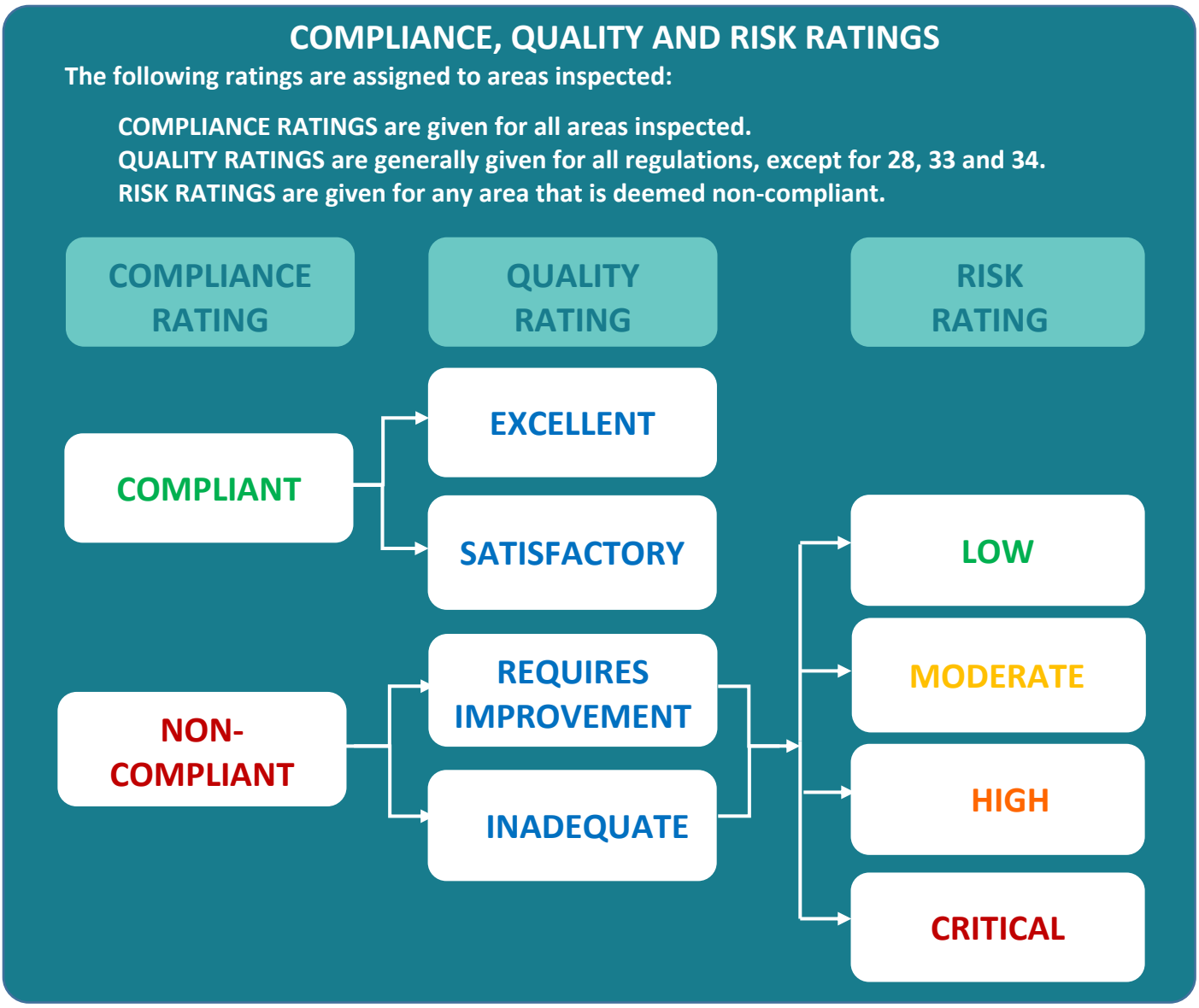
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In Brief

St. Joseph's Intellectual Disability Service (IDS) was located on the grounds of the now closed St. Ita's Hospital in Portrane, Co. Dublin and provided continuing care beds for people with an intellectual disability as part of CHO 9 Dublin North City and County. The approved centre comprised 13 units and could accommodate up to 124 residents; there were 101 residents at the time of inspection. No resident was detained under the Mental Health Act 2001. The approved centre was closed to new admissions.

There had been an improvement in compliance with regulations, rules and codes of practice from 54% compliance in 2016 to 73% in 2018. Two compliances with regulations were rated as excellent.

Safety in the approved centre

Medication ordering, prescription, storage and administration were carried out in a safe manner. Food safety audits had been completed periodically and food preparation and service areas were clean.

Not all health care staff were trained in the following: fire safety, Basic Life Support, management of violence and aggression, The Mental Health Act 2001 and Children First.

The seclusion room was designed with furniture and fittings which endangered resident safety, and therefore residents in seclusion had access to hazardous objects. The corner chair in the seclusion room in House 11 was refurbished with a hard seat edging which could possible result in injury to a resident. The door of two seclusion rooms had a hard surface, with edging surrounding the viewing pane. Both the door surface and hard edging could potentially be hazardous.

Appropriate care and treatment of residents

Each resident had a multi-disciplinary individual care plan (ICP), developed following an assessment. The residents' individual assessments, in some cases, did not include their current medical, psychiatric, and psychosocial needs. Not all ICPs identified appropriate goals for the resident, and some goals were out-dated. Not all ICP did not identify the care and treatment required to meet the goals identified. The multidisciplinary team (MDTs) reviewed ICPs in consultation, where appropriate, with the resident at least every six months. The residents had access to their ICPs and were kept informed of any changes.

Not all residents had access towards adequate therapeutic services and programmes as only 45 out of the 98 residents attended the resource centre for activities. Outreach staff visited some of the other 53 residents inside the approved centre. Some houses within the approved centre had no resources or facilities for therapeutic services and programmes. There was a multisensory room in two locations but no staff member was trained in its use.

The six-monthly general health assessments documented physical examination, blood pressure, smoking status, medication review, and weight. However, it did not document body mass index (BMI), waist circumference, nutritional status, diet, physical activity and dental health. For residents on antipsychotic medication an annual assessment recorded glucose regulation, blood lipids and prolactin but did not detail or evidence an electrocardiogram taking place.

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Residents had access to national screening programmes appropriate to age and gender. Current residents had access to smoking-cessation programmes and supports.

Respect for residents' privacy, dignity and autonomy

A self-advocacy group had been set up, facilitated by Social Work and Teachers. This was aimed at facilitating residents to communicate their needs and wishes regarding their living environment and to engage in decision making. Residents could meet visitors in private and had free access to mobile phones and the Internet. Residents were dressed appropriately to ensure their privacy and dignity. Some bathrooms, showers, and toilets did not have locks because locks were identified as a potential risk to residents with impaired capacity. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

The approved centre was non-compliant with Part 5 of the Rules Governing the Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others because in one case, the duration of the mechanical restraint order was not recorded in the clinical file and associated mechanical restraint order form. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others and following risk assessment. Staff had first considered all other interventions to manage each resident's unsafe behaviour. Cultural awareness and gender sensitivity was demonstrated in the episodes of physical restraint.

Responsiveness to residents' needs

Easy read booklets for residents had been developed to help them understand the house they reside in and other service aspects. Residents on normal diets had at least two choices for meals, but residents on modified diets did not always have a second meal choice. Residents had an adequate supply of their own individualised clothing, which they stored in their personal wardrobes.

The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Residents had access to personal storage facilities for their personal property. Residents' rights to practice religion were facilitated within the approved centre with facilities available to support their religious practices.

Accommodation for most residents in the approved centre assured their comfort and privacy and met their assessed needs. Most residents had single bedrooms, but not all bedrooms were appropriately sized to meet residents' needs. Four residents in St. Clare's and Hillview were accommodated in dormitory bedroom facilities which were not appropriate to the residents' dignity and needs.

St. Clare's and Hillview were in a poor state of repair. There was no programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Instead, maintenance was reactive to demand. There was no future plan of maintenance available. The approved centre was clean, hygienic and free from offensive odours.

Governance of the approved centre

St. Joseph's IDS was part of the North Dublin Mental Health Service (NDMHS) in Community Healthcare Organisation (CHO) 9 area, and responsibility for the management of St. Joseph's IDS was designated to the senior management team of NDMHS.

The service had robust risk assessment, management and review processes in place. The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Multi-disciplinary teams were involved in the development, implementation, and a review of individual risk management processes occurred weekly.

The introduction of the most recent forum, the MHID Consultation Group, was a communication channel between disciplines and also facilitated communication to staff on the ground.
The NDMHS Quality and Patient Safety Committee, met every two to three months. Nursing management had also introduced a 'Walk-rounds' initiative with the aim of further strengthening clinical governance.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had implemented a pilot of a new Medication Prescription and Administration Records (MPAR) within five locations.

2. Easy read booklets have been developed for residents to help them understand their accommodation facilities and arrangements, as well as, other services available to them.

3. Nurse managers have initiated Walk-rounds of all Units to review clinical and health and safety issues and meet with front-line staff and residents.

4. The approved centre had undertaken the renovation of a house, which has enabled an individual resident with specific needs access to much larger space. This will enable the resident the opportunity to withdraw from other residents when he/she chooses.

5. A programme of walking within the campus had been introduced by staff as part of a 'Healthy Living' initiative for residents.

6. Phase 1 of the 'Tobacco Free Campus' initiative had been implemented across the campus accompanied by the provision of new signage. Areas where staff and service users/visitors currently smoke have been identified and plans made for the removal of any shelters.

7. A self-advocacy group – facilitated by Social Work/Teachers had been introduced through the Knockamann Resource Centre, which residents attend. The 'Circles' programme teaches residents to communicate their needs and wishes regarding their living environment, to engage in decision making and how to behave with another person.

8. The approved centre had made provision for mindfulness resources and also access to a mindfulness programme for residents.

9. Healthcare staff have embraced the importance of introductions in healthcare through the implementation of the '#Hello, my name is……' staff greeting and communication protocol to residents and relatives.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

St. Joseph's Intellectual Disability Service (IDS) was located on the grounds of the now closed St. Ita's Hospital in Portrane, Co. Dublin and provided continuing care beds for the Psychiatric Services of CHO 9 Dublin North City and County. As the approved centre was an intellectual disability service it only admitted residents with mental health/intellectual disabilities and the resident profile at the time of the inspection reflected this practice.

The approved centre comprised 13 occupied units, 8 numbered and 5 named units, and had the capacity to accommodate up to 124 residents at the time of the inspection. The Knockamann development, completed in 2010 comprised modern six-bed houses, numbered 1, 2, 5, 6, 7, 8, 10, and 11 were located within an urban style streetscape. Houses 1,2,10 and Failte accommodated male residents only. House 2 accommodated female residents only. All other residences accommodated male and female residents. Houses 3 and 4 were not in use at the time of inspection, with tentative proposals to develop an acute admission and assessment unit within the facility in the future. Adjoining the development was the Knockamann Resource Centre, which acted as the hub of social, vocational, educational, and leisure activities for residents of all units. The resource centre had a café, gymnasium, and multi-sensory rooms and was a vibrant focal point for residents and staff alike.

The five named units consisted of Hillview, Seafield, and St. Clare's, all of which were 20-bed units, the 5-bed Fáilte, and the 11-bed Grove Lodge. The named units were older buildings; however, a considerable amount of work had been done in modernising and upgrading Seafield in 2014, which resulted in a bright and pleasant environment for residents. Although Hillview and St Clare's were in particular need of modernisation, it was expected as part of the current transition plan for the service that Hillview would be decommissioned by December 2018, following the relocation of a number of residents to more appropriate care settings. Similar plans were in existence for St Clare's with an expected completion date in 2019.

The approved centre had 101 residents registered, 29 residents did not have a mental health diagnosis. These residents were long-standing residents of the service whose intensive support needs could not be met in a less supported environment. At the time of the inspection, four beds were occupied in House 1, six beds in House 2, five beds in House 5, six beds in House 6, six beds in House 7, six beds in House 8, four beds in House 10, and five beds in House 11. Five beds were occupied in Fáilte, eight in Grove Lodge, 15 in St Clare's, 16 in Hillview, and 15 in Seafield. This was in keeping with the services desire to reduce bed occupancy within each of the residences in promoting less congested accommodation and higher resident staffing ratios. The approved centre was closed to new admissions.

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

Resident Profile	
Number of registered beds	***126***
Total number of residents	**101**
Number of detained patients	None
Number of wards of court	6
Number of children	None
Number of residents in the approved centre for more than 6 months	100

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

St. Joseph's IDS was part of the North Dublin Mental Health Service (NDMHS). NDMHS was part of Community Healthcare Organisation (CHO) 9 area, and responsibility for the management of St. Joseph's IDS was designated to the senior management team of NDMHS. There was an organisational chart and clear governance structures and processes in place reflecting the North Dublin Mental Health service as it is currently structured. The service governance arrangements accommodated the nature of the conjoined ID and MH services and the funding and management arrangements.

The NDMHS management team meetings took place at least once a month. The management working team met approximately every week – two meetings addressed clinical reviews, one meeting focused on compliance issues and one which dealt with business issues. These structures were supported by Quality & Patient Safety, Health & Safety, Drug and Therapeutic and Emergency Planning Committees. Minutes of all the management team meetings since the last inspection were provided to the inspection team. Representatives from St. Joseph's IDS attended these meetings and a regular item on the agenda was "IDS update", and the current "Transition Project" for Hillview and St. Clare's was discussed. Quality and safety issues, including serious incidents, were also reviewed at this meeting. It was also clear from the interviews with Heads of Service, the risk advisor and in reviewing the risk register, that the service had robust risk assessment, management and review processes in place.

The introduction of the most recent forum, the MHID Consultation Group, appears to have been well received by staff and acted as a communication conduit between disciplines and also facilitated communication upwards as well as downwards to staff on the ground.
The NDMHS Quality and Patient Safety Committee, met every two to three months. Minutes of the previous four meetings were provided to the inspection team and issues discussed included serious incidents,

training, risk registers, infection prevention and control, and compliance. Nursing management had also introduced a 'Walk- round' initiative with the aim of further strengthening clinical governance.
There were however no local management controls in relation to maintenance as this was managed by Estates off site.

4.5 Use of restrictive practices

The entrance door into each of the houses and units within the approved centre was by requested entry, or swipe card. This was in consideration of the assessed clinical needs of the residents and in ensuring the safeguarding of residents. Residents had access to personal mobile phones however Wi-Fi access was limited to the location of the Resource building.

5.0 Compliance

5.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 15: Individual Care Plan	✗	Moderate	✓		✗	High
Regulation 16: Therapeutic Services and Programmes	✗	Moderate	✓		✗	High
Regulation 19: General Health	✓		✓		✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	Moderate
Regulation 26: Staffing	✗	High	✗	High	✗	High
Regulation 27: Maintenance of Records	✗	Moderate	✗	Low	✗	Moderate
Rules Governing the Use of Seclusion	✗	High	✗	High	✗	High
Rules Governing the Use of Mechanical means of Bodily Restraint	✓		✓		✗	Low
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	High	✗	Moderate	✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	Low	✗	Moderate

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 7: Clothing
Regulation 25: CCTV

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no detained patients in the approved centre, Part 4 of the Mental Health Act 2001: Consent to Treatment 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.

The inspection team met with 14 residents, four of whom met the inspectors as a group. Residents were complimentary of staff and most but not all expressed satisfaction with the food and activities. Inspectors also engaged with residents throughout the inspection process.

The lead inspector also spoke with representatives of the parents and friends group - St Joseph's Association for the Intellectually Disabled, Portrane.

The group welcomed the opportunity of meeting with the lead inspector and expressed the hope that their concerns and comment would be 'taken on board'. Reassurance was offered that the groups concerns would be noted in the report.

Explanation was provided by the lead inspector on the Mental Health Commission (MHC) inspection process. Part of which seeks to determine the extent to which resident needs and requirements are met within individual care plans. The lead inspector also outlined provisions and protocols that are in place with regard to resident rights and privacy regarding visits and inspections in approved centres such as St Joseph's Intellectual Disability Service.

The group had a number of concerns which are briefly outlined here:

1. Concern that residents in need of one to one supervision within an acute general hospital can be left without appropriate support and supervision following admission.

2. Reduced day service availability and continuity of care due to staff shortages.

3. Disappointment felt by some members at the discontinuation of visits by St. Joseph's Association for the Intellectually Disabled to the service.

4. Some concerns about the plans for the residents moving on from existing congregated settings.

The meeting also had discussion around other ideas of how the Association could connect with residents and staff, which was welcomed by the group. The group were thanked for their contribution and time given to the meeting.

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:

- Area Director of Mental Health Nursing
- Assistant Director of Nursing
- Senior Clinical Psychologist
- Service Manager
- Head of Service Mental Health
- Senior Occupational Therapist
- Consultant Psychiatrist
- Day Services Manager
- Occupational Therapy Manager
- Psychology Services Manager
- Senior Social Worker

Apologies were received from the Mental Health Engagement representative.

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. The following clarifications arising from the meeting were noted by the inspection team:

- Speech & Language Therapist will be available in May.
- Dietitian being recruited (not in place yet) on a sessional basis (number of sessions unclear at this time).
- Review of Risk Register is quarterly and as required at area level.
- Mechanical Restraint Practice to be reviewed in relation to maximum time periods.
- Central log of transfers kept in ADONs office. Copy to be forwarded to lead inspector.
- Title of management meeting – North Dublin Mental Health Intellectual Disability (NDMHID) Management Meeting.
- Resident transfer – resident was not yet registered with GP hence no transfer letter forwarded
- Duplication in the evaluation of Care Plans process discussed.
- The name of the Pharmacy service in St Mary's Hospital, Phoenix Park is 'St Brendan's'.
- Reference to 'referral to MDT' within new assessment documentation acknowledged as misleading.
- Estates management is separate from ID service management.
- Day services support all residents within the campus, with 'outreach' to those unable to attend Resource Centre.
- Wi-Fi was available to residents.

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

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

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

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

The identifiers used were person-specific, and appropriate to the residents' communication abilities. There was an appropriate identifier and alert system in place on clinical files, to assist staff in distinguishing between 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 training and education pillar.

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre's menus were not approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. An evidence-based nutrition assessment tool was not used by the approved centre.

Residents on normal diets had at least two choices for meals, but residents on modified diets did not always have a second meal choice. Food, including modified consistency diets, was not presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Modified diet food types had a bland appearance.

Hot meals were provided on a daily basis and a source of fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. In relation to residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Their special dietary needs were regularly reviewed by a dietitian who was brought into the approved centre, where necessary.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). This 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. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was appropriate and sufficient catering equipment, crockery, and cutlery available to residents in the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in two houses within the approved centre only. Food for the other houses, was prepared in the main campus kitchen and delivered to the houses in hot boxes. Hygiene was maintained to support food safety requirements.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. No current residents were prescribed to wear night clothes during the day.

Evidence of Implementation: No resident was wearing night clothing during daytime hours over the course of the inspection. Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs. They had an adequate supply of their own individualised clothing, which they stored in their personal wardrobes.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in May 2017. The policy addressed all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Personal property logs were not monitored in the approved centre, the last review of property logs in Fáilte was in 2012. Documented analysis had not been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions, as necessary. There was a safe in each unit and central finance managed residents' access to their monies. The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Residents had access to personal storage facilities for their personal property, and they were entitled to bring personal property and possessions with him/her as agreed at admission.

The approved centre maintained a signed property checklist detailing each resident's personal property and possessions. The property log was not updated annually as stipulated by the policy requirements. The property checklist was kept separately to the resident's ICP and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **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 January 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident attendance. Documented analysis had 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. Residents either attended the on-site resource centre for recreational activities, or the recreation teams came to the residents in their houses, depending on staff availability and residents' needs. A daily schedule of recreational activities was available to residents on a timetable each day. The timetable was displayed in the resource centre. There was no timetable available for more than one day in advance, and the information did not include the types and frequency of appropriate recreational activities available within the approved centre.

Opportunities were provided for indoor and outdoor exercise and physical activity; the outdoor activities were weather dependent. Resident preferences on recreational activities were sought by staff when developing daily recreational programmes, and for one to one sessions. Communal areas provided were suitable for recreational activities. There was an on-site resource centre, and each house had communal areas which were used for activities such as jigsaw making, board games, and film-watching. The resource centre documented attendance at each activity.

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

Regulation 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. The policy was last reviewed in May 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation of the policy to support residents' religious practices was not reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable, with facilities available to support their religious practices. There was a Church on the grounds of the approved centre. Residents had access to multi-faith chaplains through the local community. Residents were facilitated to observe or abstain from religious practice in accordance with their own will and preferences.

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 in relation to visits. The policy was last reviewed in January 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: There were no restrictions on residents' rights to receive visitors at the time of the inspection. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed on all units of the approved centre. The approved centre had a dedicated visitor room on a number of units, and a dedicated visiting area in House 9. These rooms facilitated residents to meet their 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. The approved centre did not have any dedicated child-friendly facilities, and the meeting room in House 9 was unsuitable for children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in March 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: No current residents' communication was subject to examination. Residents could access and use mail, fax, Internet, and personal telephone if they desired. Individual risk assessments were completed for residents, as deemed necessary, in relation to any risks associated with their external communication and documented in the individual care plan.

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

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in January 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

There were no searches conducted in the approved centre since the last inspection, therefore the approved centre was assessed under the two pillars of processes and training and education only.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy dated July 2017 in relation to care of the dying. The policy included most of the requirements of the *Judgement Support Framework* criteria. It addressed staff roles and responsibilities in relation to care of the dying. The identification and implementation of residents' physical, emotional, social, psychological, spiritual and pain management needs in relation to end of life care was detailed in the policy.

The policy did not include 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). Consideration of Do Not Attempt Resuscitation (DNAR) orders was not addressed.

Training and Education: Relevant staff had read and understood the policy and protocols on care of the dying. Relevant staff could articulate the processes for end of life care, as set out in the policy.

Monitoring: End of life care provided to residents was not systematically reviewed to ensure that the approved centre consistently complied with Section 2 of the Regulation. A documented analysis had not been completed to identify opportunities to improve the processes for the care of the dying.

Evidence of Implementation: One expected death of a resident had occurred in an external hospital since the last inspection. The end of life care provided in the approved centre was appropriate to the resident's physical, emotional, social, psychological, comfort, and spiritual needs, and this was documented in the resident's individual care plan.

Religious and cultural practices were respected. The privacy and dignity of the resident was protected. Representatives, family, next-of-kin, and friends of the resident were involved, supported, and accommodated during end of life care. The death was reported to the Mental Health Commission in writing within the required 48-hour timeframe.

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 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in May 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. Not 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 not 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, and most residents were in the approved centre on a long-term basis. All ICPs were a composite set of documentation detailing goals, treatment, care, and resources required. Staff were using different templates for ICP purposes such as nursing care plans with an additional page added to it for psychiatry and medical details. Some templates had a page for medical details, and some templates incorporated medical and physical health sections under nursing goals. The ICPs, which were stored within each resident's clinical file, was identifiable, uninterrupted, and was not amalgamated with progress notes.

Each resident had been assessed at admission by the admitting clinician and an initial ICP was developed. The ICPs were then developed by the MDT following an assessment, as soon as was possible but within seven days of admission. Evidence-based assessments were used. The residents' individual assessments, in some cases, did not include their current medical, psychiatric, and psychosocial needs. Their assessments did include medication history and current medications, a detailed risk assessment, social, interpersonal, and physical environment-related issues, including resilience and strengths, communication abilities, and educational, occupational, and vocational history. Residents received a physical examination separate to their admission assessment.

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. Not all ICPs identified appropriate goals for the resident, and some goals were out-dated. For one resident there were no goals for the Montessori school or ASDAN (Award Scheme Development and Accreditation Network), though some were documented in the minutes of the care plan review. Medical goals were not detailed in all ICPs inspected. Some ICP goals were missing a page. The ICP did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.

One inappropriate goal, which was written in a resident's ICP, stated staff to be familiar with risk assessments. A key worker was not identified in residents' ICPs and clinical files inspected, to ensure continuity in the implementation of a resident's ICP. ICPs included an individual risk management plan.

The MDTs reviewed ICPs in consultation, where appropriate, with the resident at least every six months. The review was written up by the key worker and agreed at the ICP meeting. Some review document changes required the key worker to re-type parts of the ICP, while these changes were notified to the key worker the changes were not always documented in the ICP.

The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances, and goals. The residents had access to their ICPs and were kept informed of any changes. Residents were offered a copy of their ICPs, including any reviews, and this was documented. When a resident declined or refused a copy of their ICP, this was recorded, and any refusal reasons were also recorded.

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

a) **Not all goals were regularly reviewed.**
b) **The ICP did not always specify appropriate goals for the resident.**
c) **Care and treatment required to meet goals was not consistently identified.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- The planning and provision of therapeutic services and programmes within the approved centre.
- The resource requirements of the 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: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. Not all clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: There was no monitoring of the range of services and programmes provided in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence Of Implementation: A list of all therapeutic services and programmes provided in the approved centre was not available to residents. The therapeutic services and programmes provided by the approved centre were not, in all cases, linked to identified needs. There was inconsistent documenting of residents assessed needs in their individual care plans.

Not all residents had access towards adequate therapeutic services and programmes aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Forty-five out of the 98 residents attended the resource centre for recreational activities. Outreach staff visited a selection of the other 53 residents inside the approved centre. While these residents were within the approved centre, they were deemed outreach residents because they did not attend Knockamann centre.

There was a school in Knockamann centre, which was defined as a Montessori School. It was, however, an education centre which was run by Montessori teachers and it aimed to bring adults up to Leaving Certificate standard. Where a resident required a therapeutic services 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 such as physiotherapy and chiropody services.

Adequate and appropriate resources and facilities were not available to provide therapeutic services and programmes. Some houses within the approved centre had no resources or facilities. There was a multisensory room in two locations but no individual was trained in its use.

Therapeutic services and programmes were not provided in a separate dedicated room containing facilities and space for individual and group therapies. There was a self-advocacy group of six residents, and they met weekly. They discussed communication, expressed thoughts and voiced concerns. They used the Hi5 model to learn about rights and responsibilities.

A record was not maintained of participation and engagement in outcomes achieved in therapeutic services and programmes. The clinical nurse manager 3 maintained a therapy plan in house but mainly recreational activities were recorded in it.

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

a) **The registered proprietor did not ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.**
b) **The registered proprietor did not ensure that the programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning for all residents.**

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies and procedures in relation to the transfer of residents. The transfer of residents policy was last reviewed in November 2017. The policies addressed all the requirements of the *Judgement Support Framework* with the following exceptions:

- The process for managing resident medications during transfer from the approved centre.
- The process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- The process for managing resident property during the transfer process.
- The process 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 policies.

Monitoring: A log of transfers was not maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was examined. The resident was transferred to another health care facility in an emergency situation. Justification as to why consent of the resident was not received was available. Communications between the approved centre and receiving facility were documented with a written referral.

The resident was risk assessed prior to the transfer and this was documented and provided to the receiving facility. Written information accompanied the resident as part of the transfer, including a letter of referral, and the resident's hospital passport, both of which were provided to the receiving facility. A resident transfer form was not documented to verify the completeness of information transferred.

A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the residents' clinical file.

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

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to responding to medical emergencies. The medical emergencies policy was last reviewed in September 2017. The policies and procedures included the requirements of the *Judgement Support Framework* with the following exceptions:

- The roles and responsibilities in relation to the provision of general health services to residents.
- Resident access to a registered medical practitioner.
- Ongoing assessment of residents' general health needs.
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The incorporation of general health needs into the resident individual care plan.
- The referral process for residents' general health needs.
- The documentation requirements in relation to general health assessments.
- Access to national screening programmes available for residents through the approved centre.

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

Monitoring: Residents' take-up of national screening programmes was recorded and monitored. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had three emergency resuscitation trolleys and staff had access at all times to an Automated External Defibrillator (AED). The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided; and the records was present in the clinical file.

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

The six-monthly general health assessments documented: physical examination, blood pressure, smoking status, medication review, and weight. However; it did not document Body Mass Index, waist circumference, nutritional status (diet and physical activity, including sedentary lifestyle), and dental health. For residents on antipsychotic medication an annual assessment recorded glucose regulation, blood lipids and prolactin but it did not detail or evidence an electrocardiogram taking place.

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

Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre. Current residents had access to smoking-cessation programmes and supports. The service was in the process of developing a smoke-free campus which was applicable to all staff at the time of the inspection, and scheduled to apply to residents from the end of 2018. Substitute medication was prescribed to assist cessation.

The approved centre was non-compliant with this regulation because it failed to ensure that the physical examinations, which were undertaken since February 12th 2018, fulfilled the criteria stipulated by the Mental Health Commission, 19 (1) (b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents. The policy was last reviewed in July 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for managing the provision of information to residents' representatives, family, and next of kin, as appropriate.

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

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

Evidence of Implementation: Residents were provided with a number of information booklets on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. Residents were provided with details of their multi-disciplinary team (MDT). The information booklets were 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. At the time of the inspection there were no restrictions on information regarding a resident's diagnosis, applied to any resident.

Information was provided to residents on the likely adverse effects of treatments, including the risks and other potential side-effects. Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. The content of medication information sheets included

information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services when needed.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, and training and education 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 written policy in relation to resident privacy, which was last reviewed in March 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A documented annual review had 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 not been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence Of Implementation: Residents appeared to be called by their preferred name. The general demeanour of staff and the way in which staff addressed and interacted with residents was respectful. All staff wore an identity badge. Residents were dressed appropriately to ensure their privacy and dignity.

All bathrooms, showers, and toilets, did not have locks because locks were identified as a potential risk to residents with impaired capacity. Where residents had capacity, toilets and bathrooms did have locks.

Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls where residents had capacity.

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

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: The approved centre had not completed hygiene or ligature audits. Documented analysis had not been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit, heated, and ventilated. There were enough toilets and showers for residents, and toilets were clearly marked and close to day and dining areas. There was a wheelchair accessible toilet. Accommodation for most residents in the approved centre assured their comfort and privacy and met their assessed needs. Most residents had single bedrooms, but not all bedrooms were appropriately sized to meet residents' needs. Four residents in St. Clare's and Hillview were accommodated in dormitory bedroom facilities which were not appropriate to the residents' dignity and needs.

The approved centre provided appropriately sized communal rooms. There were adequate and suitable furnishings. The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, with the exception of the seclusion room, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were not minimised to the lowest practicable level, and monitored, however the residents were assessed to be of a low suicide-risk.

St. Clare's and Hillview parts of the approved centre were in a poor state of repair. There was no programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Instead, maintenance was reactive to demand. There was no future plan of maintenance available. The approved centre was clean, hygienic and free from offensive odours. Remote or isolated areas of the approved centre were monitored.

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

a) **St. Clare's Ward and Hillview Ward premises were not maintained in good decorative condition, 22 (1) (a).**
b) **There was no programme of routine maintenance, 22 (1) (c).**
c) **Bedroom furnishings in some wards were not suitable for the needs of residents, 22 (2).**

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

- The process for ordering resident medication.
- The process for medication management at admission and discharge.
- The process for medication reconciliation.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, and 10 in total of these were inspected across five separate units of the approved centre. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. 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.

There was no dedicated space for once-off medications on MPARs. Not all micrograms were written in full, eltroxin medication was written as MCG within one MPAR. All entries in the MPAR were legible, and written in black indelible ink. Medicinal products were administered in accordance with the directions of the prescriber, and the advice provided by the resident's pharmacist regarding the appropriate use of the product. Pharmacy services attended weekly multi-disciplinary team (MDT) meetings.

The expiration date of the medication was checked prior to administration; and expired medications were not administered. Medication was reviewed and rewritten at least six-monthly or more frequently where

there was a significant change in the resident's care or condition. This was documented in the resident's clinical file.

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

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Refrigerators used for medication were used only for this purpose but a log was not maintained of every single fridge temperature. While Grove House fridge's temperature was logged, Seafield House had a domestic fridge with no temperature log maintained.

Food and drink was not stored in areas used for the storage of medication. An inventory of medications was conducted on a monthly basis, checking the name and dose of medication, quantity of medication, and expiry date. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident and were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in August 2017. The policies addressed all of the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in March 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence Of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. A resident was monitored solely for the purposes of ensuring his/her health, safety, and welfare. The Mental Health Commission had been informed about the approved centre's use of CCTV. The cameras were incapable of recording or storing a resident's image in any format, and they did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The policy was last reviewed in November 2017. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

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

Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated through e-mail and noticeboards, to all relevant staff, and they were supported through tuition support, scheduled time away from work, or recognition for achievement.

The number and skill mix of staffing were sufficient to meet resident needs. Three disciplines of nursing were employed, approximated as follows: Registered General Nurses (10%); Registered Psychiatric Nurses (40%) and Registered Nurse Intellectual Disability (50%). A registered psychiatric nurse was always in charge within the approved centre. A written staffing plan was available within the approved centre. Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as

detailed in the staff training plan. Staff were trained in manual handling, infection control and prevention, dementia care, end of life care, resident rights, risk management, and treatment, incident reporting, and the protection of children and vulnerable adults. In addition, staff were trained in care for residents with an intellectual disability, and recovery-centred approaches to mental health care. Not 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

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

Ward or Unit	Staff Grade	Day	Night
	CNM2	1	
	RPN	4	2
Houses 1 & 2	HCA	3	2

Ward or Unit	Staff Grade	Day	Night
	CNM2	1	
	RPN	3	3
Houses 5 & 6	HCA	3	2

Ward or Unit	Staff Grade	Day	Night
	CNM2	1	
	RPN	4	2
Houses 7 & 8	HCA	2	2

Ward or Unit	Staff Grade	Day	Night
	CNM2	1	
	CNM1	1	
Houses 10 & 11	RPN	3	2
	HCA	2	2

Ward or Unit	Staff Grade	Day	Night
	CNM2	1	
Hillview	RPN	3	1
	HCA	3	1

Ward or Unit	Staff Grade	Day	Night
St. Clare's	A/CNM2	1	
	RPN	2	2
	HCA	3	1
	Student (3rd year)	1	

Ward or Unit	Staff Grade	Day	Night
Seafield	CNM2	1	
	RPN	3	2
	HCA	2	2
	Intern	2 (1 RPN)	

Ward or Unit	Staff Grade	Day	Night
Fáilte	CNM2		
	RPN	2	1
	HCA	2	1

Ward or Unit	Staff Grade	Day	Night
Grove Lodge	CNM2	1	
	RPN	2	1
	HCA	3	1
	Student (Intern)	1	

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

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

a) **Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, and Children First, 26(4).**
b) **Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating	**Requires Improvement**
Risk Rating	**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. The policy was last reviewed in November 2015. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

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

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

Evidence of Implementation: Resident records were reflective of the residents' current status and the care and treatment being provided. Records had no loose pages. Resident records were physically stored together in the secure nurses' offices.

All residents' records were secure, up to date, and constructed, maintained, and used in accordance with national guidelines and legislative requirements. Records were developed and maintained in a logical sequence, with no loose pages. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation.

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

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Records were retained/destroyed in accordance with legislative requirements and the policy and procedure of the approved centre. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

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

a) **The policy did not specify retention periods or procedure for destruction of records as required under 27 (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 register of residents admitted. The register contained 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 October 2017. It included all of the requirements of the *Judgement Support Framework*.

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

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

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

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

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in December 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

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

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in December 2017. The policy and procedures addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: There were no complaints since the last inspection, and therefore monitoring was not inspected against.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed, and it was detailed within the easy-to-read resident information booklet.

Resident and their representatives were facilitated to make complaints using the methods detailed in the complaints policy and procedure. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

No complaints had been received since the last inspection. A method for addressing minor complaints within the approved centre was provided. There had been no minor complaints since the last inspection.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies and guidelines in relation to risk management and incident management procedures. The clinical risk management policy was last reviewed in January 2017. The incident management reporting policy was last reviewed in January 2016.

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

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

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

Clinical risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint, mechanical restraint, resident seclusion, resident admission, resident transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, remained but were considered to be a low risk to the resident profile.

Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre and were documented in a risk register. Health and safety risks were identified, assessed, treated, reported, and monitored by the approved as required. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the multi-disciplinary team at their regular weekly meeting. A record was maintained of this review and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission, in line with the Code of Practice on the Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the 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 by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration which was displayed prominently in the corridor of House 9 Administration.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was last reviewed in March 2018. There was a separate written policy and procedures for training staff in relation to seclusion. The policies included the relevant guidance criteria of this rule pursuant to Section 69 of the Mental Health Act 2001, with the exception of ways of reducing rates of seclusion use, and areas to be addressed in training including alternatives to seclusion.

Training and Education: The approved centre maintained a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy. A record of attendance at training was maintained, and relevant staff were up-to-date in training on the use of seclusion.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission. The record was available to the inspector.

Evidence of Implementation: There were four seclusion rooms in the approved centre; House 1, House 2, House 10, and House 11 each had a seclusion room. The seclusion rooms in House 2, and House 10 had not been used since the last inspection. Seclusion rooms were not used as bedrooms. Residents in seclusion had access to adequate toilet and washing facilities, and these facilities were located opposite the seclusion room rather than within it.

Three seclusion episodes and associated clinical files were reviewed on this inspection. In all episodes, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical files. CCTV was evident in the seclusion area and clearly labelled. It was viewed only by nursing staff and the dignity of the resident was not compromised.

The seclusion room was designed with furniture and fittings which endangered resident safety, and therefore residents in seclusion had access to hazardous objects. The corner chair in the seclusion room in House 11 was refurbished with a hard seat edging which could possible result in injury to a resident. The door of two seclusion rooms had a hard surface, with edging surrounding the viewing pane. Both the door surface and hard edging could potentially be hazardous.

Residents were informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The residents were under direct observation by a registered nurse for the first hour and continuous observation thereafter. A written record of each resident was made by the nurse every 15 minutes. The resident was informed of the ending of seclusion on all occasions.

All episodes of seclusion were recorded in the resident's clinical file and all uses of seclusion were recorded in the seclusion register. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the resident's clinical file and available to inspectors.

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

a) **The seclusion policy did not include ways of reducing rates of seclusion, 10.2 (a).**
b) **The seclusion policy did not include use and areas to be addressed in training including alternatives to seclusion, 11.1 (b).**
c) **Residents in seclusion had access to hazardous objects, 4.3.**
d) **All furniture and fittings were not designed of a quality so as to not endanger patient safety, 8.3.**

Section 69: The Use of Mechanical Restraint

NON-COMPLIANT

Risk Rating **LOW**

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

INSPECTION FINDINGS

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

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

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

One resident's clinical file detailed the duration of mechanical restraint. The second resident's clinical file and associated mechanical restraint order form inspected, showed that the duration of the mechanical restraint was not recorded on the contemporaneous record.

The approved centre was non-compliant with Part 5 of the Rules Governing the Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others because in one case, the duration of the mechanical restraint order was not recorded in the clinical file and associated mechanical restraint order form, 21.5 (e).

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable during 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.

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

- The provision of physical restraint information to the resident.
- Staff who receive training in the use of physical restraint.
- Areas addressed within the training programme.
- The identification of appropriately qualified personnel to deliver training.
- The mandatory nature of training for those involved in physical restraint.
- The frequency of training.

The policy did not identify specifically who can initiate and implement physical restraint in the approved centre.

Training and Education: The approved centre maintained a written record indicating that all staff involved in physical restraint had read and understood the policy. This was provided to the Mental Health Commission (MHC) on inspection. A record of training was maintained.

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

Evidence of Implementation: The files of three residents who had been physically restrained were reviewed. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour. In all three cases, the restraint lasted for less than 30 minutes.

All three residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The resident's next of kin was informed about the physical restraint in two cases.

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

The approved centre was non-compliant with this code of practice because the policy did not identify specifically who can initiate and implement physical restraint in the approved centre, 9.2 (a).

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in January 2014, included the policy-related criteria for this code of practice with the exception of privacy, confidentiality, and consent requirements,

Transfer: The four transfer policies in place, which were last reviewed in January 2014, included the policy-related criteria for this code of practice with the exceptions of arrangements for transfer abroad, and the safety of residents and staff during the transfer process.

Discharge: The discharge policy, which was last reviewed in January 2014, included the procedure for the discharge of an involuntary patient, the roles and responsibilities of staff in providing follow up care, and a protocol for discharging people with an intellectual disability. It did not include the following:

- Prescriptions and supply of medication on discharge.
- The protocol for the discharge of homeless people.
- Relapse prevention strategies, and crisis management plans upon following up with residents who were discharged.
- When and how much follow-up contact residents should have.
- Procedures for managing discharge against medical advice.
- A protocol for discharging older persons.

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

Admission: The approved centre's admission process was compliant with the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Residents' Personal Property and Possessions, Regulation 20: Provision of Information to Residents, and Regulation 27: Maintenance of Records. It did not comply with the Regulation 15: Individual Care Plan.

The clinical file of one resident was inspected in relation to the admission process. Their admission was not on the basis of a mental health illness or mental disorder, instead their admission was on the basis of Autism Spectrum Disorder (ASD), challenging behaviour, and moderate intellectual disability. No psychiatric diagnosis was documented. The resident's family member/carer/advocate was involved in the admission process, with the resident's consent.

The decision to admit was made by the registered medical practitioner (RMP)/Consultant Psychiatrist. The admission assessment was comprehensive; and it included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information; such as work situation, education, dietary requirement. In addition, the resident was physically examined, which was part of their admission assessment. All assessments and examinations were documented within the clinical file, and the resident was assigned a key worker.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents. The clinical file of one resident who had been transferred was inspected in relation to the admission process. The resident needed specialised treatment in another facility.

The decision to transfer was made by the registered medical practitioner. The decision to transfer was agreed with the receiving facility, and was documented in the resident's clinical file. Members of the multi-disciplinary team were involved in the transfer. An assessment; including a risk assessment was completed in advance of the resident being transferred. The resident's family member/carer/advocate was involved in the transfer and this was documented.

The clinical file did not document the return of the resident's property in line with the approved centre's policy.

Discharge: The file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan (ICP). Not all aspects of the discharge process were recorded in the resident's clinical file.

A discharge meeting was documented in the resident's clinical file. A comprehensive pre-discharge assessment was completed; which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, and a comprehensive risk assessment and risk management plan.

There was appropriate multi-disciplinary team (MDT) input into discharge planning. A preliminary discharge summary was not sent to the general practitioner within three days because the resident needed to register with a GP at the time of the inspection. The family member/carer/advocate were not involved in the discharge process. A timely follow up appointment was arranged for the resident.

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

a) **The admission policy did not address privacy, confidentiality, and consent requirements, 4.18.**
b) **The transfer policy did not address arrangements for transfer abroad, 4.13,**
c) **The discharge policy did not include:**
   - the protocol for the discharge of homeless people, 4.12
   - procedures for managing discharge against medical advice, 4.15
d) **Audits had not been completed on the implementation of and adherence to the admission, and transfer policies, 4.19.**
e) **The family member/carer/advocate were not involved in the discharge process, 39.1.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan

Report reference: Page 31-32

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. Not all goals were regularly reviewed. 2. The ICP did not always specify appropriate goals for the resident.	*New*	Corrective Action(s): 1.1 All ICP's held on a six monthly basis will specify all goals that are developed to meet the individual needs of the residents. Post-Holder(s) responsible: • Key worker • CNM of the clinical area • MDT • Nurse Practice Development Coordinator • Senior management team	1.1a ICP's will be developed to reflect the individualised needs and goals of the resident 1.1b Care plan audits will be conducted to determine compliance 1.1c Audits will be conducted following ICP's	Staffing shortages are a challenge, however we will endeavour to ensure there are audits conducted yearly	6 monthly ICP meetings Annual audits
		Preventative Action(s): 2.1 Care plan audits will be conducted to determine compliance Post-Holder(s) responsible: • Key worker • CNM of the clinical area • MDT	2.1a Care plans will be audited and findings will be used to determine evidenced based practices to support the delivery of quality care for the residents		

		• Nurse Practice Development Coordinator • Senior management team	Audits will be conducted following ICP's		
3. Care and treatment required to meet goals was not consistently identified.	*New*	Corrective Action(s): 3.1 All aspects of care and treatment that is required to meet the individualised goals/needs of the resident will be consistently identified Post-Holder(s) responsible: • Key worker • CNM of the clinical area • MDT • Nurse Practice Development Coordinator • Senior management team	3.1a ICP's will be developed to reflect the individualised needs and goals of the resident to include the care and treatment 3.1b Care plan audits will be conducted to determine compliance 3.1c Audits will be conducted following ICP's	Staffing shortages are a challenge, however we will endeavour to ensure there are audits conducted yearly	6 monthly ICP meetings Annual audits
		Preventative Action(s): 3.2 Care plan audits will be conducted to determine compliance Post-Holder(s) responsible: • Key worker • CNM of the clinical area • MDT • Nurse Practice Development Coordinator • Senior management team	3.2a Care plans will be audited and findings will be used to determine evidenced based practices to support the delivery of quality care for the residents Audits will be conducted following ICP's		

Regulation 16: Therapeutic Services and Programmes

Report reference: Page 33 & 34

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. The approved centre did not ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.	*New*	Corrective Action(s): 1.1 Each resident will have access to appropriate therapeutic services and programmes that are identified in their individual care plan Post-Holder(s) responsible: • Key worker • CNM of the clinical area • MDT • Nurse Practice Development Coordinator • Senior management team • Service Manager	1.1a Schedules will be revised and drawn up to demonstrate that residents have access to appropriate therapeutic services and programmes 1.1b An Assessments of need for each resident will be conducted. This will determine access to appropriate range of therapeutic services and programmes that reflect the individualised needs of the resident and this will be documented in the residents care plan 1.1c Records of attendance of services will be documented 1.1d Audits will be conducted to determine compliance with regulation 16	Lack of resources capacity to provide access to appropriate therapeutic services and programmes for the resident	Schedule will be revised November 30th 2018 Care plans will be reviewed by key worker on a three monthly basis ICP's will be reviewed by the MDT on a six monthly basis Audits of residents care plans/ attendance records /schedules will be conducted annually
		Preventative Action(s): 1.2 An Assessments of need for each resident will be conducted to determine access to appropriate range of therapeutic services and programmes that reflect the			

		individualised needs of the resident and this will be documented in the residents care plan 1.3 Schedules will be revised and drawn up to demonstrate that residents have access to appropriate therapeutic services and programmes Post-Holder(s) responsible: • Key worker • CNM of the clinical area • MDT • Nurse Practice Development Coordinator • Senior management team • Service manager	Audits will be conducted to determine compliance with regulation 16		Audits of residents care plans/ attendance records /schedules will be conducted annually
2. The approved centre did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning for all residents.	New	Corrective Action(s): 2.1 An Assessments of need for each resident will be conducted to determine access to appropriate range of therapeutic services and programmes that reflect the individualised needs of the resident cognisant of restoring and maintaining optimal levels of physical and psychosocial functioning of all residents Post-Holder(s) responsible: • Key worker • CNM of the clinical area • MDT • Nurse Practice Development Coordinator	2.1a Resident Care plans will reflect the individualised needs of the residents in receiving therapeutic services and programmes and these will be aimed at promoting the restoration and maintenance of physical and psychosocial functioning at optimal levels	Staffing shortages/ redeployment may impinge on conducting accurate assessments of needs	December 2018

		• Senior management team • Service manager			
		Preventative Action(s): 2.2 An audit will be conducted of the therapeutic services and programmes to determine if they are directed towards restoring and maintaining optimal levels of physical and psychosocial functioning for all residents Post-Holder(s) responsible: Nurse Practice Development Coordinator			Audits of residents care plans/ attendance records /schedules will be conducted annually

Regulation 19: General Health

Report reference: Page 36 & 37

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. The approved centre failed to ensure that the physical examinations, fulfilled specified criteria including Body Mass Index, waist circumference, nutritional status (diet and physical activity, including sedentary lifestyle), and dental health. For residents on antipsychotic medication it did not detail or evidence an electrocardiogram taking place. 19 (1) (b).	*New*	Corrective Action(s): 3.1 Physical examinations are conducted on a six monthly basis. An assessment will be conducted to determine what residents did not have a complete physical examination in line with regulation 19 and this will be conducted Post-Holder(s) responsible: • Consultant Psychiatrist • General Practitioner	3.1a All residents will have a complete physical examination completed and documented in their clinical file to include - Body Mass Index, waist circumference, nutritional status (diet and physical activity, including sedentary lifestyle), and dental health. For residents on antipsychotic medication an electrocardiogram will take place. 19 (1) (b).		December 2018
		Preventative Action(s): 3.2 An audit will be conducted to determine compliance with regulation 19 A schedule of physical examinations to be conducted Post-Holder(s) responsible: • Nurse Practice Development Coordinator • Consultant Psychiatrist • General Practitioner			

Regulation 22: Premises

Report reference: Page 41 & 42

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
4. St. Clare's Ward and Hillview Ward premises were not maintained in good decorative condition, 22(1)(a).	*Reoccurring*	Corrective Action(s): There is an reactive maintenance programme in place Post-Holder(s) responsible: Estates management/CNM	Maintenance log books in each area. Maintenance records of works completed. Records of service contracts conducted	Achievable Achievable Achievable	On-going In place In place
		Preventative Action(s): Processes involved to communicate with maintenance and contact details when maintenance requests are necessary • Phone calls • Emails • Out of office hours • Reactive maintenance response There is a comprehensive list of Services contracts (e.g. heating/plumbing/etc) used by maintenance There is a list of clinical equipment service contractors (hoists/ beds/ BP machines/ medical equipment.	Records of maintenance carried out Records of Procurement available Records with Stores department	Achievable Achievable	

		Post-Holder(s) responsible: Estates Management / CNM / Procurement			
5. There was no programme of routine maintenance, 22(1)(c).	*Reoccurring*	Corrective Action(s): There is an reactive maintenance programme in place Post-Holder(s) responsible: Estates management/CNM	Maintenance log books in each area. Maintenance records of works completed. Records of service contracts conducted	Achievable Achievable Achievable	On-going In place In place
		Preventative Action(s): Processes involved to communicate with maintenance and contact details when maintenance requests are necessary • Phone calls • Emails • Out of office hours • Reactive maintenance response There is a comprehensive list of Services contracts (e.g. heating/plumbing/etc) used by maintenance There is a list of clinical equipment service contractors (hoists/ beds/ BP machines/ medical equipment. Post-Holder(s) responsible:	Records of maintenance carried out Records of Procurement available Records with Stores department	Achievable Achievable	

		Estates Management / CNM / Procurement			
6. Bedroom furnishings in some wards were not suitable for the needs of residents, 22(2).	*Reoccurring*	Corrective Action(s): There is a procurement process in place Post-Holder(s) responsible: CNM / Procurement	Records of Procurement	Achievable	In Place
		Preventative Action(s): There is a list of clinical equipment service contractors (hoists/ beds/ BP machines/ medical equipment. Post-Holder(s) responsible: CNM / Procurement			

Regulation 26: Staffing

Report reference: Page 47 – 50

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
7. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, and Children First, 26(4). 8. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).	*Reoccurring*	Corrective Action(s): 7.1 Mandatory training is provided to all nursing staff Post-Holder(s) responsible: • Director of Nursing • Service Manager • Senior management team • Nurse Practice Development Coordinator	7.1a/8.1a training trackers are maintained of all nursing staff who receive training and a number of mandatory training sessions have been held and a programme is in place to monitor this.	Staffing shortages prevents staff attendance at training Not enough instructors (internal or external) to conduct some of the training Funding/ training for non-nursing staff	Ongoing
		Preventative Action(s): 8.1 Ensuring all staff complete their training Post-Holder(s) responsible: • CNM • ADON • Line managers • Director of Nursing • Service Manager • Senior Management team • Nurse Practice Development coordinator			

Regulation 27: Maintenance of records

Report reference: Page 51 & 52

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
9. The policy did not specify retention periods or procedure for destruction of records as required under 27 (2).	Reoccurring	Corrective Action(s): 9.1 Policy will be amended to reflect retention and destruction Post-Holder(s) responsible: Nurse Practice Development Coordinator	9.1a Policy review group will meet to develop the policy and audit it against Regulation 27		November 2018
		Preventative Action(s): 9.2 Annual audit of policies will be conducted to determine compliance with this regulation Post-Holder(s) responsible: Nurse Practice Development Coordinator	9.2a Annual audits of policy for compliance	Staffing shortages may determine if audits are conducted	Annually

Rule: The Use of Seclusion

Report reference: Page 63 & 64

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
10. The seclusion policy did not include ways of reducing rates of seclusion, 10.2 (a). 11. The seclusion policy did not include use and areas to be addressed in training including alternatives to seclusion, 11.1 (b).	*Reoccurring*	Corrective Action(s): 10.1 Policy is amended to reflect this Post-Holder(s) responsible: Nurse Practice Development Coordinator			Completed
		Preventative Action(s): 11.1 Annual audit of policies will be conducted to determine compliance with this regulation Post-Holder(s) responsible: Nurse Practice Development Coordinator			Annually
12. Residents in seclusion had access to hazardous objects, 4.3. 13. All furniture and fittings were not designed of a quality so as to not endanger patient safety, 8.3.	*New*	Corrective Action(s): 12.1 Staff will ensure that residents have no access to hazardous objects in seclusion room 12.2 Risk assessment of all furniture and fittings is conducted to determine patient safety in seclusion room 12.3 Furniture and fittings that are determined to compromise the safety of the resident and will be	Audits will be conducted and finding presented to determine compliance Records of maintenance of works carried out NIMS	Lack of resources	December 2018

		replaced with furniture and fittings that are designed to protect the resident while in seclusion Post-Holder(s) responsible: • All frontline staff/CNM/ADON • Director of Nursing • Service Manager • Senior management team			
		Preventative Action(s): walk about audits will be conducted Risk assessments are conducted to determine non compliance Post-Holder(s) responsible: • Director of Nursing • Service Manager			

Rule: The Use of Mechanical Restraint

Report reference: Page 65

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
14. In one case, the duration of the mechanical restraint order was not recorded in the clinical file and associated mechanical restraint order form, 21.5(e).	New	Corrective Action(s): 14.1 All incidents of mechanical restraint will be recorded in the residents clinical files and associated mechanical restraint forms Post-Holder(s) responsible: Clinical Director	14.1a Documentation in the residents clinical file		Immediate
		Preventative Action(s): 14.2 Review on the use of mechanical means of bodily restraints in the approved centre Post-Holder(s) responsible: Clinical Director	14.2b Audits conducted to determine compliance		Annually

Codes of Practice: Use of Physical Restraint

Report reference: Page 68

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
15. The policy did not identify specifically who can initiate and implement physical restraint in the approved centre, 9.2(a).	*Reoccurring*	Corrective Action(s): 15.1 Policy is amended to reflect this Post-Holder(s) responsible: Nurse Practice Development Coordinator			Completed
		Preventative Action(s): 15.2 Annual audit of policies will be conducted to determine compliance with this regulation Post-Holder(s) responsible: Nurse Practice Development Coordinator			Annually

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 69 & 70

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
16. The admission policy did not address privacy, confidentiality, and consent requirements, 4.18.	*Reoccurring*	Corrective Action(s): 16.1 Policy will be amended to reflect 4.18 Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	16.1a Policy review group will meet to develop the policy and audit it against the Code of Practice: Admission, Transfer and Discharge	Staffing shortages may determine if Policy Review groups meet	November 30th 2018
		Preventative Action(s): 16.2 Annual audit of policies will be conducted to determine compliance with this regulation Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	16.2a Annual audits of policy for compliance	Staffing shortages may determine if Policy audit group conducts the audit	Annually
17. The transfer policy did not address arrangements for transfer abroad, 4.13,	*Reoccurring*	Corrective Action(s): 17.1 Policy will be amended to reflect 4.13 Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	17.1a Policy review group will meet to develop the policy and audit it against the Code of Practice: Admission, Transfer and Discharge	Staffing shortages may determine if Policy Review groups meet	November 30th 2018
		Preventative Action(s): 17.2 Annual audit of policies will be conducted to determine compliance with this regulation	17.2a Annual audits of policy for compliance	Staffing shortages may determine if	Annually

		Post-Holder(s) responsible: Nurse Practice Development Co-ordinator		Policy audit group conducts the audit	
18. The discharge policy did not include: - the protocol for the discharge of homeless people, 4.12 - procedures for managing discharge against medical advice, 4.15	*Reoccurring*	Corrective Action(s): 18.1 Policy will be amended to reflect 4.12, 4.15 Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	18.1a Policy review group will meet to develop the policy and audit it against the Code of Practice: Admission, Transfer and Discharge	Staffing shortages may determine if Policy Review groups meet	November 30th 2018
		Preventative Action(s): 18.2 Annual audit of policies will be conducted to determine compliance with this regulation Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	18.2a Annual audits of policy for compliance	Staffing shortages may determine if Policy audit group conducts the audit	Annually
19. Audits had not been completed on the implementation of and adherence to the admission, and transfer policies, 4.19	*New*	Corrective Action(s): 19.1 Policy will be audited to determine compliance regarding the implementation and adherence to this policy 4.19 Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	19.1a Policy review group will meet to develop the policy and audit it against the Code of Practice: Admission, Transfer and Discharge	Staffing shortages may determine if Policy Review groups meet	November 30th 2018

		Preventative Action(s): 19.2 Annual audit of policies will be conducted to determine compliance with this regulation Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	19.2a Annual audits of policy for compliance	Staffing shortages may determine if Policy audit group conducts the audit	Annually
20. The family member/carer/advocate were not involved in the discharge process, 39.1.	*Reoccurring*	Corrective Action(s): 20.1 Policy will be amended to reflect 39.1 Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	20.1a Policy review group will meet to develop the policy and audit it against the Code of Practice: Admission, Transfer and Discharge	Staffing shortages may determine if Policy Review groups meet	November 30th 2018
		Preventative Action(s): 20.2 Annual audit of policies will be conducted to determine compliance with this regulation Post-Holder(s) responsible: Nurse Practice Development Co-ordinator	20.2a Annual audits of policy for compliance	Staffing shortages may determine if Policy audit group conducts the audit	Annually