

# Selskar House, Farnogue Residential Healthcare Unit

**ID Number:** AC0092

## 2018 Approved Centre Inspection Report (Mental Health Act 2001)

Selskar House, Farnogue Residential Healthcare Unit  
Old Hospital Road  
Wexford

**Approved Centre Type:**  
Psychiatry of Later Life

**Most Recent Registration Date:**  
2 May 2016

**Conditions Attached:**  
None

**Registered Proprietor:**  
HSE

**Registered Proprietor Nominee:**  
Mr David Heffernan, General Manager,  
CHOS Mental Health Services

**Inspection Team:**  
Noeleen Byrne, Lead Inspector  
Siobhán Dinan  
Karen McCrohan

**Inspection Date:**  
29 May – 1 June 2018

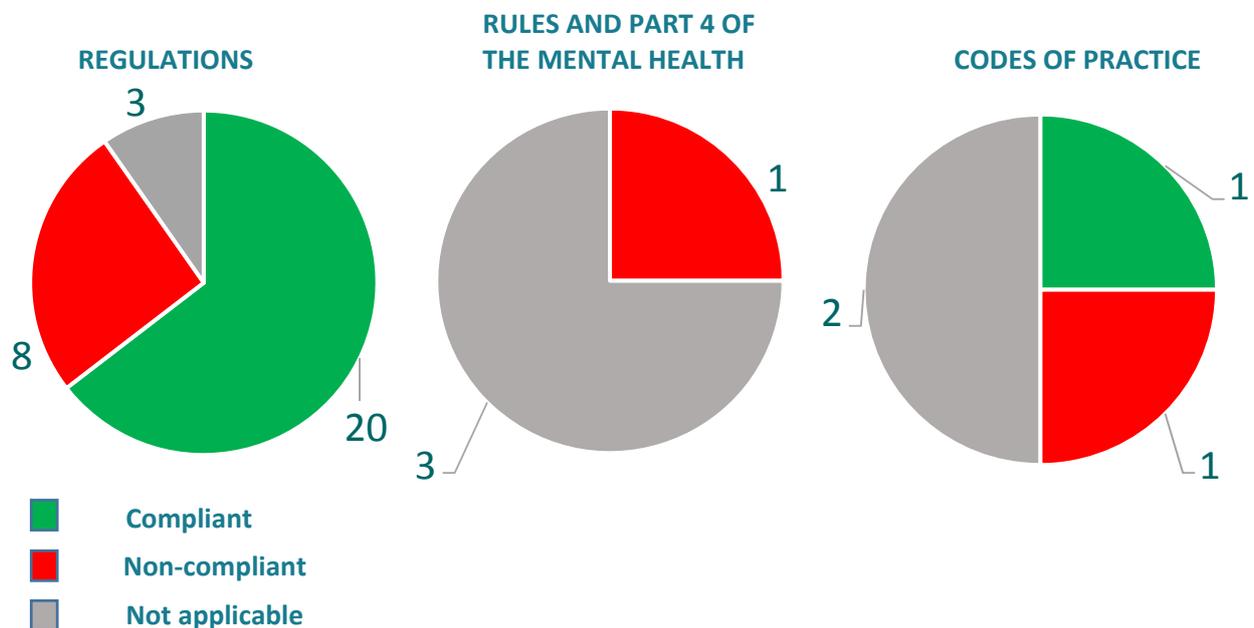
**Previous Inspection Date:**  
8 – 11 August 2017

**Inspection Type:**  
Unannounced Annual Inspection

**The Inspector of Mental Health Services:**  
Dr Susan Finnerty MCRN009711

**Date of Publication:**  
15 November 2018

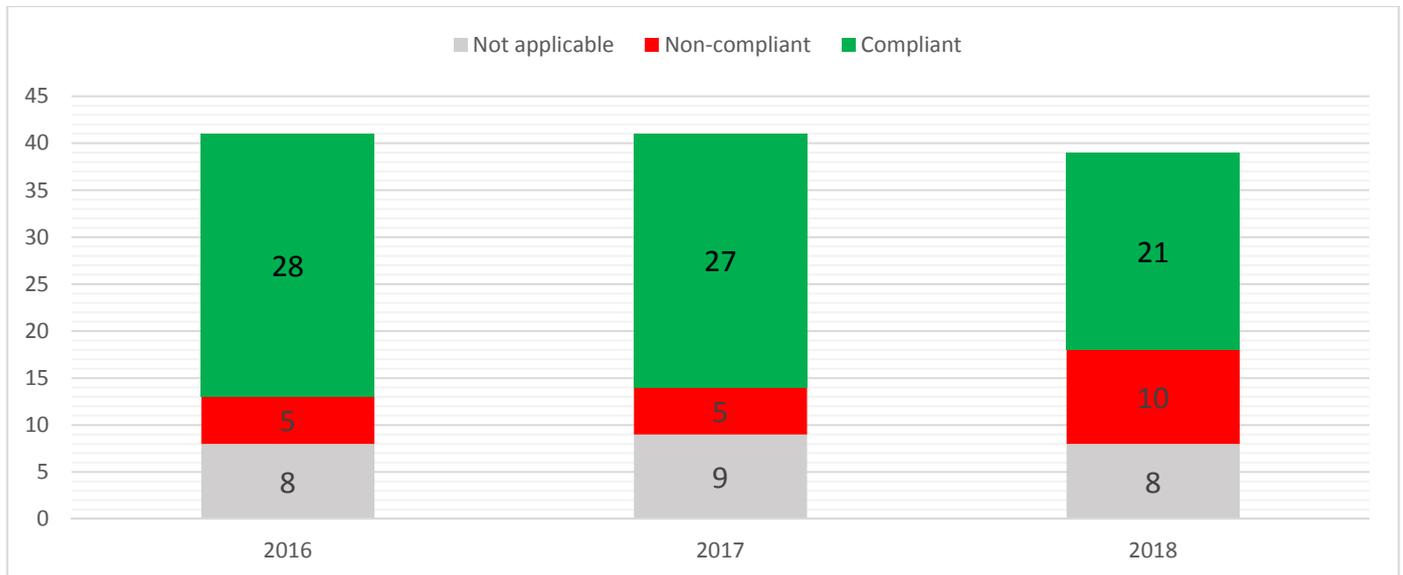
## 2018 COMPLIANCE RATINGS



## RATINGS SUMMARY 2016 – 2018

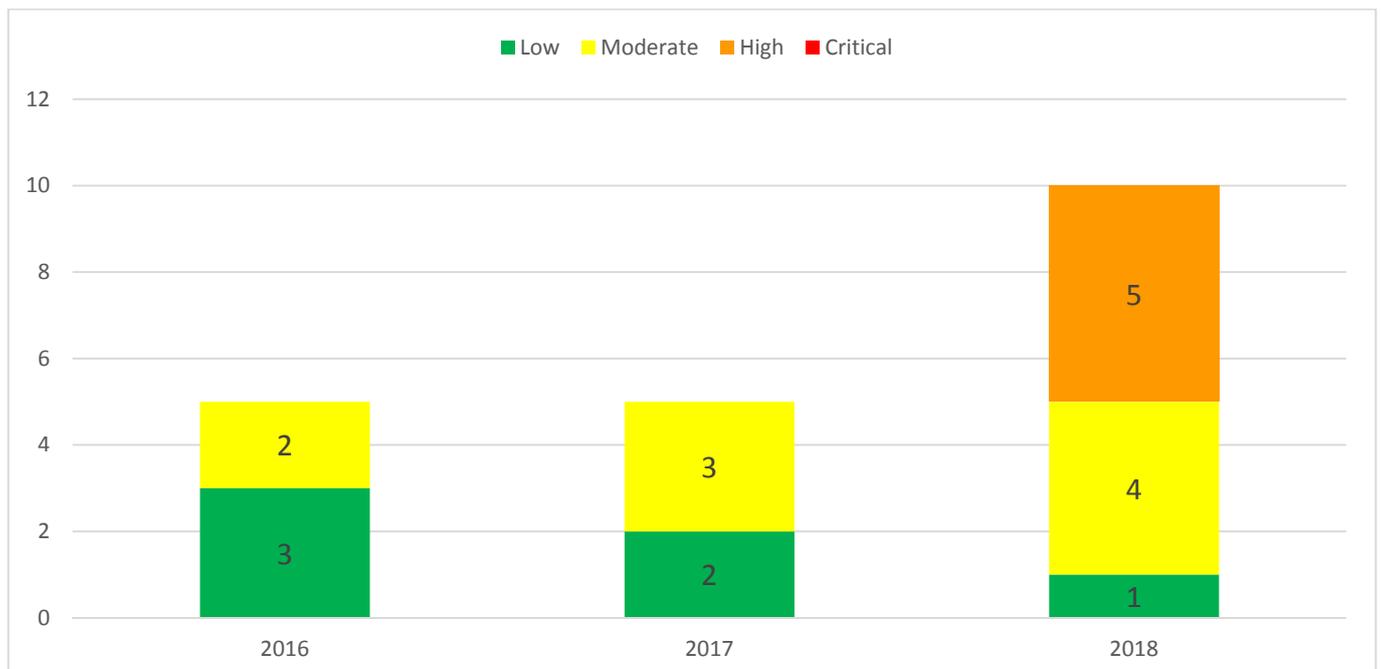
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

**Chart 1 – Comparison of overall compliance ratings 2016 – 2018**



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

**Chart 2 – Comparison of overall risk ratings 2016 – 2018**



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# 1.0 Introduction to the Inspection Process

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

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

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

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

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

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

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

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

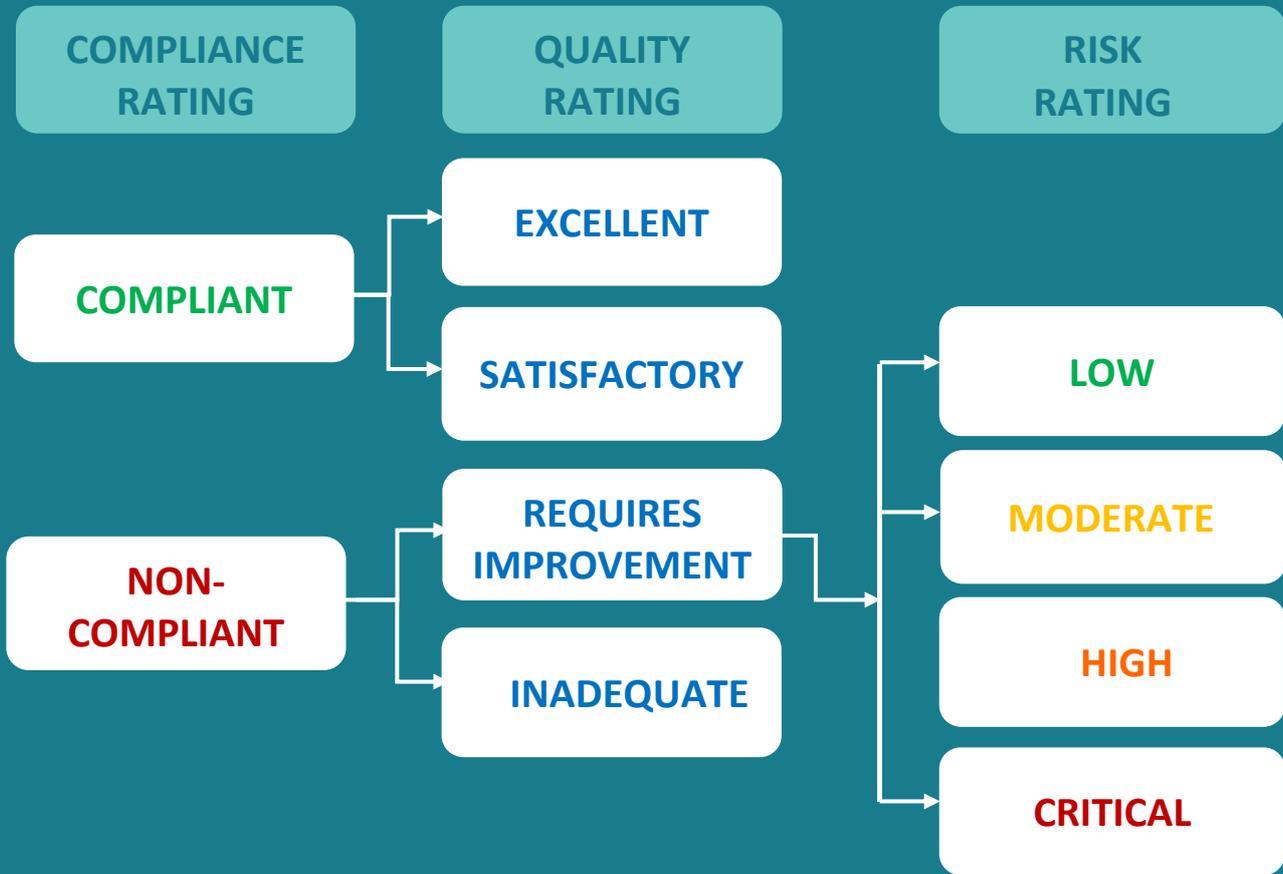
## COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

**COMPLIANCE RATINGS** are given for all areas inspected.

**QUALITY RATINGS** are generally given for all regulations, except for 28, 33 and 34.

**RISK RATINGS** are given for any area that is deemed non-compliant.



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

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

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

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

## 2.0 Inspector of Mental Health Services – Review of Findings

### Inspector of Mental Health Services

Dr Susan Finnerty

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

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

### In brief

Selskar House was a 20-bed unit for residents with mental illness and dementia, which was situated near Wexford General Hospital. The approved centre was built in 2013, and Selskar House occupied the ground floor of the modern, purpose-built facility, which was spacious and bright. It was under the care of a psychiatrist for later life.

There had been reduced compliance in Regulations, Rules and Codes of Practice from 85% in 2016 to 68% in 2018. Two compliances with Regulations were rated excellent.

### Safety in the approved centre

Food safety audits were carried out periodically and kitchen and food areas were clean. Residents had appropriate identifiers for administration of medication and health care. There were a significant number of deficits in the prescription of medication. Ordering, storing and administration of medication was satisfactory.

The management of risk was satisfactory and the risk management policy was comprehensive. Minimisation of ligature points throughout the approved centre had been implemented and a ligature audit had been completed. Not all staff were up to date with fire safety, management of violence and aggression, Basic Life Support and the Mental Health Act training.

### Appropriate care and treatment of residents

A small number of Individual Care Plans (ICPs) contained a number of deficits: An ICP not reviewed by the resident's MDT within six months; treatment and care required for an identified mental health need and goal not outlined; resources not identified for an identified mental health need and goal; and one ICP was not discussed, agreed and drawn up with the participation of the resident. The Pool Activity Level (PAL) assessment tool had been introduced in the approved centre to assess all residents' engagement needs and interests. A Therapeutic Programme committee met bi-weekly to plan and evaluate the therapeutic programme. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes.

The six-monthly general health assessment of two residents did not document the following: family/personal history, BMI, weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health. For residents on antipsychotic medication, there was no annual assessment of ECG or prolactin. Residents had access to a dietician and physiotherapist at a local community care centre through referral.

End of Life care was carried out with respect for residents' privacy and dignity and spiritual, psychological and physical needs were met.

The discharge process was not satisfactory and risked the lack of appropriate treatment post-discharge for residents.

### **Respect for residents' privacy, dignity and autonomy**

Residents were restricted from leaving the approved centre and the entrance door was locked. This was to ensure the safety of residents who have cognitive impairment. This restrictive practice was also imposed on residents who did not have cognitive impairment. Residents wore their own clothing and had storage facilities. Residents' finances were handled appropriately.

A resident's diagnosis was displayed on a sign on their bedroom door, which was a serious breach of confidentiality. Clinical files were not maintained in good order and had several loose pages which risked a breach of confidentiality.

The review date in one episode of the use of mechanical restraint was overdue, but the resident continued to be mechanically restrained. The approved centre met all of the set criteria in terms of the appropriate use of Physical Restraint. The medication policy continued to outline that medication could be given to a patient who was unwilling to consent, despite this provision having been removed from the Mental Health Act in 2015.

### **Responsiveness to residents' needs**

There was a good choice of food at mealtimes and modified diets were attractively presented. Nutritional assessments were completed and healthy food provided. Residents could communicate freely by mail, mobile phone and the internet. Residents were free to practice their religion and there was access to multi-faith chaplains.

There was an information leaflet for residents but this contained insufficient information. Residents were not provided with suitable verbal and written information on diagnosis, medication or relevant advocacy and voluntary agencies.

Premises were not maintained in good structural and decorative condition, nor were they adequately ventilated. They were, however, clean.

### **Governance of the approved centre**

The approved centre was governed by Wexford/Waterford Mental Health Services. It was part of Community Healthcare Organisation (CHO) 5, which included Wexford/Waterford and South Tipperary, Carlow and

Kilkenny Mental Health Services. The consultant psychiatrist in Selskar House chaired a business meeting once a month.

The inspection team sought to meet with heads of discipline during the inspection. The Principal Psychologist and the Occupational Therapist Manager were unable to meet the inspection team, which was disappointing. There was no appointed Principal Social Worker at the time of the inspection. The consultant psychiatrist of later life was based in the approved centre and was on-site most days. Clear lines of responsibility were evident in both departments, with heads of discipline attending regular meetings with staff and both departments providing supervision to their staff. The operational risks identified were maintaining safe levels of staff, filling vacant posts and responding to the high demand for beds in the area.

## 3.0 Quality Initiatives

**The following quality initiatives were identified on this inspection:**

1. Dementia friendly signage was introduced to assist those living with dementia to navigate and find key areas.
2. As part of wound management vigilance, weekly head to toe skin assessments were carried out.
3. Imagination exercises were introduced through an imagination gym. These exercises are audio based and designed to stimulate the listener in multiple ways.
4. Two community employment workers provided daily therapeutic activities including Sonas, a therapeutic programme for people with dementia.
5. An annual audit programme had been put in place and members of the multi-disciplinary team (MDT) have taken responsibility for the completion of audits.

## 4.0 Overview of the Approved Centre

### 4.1 Description of approved centre

Selskar House was situated on the Old Hospital Road, behind Wexford General Hospital. The approved centre was built in 2013, and Selskar House occupied the ground floor of the modern, purpose-built facility. Selskar House accommodated 20 residents in single rooms with en suite bathroom facilities. There were no involuntary patients, none of the residents were on approved leave, and there were no wards of court.

The approved centre was spacious and bright. A courtyard area was used by residents throughout the day. There was a television and sitting room and a small resident dining area. There were two nursing stations and a clinical room. There was a suitable space for recreational activities at an unused nurses' station. This space was appropriate to the needs of the residents.

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

Resident Profile	
<i>Number of registered beds</i>	<b>20</b>
<b>Total number of residents</b>	<b>20</b>
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	18
Number of patients on Section 26 leave for more than 2 weeks	0

### 4.2 Conditions to registration

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

### 4.3 Reporting on the National Clinical Guidelines

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

### 4.4 Governance

The approved centre was governed by Wexford/Waterford Mental Health Services. It was part of Community Healthcare Organisation (CHO) 5, which included Wexford/Waterford and South Tipperary, Carlow and Kilkenny Mental Health Services. The Wexford and Waterford services shared the same governance structures and had adopted the same policies and procedures where appropriate.

The Consultant Psychiatrist in Selskar House chaired a business meeting once a month. Agenda items included maintenance of the approved centre, corrective actions, and challenges for the approved centre.

Minutes of the monthly executive management team meetings were available to the inspection team. The minutes included discussions in relation to budget and finance, capital development, and priority staffing posts.

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

- Area Director of Nursing
- Clinical Director
- Area lead for mental health engagement

The Principal Psychologist and the Occupational Therapist Manager were unable to meet the inspection team. There was no appointed Principal Social Worker at the time of the inspection.

Heads of discipline from medical and nursing provided an overview of the governance within their respective departments. The Clinical Director was newly appointed to the role and had not visited the approved centre often. The Consultant Psychiatrist of Old Age was based in the approved centre and was on-site most days. The Area Director of Nursing visited the approved centre monthly. Clear lines of responsibility were evident in both departments, with heads of discipline attending regular meetings with staff and both departments providing supervision to their staff. The operational risks identified were maintaining safe levels of staff, filling vacant posts and responding to the high demand for beds in the area. The Area Lead for Mental Health Engagement outlined the process to set up forums for service users and their families. The forum planned for Wexford was not yet set up.

## 4.5 Use of restrictive practices

Residents were restricted from leaving the approved centre and the entrance door was locked. This was to ensure the safety of residents who have cognitive impairment. This restrictive practice was also imposed on residents who did not have cognitive impairment. Staff and relatives accompanied residents outside the approved centre.

# 5.0 Compliance

## 5.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) 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	✓		✓		X	High
Regulation 19: General Health	✓		✓		X	High
Regulation 20: Provision of Information to Residents	✓		✓		X	Moderate
Regulation 21: Privacy	✓		✓		X	Low
Regulation 22: Premises	✓		✓		X	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicine	✓		✓		X	High
Regulation 26: Staffing	X	Moderate	X	Moderate	X	High
Regulation 27: Maintenance of Records	X	Low	✓		X	Moderate
Rules Governing the Use of Mechanical Means of Bodily Restraint	✓		X	Moderate	X	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	X	Low	X	Moderate	X	High

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

## 5.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 12: Communication

## 5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice 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.
- The area lead from the HSE Mental Health Engagement Office was contacted.

With the residents' permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

The resident profile in the approved centre was primarily a population of residents in later life with a diagnosis of dementia. Family members of two residents chose to speak to the inspection team. Two service user experience questionnaires were returned by family members. All were satisfied with the care and treatment received by their relatives. The families praised the dignity and respect shown towards their relatives by the staff, and they highlighted the caring nature of the staff. In addition, one resident met with the inspection team and discussed the experience of their stay in the approved centre.

## 7.0 Feedback Meeting

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

- Registered Proprietor
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Head of Service
- Social Work Team Lead
- Clinical Nurse Manager
- Area Lead Mental Health Engagement
- Deputy Manager
- Consultant Psychiatrist
- Occupational Therapist
- Risk Manager
- Assistant Director of Nursing

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

## 8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation

Regulation 2: Commencement and Regulation

Regulation 3: Definitions

## Regulation 4: Identification of Residents

**COMPLIANT**

Quality Rating

Excellent

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the identification of residents, which was last reviewed in April 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 identifying residents, as set out in the policy.

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

**Evidence of Implementation:** At least two of the following resident identifiers were used in the approved centre: photograph, name, date of birth, and hospital number. Two appropriate resident identifiers were used before administering medications, medical investigations and providing other healthcare services. Identifiers used were person specific. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. The use of appropriate identifiers and alerts were used for the same and similar named residents in the form of an alert sticker.

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

## Regulation 5: Food and Nutrition

**COMPLIANT**

Quality Rating

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 July 2015. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for monitoring residents' food and water intake.

**Training and Education:** Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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:** Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Hot and cold drinks were offered to residents regularly. An evidence-based nutrition assessment tool was not used. However, the unit had a plan to introduce an evidence-based nutrition assessment tool. The four-week menu was difficult to read as it was displayed on top of the kitchen door. However, staff reported that they would inform the residents of what was on the menu and would ask for their preference, where possible.

The catering manager reported that resident meal preferences could also be accommodated for, once given adequate notice. Weight charts were implemented, monitored, and acted upon for residents on a monthly basis. As required, and with the residents' consent, family were invited to the six monthly Multi-Disciplinary Team (MDT) meeting. Residents could be referred to a Dietitian as required. Residents had access to a Speech and Language Therapist (SALT).

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

## Regulation 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 March 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the management of catering and food safety equipment.

**Training and Education:** Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. Not 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 not recorded in line with food safety recommendations. A food temperature log sheet was not maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

**Evidence of Implementation:** There was suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. It was noted that staff did not have proper facilities to make themselves tea or coffee. As a result, they utilized the main kitchen. The catering manager reported that this would be against best practice. The staff's fridge was also kept in the residents' dining area.

Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

## Regulation 7: Clothing

**COMPLIANT**

Quality Rating

Satisfactory

The registered proprietor shall ensure that:

- (1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
- (2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to residents' clothing, which was last reviewed in April 2018. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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. This was documented. No residents were prescribed night attire at the time of inspection.

**Evidence of Implementation:** Residents were provided with emergency personal clothing that was appropriate to the resident and considered the residents' preferences, dignity, bodily integrity, and religious and cultural practices. This was kept in the linen room. Residents changed out of night clothes during day time hours unless specified in the resident's individual care plan. All residents had an adequate supply of individualised clothing. Each resident had a large wardrobe and a bedside locker to store their clothing and belongings in.

**The approved centre was compliant with this regulation. The quality assessment was rated as 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 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 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 residents' personal property and possessions, as set out in the policy.

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

**Evidence of Implementation:** A safe was available in the clinical nurse manager's office in the approved centre for the storage of small amounts of money. Valuables could be managed by residents in their single rooms, which were locked during the day. All residents' clinical files inspected contained property checklists detailing each resident's personal property and possessions. These were recorded on admission. The property book was kept separate to the resident's individual care plan. Residents were supported to manage their own property, unless this poses a danger to the resident or others, as indicated in their individual care plan.

The access to and use of resident monies was not always overseen by two members of staff and the resident and their representative. Cash logs were reviewed and expenditures were not always signed by two staff members.

**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 of implementation pillar.**

## Regulation 9: Recreational Activities

**COMPLIANT**

Quality Rating

Satisfactory

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 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 uptake and attendance. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.

**Evidence of Implementation:** The approved centre provided access to recreational activities appropriate to the resident group profile. Two individuals on a Community Employment (CE) scheme facilitated recreational activities in the approved centre, including movies, TV, art and crafts, dancing, jigsaws, puzzles, music, and hand massage. Residents also had access to books and magazines. The approved centre provided access to recreational activities on weekdays and during the weekend.

Information was not provided to residents in an accessible format. No activity schedule was available. The information provided did not include the types and frequency of appropriate recreational activities available within the approved centre.

Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities, particularly in relation to outdoor activities. Opportunities were provided for indoor and outdoor exercise and physical activity. Residents were facilitated to walk in the internal courtyard garden. Two other outdoor areas were available to residents but these were not used often. Communal areas were provided that were suitable for recreational activities, including a dayroom and a sunroom.

**The approved centre was compliant with this regulation. The quality assessment was rated as 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, which was last reviewed in May 2016. The policy included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 are facilitated within the approved centre insofar as is practicable. Any specific religious requirements were identified on admission and any additional requirements were included in the Individual Care Plan (ICP). There were facilities provided within the approved centre for residents' religious practices, insofar as was practicable. Residents had access to multi-faith chaplains. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. Care and services that were provided within the approved centre were respectful to the residents' religious beliefs and values. The residents were facilitated to observe or abstain from religious practice in accordance with his/her wishes.

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

## 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 September 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the required identification methods.

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

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

**Evidence of Implementation:** Visiting times were publicly displayed. Visiting times were appropriate and reasonable. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or to others. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting room or visiting area was suitable for visiting children.

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

## Regulation 12: Communication

**COMPLIANT**

Quality Rating

Excellent

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written operational policy in relation to resident communication. 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 communication, as set out in the policy.

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

**Evidence of Implementation:** Residents had access to mail, fax, e-mail, internet (where available), telephone, or any device for the sending or receiving of messages. There was no public phone box on the unit but a portable phone was available at the nurse's station.

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

## Regulation 13: Searches

COMPLIANT

- (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 May 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. Relevant staff interviewed 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 and protocols in relation to care of the dying. The policy was last reviewed in July 2015. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

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

**Monitoring:** End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. There had been no sudden or unexpected deaths in the approved centre since the last inspection. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

**Evidence of Implementation:** One expected death had occurred in the approved centre since the last inspection. This clinical file was inspected. An end of life care plan was in place for the resident that was dying. End of life care was appropriate to the residents' physical emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, insofar as is practicable. Last rights were given to the resident before their death.

The privacy and dignity of the resident was protected. The resident was nursed in a single room during the provision of end of life care. Representatives, family, next-of-kin and friends were involved, supported and accommodated during end of life care. The resident's family, next-of-kin and friends were accommodated and offered supports following their loved one's death. Notification of the resident's death was sent to the Mental Health Commission within 48 hours.

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

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

**Training and Education:** All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. All multi-disciplinary team (MDT) members had received training in individual care planning.

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

**Evidence of Implementation:** The ICPs inspected were a composite set of documents. Ten ICP's were inspected and all specified appropriate goals. One ICP did not specify the care and treatment required to meet the goals identified. In addition, one ICP did not identify the resources required to provide the care and treatment identified. In one ICP inspected there was no documentary evidence that the ICP was discussed, agreed and drawn up with the participation of the resident or family member/next of kin. One ICP was not reviewed by the resident's MDT within six months and in consultation with the resident. Residents had access to their ICP's in the approved centre, including any reviews. This was documented.

ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. The ICPs were developed by the MDT following a comprehensive assessment, within seven days of admission.

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

- a) One ICP was not reviewed by the resident's MDT within six months.
- b) One ICP did not specify the treatment and care required for an identified mental health need and goal.
- c) One ICP did not identify the resources for an identified mental health need and goal.
- d) One ICP was not discussed, agreed where practical and drawn up with the participation of the resident.

## Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

Quality Rating

Satisfactory

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

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

### INSPECTION FINDINGS

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

- The planning and provision of therapeutic services and programmes within the approved centre.
- The provision of therapeutic services and programmes by external providers in external locations.

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

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

**Evidence of Implementation:** The Pool Activity Level (PAL) assessment tool had been introduced in the approved centre to assess all residents' engagement needs and interests. This new initiative resulted in the reference to therapeutic programmes in the residents' ICPs. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Residents had access to a dietitian and physiotherapist at a local community care centre through referral.

Community employment scheme staff facilitated a Sonas Programme and the Occupational Therapist (OT) facilitated an "Imagination Gym Class", which was an eight-week programme. There were plans to introduce a sculpture, horticulture, and music programme for the residents. The Therapeutic Programme committee met bi-weekly to plan and evaluate the therapeutic programme. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes.

No list of all therapeutic services and programmes provided in the approved centre was available to residents or their families.

**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 18: Transfer of Residents

**COMPLIANT**

Quality Rating

Satisfactory

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the transfer of residents. The policy was last reviewed in May 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 the transfer of residents, as set out in the policy.

**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 been completed to identify opportunities for improving the provision of information during transfers.

**Evidence of Implementation:** Full and complete written information for the resident was documented when he or she was transferred from the approved centre to another facility. Information was sent in advance or accompanied the resident upon transfer, to a named individual. Nursing staff reported that the medication prescription and administration record (MPAR) and clinical file also accompanied the resident.

A letter of referral, including a list of current medications, and the resident transfer form were issued (with copies retained) as part of the transfer documentation. A transfer form indicated that consent to transfer was given and the resident's next of kin was informed. However, there was no documentary evidence of a capacity assessment within the clinical file. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility, and the checklist was within the transfer form. Copies of all records relevant to the resident transfer were retained in the resident's clinical file.

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

## Regulation 19: General Health

**NON-COMPLIANT**

Quality Rating

Requires Improvement

Risk Rating

HIGH

(1) The registered proprietor shall ensure that:

- (a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
- (b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
- (c) each resident has access to national screening programmes where available and applicable to the resident.

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

### INSPECTION FINDINGS

**Processes:** The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in May 2018, and the medical emergencies policy was last reviewed in May 2018. The policies and procedures addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.

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

**Monitoring:** Residents' take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

**Evidence of Implementation:** The approved centre did not have an emergency trolley but did have an Automated External Defibrillator (AED). Registered medical practitioners assessed residents' general health needs on admission and on an ongoing basis as part of the approved centre's provision of care. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs and every six months.

The minimum six-monthly general assessment of two residents did not document family/personal history, Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, nutritional status, medication review and dental health. For residents on antipsychotic medication, Electrocardiography (ECG) or prolactin were not assessed. The Clinical Nurse Manager 2 (CNM2) confirmed that none of the residents had had an ECG as part of their annual assessment.

Adequate arrangements were in place for access by residents to general health services and for their referral to other health services including a chiropodist, speech and language therapist, and dietitian as required. Residents had access to national screening programmes that were available according to age and gender. This was evidenced in the five clinical files inspected.

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

- a) The six-monthly general health assessment of two residents did not document the following: family/personal history, BMI, weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health. 1(b)**
- b) For residents on antipsychotic medication, there was not an annual assessment of ECG or prolactin. 1(b)**

## Regulation 20: Provision of Information to Residents

**NON-COMPLIANT**

Quality Rating

Requires Improvement

Risk Rating

**MODERATE**

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

- (a) details of the resident's multi-disciplinary team;
- (b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
- (c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;
- (d) details of relevant advocacy and voluntary agencies;
- (e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

### INSPECTION FINDINGS

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

**Training and Education:** Not all staff had signed the signature log to indicate that they had read and understood the policy. All 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 not monitored on an ongoing basis to ensure it was appropriate and accurate. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

**Evidence of Implementation:** Residents received an information booklet that detailed the care and services available. The booklet provided residents with the details of visiting times and arrangements, and the complaints procedure. Housekeeping arrangements including arrangements for personal property, mealtimes, details of relevant advocacy agencies and residents' rights were contained in the booklet.

Residents were provided with details of their multi-disciplinary team (MDT). 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. There was no documentary evidence that residents, or their families where appropriate, were provided with written and verbal information on diagnosis.

There was no documentary evidence that information was provided to residents, or their families where appropriate, on the likely adverse effects of treatments, including the risks and other potential side-effects. There was no documentary evidence within the clinical file that medication information sheets as well as verbal information were provided in a format appropriate to resident needs.

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

- a) The registered proprietor did not ensure that residents were provided with suitable verbal and written information on diagnosis. 20 1 (c)
- b) The registered proprietor did not ensure that residents were provided with information on indications for use of all medications to be administered to the resident, including any possible side effects. 21 1(e)

## Regulation 21: Privacy

**NON-COMPLIANT**

Quality Rating

Requires Improvement

Risk Rating

LOW

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to resident privacy, which was last reviewed in July 2015. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The roles and responsibilities for the provision of resident privacy and dignity.
- The approved centre layout and furnishing requirements to support resident privacy and dignity.
- The approved centre's process for addressing a situation where resident privacy and dignity is not respected by staff.

**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:** The general demeanour of staff was observed as appropriate. Staff members were observed to interact with residents in a respectful and friendly manner. Staff appearance and dress was observed as being appropriate. No ageist, racist, sexist or other inappropriate comments or jokes were observed on inspection. Staffed knocked before entering residents' rooms. All residents wore clothes that respected their privacy and dignity.

Bathrooms, showers, and toilet doors had locks on the inside of the door suited to the residents' capabilities and staff could override the lock where necessary. All observation panels on doors of treatment rooms and bedrooms had opaque glass or blinds. Bedrooms had window blinds for privacy. Residents were facilitated in making and taking private phone calls.

Noticeboards did not detail resident names or other identifiable information. A resident's diagnosis was displayed on a sign on their bedroom door.

**The approved centre was non-compliant with this regulation because residents' privacy and dignity was not appropriately respected at all times. A resident's diagnosis was displayed on a sign on their bedroom door.**

## 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 had a written policy in relation to its premises, which was last reviewed in August 2015. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The approved centre's utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.
- The identification of hazards and ligature points in the premises.

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

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

**Evidence of Implementation:** Residents had access to personal space. Appropriately sized communal rooms were provided including two television rooms (sitting-room and sunroom), and a dining area where residents could sit during the day. Private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. Appropriate signage and sensory aids were provided to support resident orientation needs. Signage was in place on bedrooms and toilets, which supported resident orientation.

Hazards, including large open spaces, steps and stairs, slippery floor, hard and sharp edges, hard or rough surfaces were minimised in the approved centre. Minimisation of ligature points throughout the approved centre was evidenced on walkabout. Also, the ligature audit evidenced this. There was a programme of

general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained. There was a sufficient number of toilets and showers for residents in the approved centre. All resident bedrooms were appropriately sized to address the resident needs.

All rooms throughout the approved centre were not ventilated. Two toilets were malodorous. Chips in the walls were observed in bedrooms and in corridor areas throughout the approved centre. Painting was needed throughout the approved centre and was planned to commence in 2018. The approved centre was clean and hygienic. The approved centre did not have a dedicated therapy or examination room. All residents had single bedrooms, where physical examinations were performed.

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

- a) Premises were not maintained in good structural and decorative condition. 1(a)**
- b) Premises were not adequately ventilated. Two toilets in the approved centre were malodorous 1(b)**

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

**NON-COMPLIANT**

Quality Rating

Requires Improvement

Risk Rating

HIGH

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in July 2015 (addendum added to policy in May 2018). The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for medication reconciliation.
- The process for reviewing resident medication.

Section 20.1 of the policy referred to a resident being unwilling or unable to consent to the continued administration of medicine past an initial period of three months. Unwilling should have been removed in accordance with the Mental Health (Amendment) Act 2015.

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

**Monitoring:** Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

**Evidence of Implementation:** All entries in MPARs were legible. All entries in MPARs were written in black, indelible ink. Residents' medication was reviewed on a six-monthly basis at the individual care plan review. This was documented in the clinical file. Where there was any alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber, and any advice provided by the resident's pharmacist regarding the appropriate use of the product.

The expiration date of the medication was checked prior to administration, and expired medications were not administered. Good hand hygiene and cross-infection control techniques were implemented during the dispensing of medications. The pharmacist was consulted about the type of preparation to be used. Medication was stored in the appropriate environment as indicated on the label or packaging of the medication, or as advised by the pharmacist. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage.

Food and drink was not stored in areas used for the storage of medication. Medication dispensed or supplied to the resident was secured in two locked drug trolleys in the clinical room which was also kept locked. The medication trolleys remained locked at all times and secured in a locked room. A locked separate cupboard was available for the storage of controlled drugs. However, this was not in use at the time of inspection as no resident was being given controlled drugs.

Allergies and reactions were not recorded on six MPARs reviewed. The generic name of a medication was not written on one MPAR. In one MPAR reviewed, micrograms were abbreviated and not written in full. In eight MPARs there were gaps in the documentation of the administration of medication. A clear record of the date of initiation for each medication was not present on three MPARs. Seven MPARs inspected were receiving crushed medication. Crushed medication was written on the front page of the MPAR but not signed by a medical practitioner. The discontinuation date of a medication was not documented on two MPARs.

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

- a) A clear record of the date of initiation for each medication was not present on three MPARs.**
- b) There was no signed order by a medical practitioner to crush medication in seven MPARs.**
- c) A clear record of the date of discontinuation for each medication was not present on two MPARs.**
- d) Allergies and reactions were not recorded on six MPARs reviewed.**
- e) The policy had not been amended to reflect the changes in the Mental Health Act 2015.**
- f) The generic name of a medication was not written on one MPAR.**

## Regulation 24: Health and Safety

**COMPLIANT**

Quality Rating

Satisfactory

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in March 2016. It also had an associated safety statement, dated 2018. The policy and safety statement addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Raising awareness of residents and their visitors to infection control measures.
- Response to sharps or needle stick injuries.
- Specific infection control measures in relation to infection types, e.g. C. diff, MRSA, and Norovirus.
- The monitoring and continuous improvement requirements implemented for the health and safety processes.

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

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

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

**The approved centre was compliant with this regulation.**

## Regulation 26: Staffing

**NON-COMPLIANT**

Quality Rating  
Risk Rating

Requires Improvement  
**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 in relation to its staffing requirements. The policy was last reviewed in April 2016.

The policy and procedures did not address the following:

- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The roles and responsibilities in relation to staff training processes.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

**Monitoring:** There was no staff training plan for review. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

**Evidence of Implementation:** There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre. A planned and actual staff rota was maintained. The numbers and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty and in charge at all times. All health care professionals were trained in Children First. All staff training was documented. The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

There was no staffing plan. There was the required number of staff on duty at night to ensure safety of residents in the event of a fire or other emergency. Annual staff training plans were not completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Not all health care professionals were trained in the following: fire safety, basic life support (BLS), management of violence and aggression, and The Mental Health Act 2001 (MHA). Staff were not trained in line with the assessed needs of the resident group profile and of individual resident's.

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

<i>Ward or Unit</i>	<i>Staff Grade</i>	<i>Day</i>	<i>Night</i>
Unit A	CNM2	1	
	RPN	3	2
	HCA	2	1
	Occupational Therapist	0.2	
	Social Worker	0.2	
	Psychologist	0.2	

*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 health care professionals had up-to-date, mandatory training in BLS, fire safety, and PMAV, 26 (4)**
- b) Not all health care professionals were trained 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 in relation to the maintenance of records. The policy was last reviewed in May 2018. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

**Training and Education:** All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff had been trained in best-practice record keeping.

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

**Evidence of Implementation:** Resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were maintained appropriately. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety and fire inspections were maintained in the approved centre.

All residents' records were secure and up to date, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were stored in a locked nurses' office in a lockable trolley. Not all residents' records were in good order. Loose pages were observed. Resident records were not developed and maintained to a logical sequence.

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

- a) Resident records were not developed and maintained in a logical sequence. 27 (1)**
- b) Records were not maintained in good order and had several loose pages.27 (1)**

## Regulation 28: Register of Residents

**COMPLIANT**

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

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

### **INSPECTION FINDINGS**

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

**The approved centre was compliant with this regulation.**

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

Quality Rating

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 June 2017. It addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The standardised operating policy and procedure layout used by the approved centre.

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

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

**Evidence of Implementation:** Where generic policies (e.g. complaints, staffing, etc.) were used, the approved centre had a written statement to this effect (adopting the generic policy), which was reviewed at least every three years. Any generic policies used were appropriate to the approved centre and the resident group profile. The South-East Community Healthcare Policy Group met regularly to develop and review policies. The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice, and clinical guidelines. Prior to implementation, policies, guidelines and protocols were approved by the executive management team.

Operating policies and procedures of the approved centre were communicated to all relevant staff. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Where generic policies were used, the approved centre had a written statement to this effect (adopting the generic policy), which was reviewed at least every three years.

**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 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 in relation to the management of complaints. The policy was last reviewed in May 2018. The policy 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 not 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 interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

**Monitoring:** The complaints log indicated that there were no complaints or minor complaints since the 2017 inspection and so there was no audit completed.

**Evidence of Implementation:** There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. The provision of information about the complaints procedure to residents and their representatives was done at admission or soon thereafter. This information was provided within the resident information booklet. The complaints procedure, including how to contact the nominated person, was publicly displayed. Contact details for the nominated person were publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

Residents and their representatives were facilitated to make complaints using the methods detailed in the complaints policy and procedure, which included verbal, written, e-mail, telephone, and through complaint, feedback, or suggestion forms. An advocacy poster was displayed in the unit, as the registered

proprietor ensured access insofar as practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process.

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

## Regulation 32: Risk Management Procedures

**COMPLIANT**

Quality Rating

Satisfactory

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

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

- (a) The identification and assessment of risks throughout the approved centre;
- (b) The precautions in place to control the risks identified;
- (c) The precautions in place to control the following specified risks:
  - (i) resident absent without leave,
  - (ii) suicide and self harm,
  - (iii) assault,
  - (iv) accidental injury to residents or staff;
- (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
- (e) Arrangements for responding to emergencies;
- (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

### INSPECTION FINDINGS

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

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

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

**Monitoring:** The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. 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 known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were identified, assessed, treated, reported and monitored. There was no local risk register. Escalated risks were documented in the Management team risk register. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation. Health and safety risks were documented within the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre. Corporate risks were documented in the risk register.

Individual risk assessments were completed prior to and during physical restraint, mechanical restraint, at admission to identify individual risk factors, including general health risks, risk of absconding, risk of self-harm etc., resident transfer, resident discharge, and in conjunction with medication requirements or administration. 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.

The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on the Notification of Deaths and Incident Reporting. There was an emergency plan that specified responses by approved centre staff to possible emergencies. The emergency plan incorporated evacuation procedures.

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

## Regulation 33: Insurance

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 34: Certificate of Registration

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently.

**The approved centre was compliant with this regulation.**

## 9.0 Inspection Findings – Rules

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

## Section 69: The Use of Mechanical Restraint

**NON-COMPLIANT**

Risk Rating

**MODERATE**

Mental Health Act 2001  
Bodily restraint and seclusion  
Section 69

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section "patient" includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient.

### INSPECTION FINDINGS

**Evidence of Implementation:** Mechanical restraint for an enduring risk of harm to the self or others was only used to address an identified clinical need. Mechanical restraint was only used when less restrictive alternatives were unsuitable. Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on his/her behalf. The clinical file contained a contemporaneous record that specified the following: an enduring risk of harm to the self or others; less restrictive alternatives were implemented without success; the type of mechanical restraint; the situation in which mechanical restraint is being applied; the duration of the restraint; and the duration of the order.

In both cases of the use of mechanical restraint inspected, all the requirements of the rule were met, with the exception of the review date in one episode. The order had not been reviewed within the required timeframe.

**The approved centre was non-compliant with this rule because the review date in one episode of the use of mechanical restraint was overdue.**

# 10.0 Inspection Findings – Mental Health Act 2001

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

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

# 11.0 Inspection Findings – Codes of Practice

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

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

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

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

### INSPECTION FINDINGS

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

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

**Training and Education:** There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

**Evidence of Implementation:** The approved centre met all of the set criteria in terms of the appropriate use of Physical Restraint (PR). Physical Restraint was used in rare, exceptional circumstances and with best interests of the resident, and where the resident poses an immediate threat of serious harm to the self or others. PR was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered. The use of PR was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using PR.

**The approved centre was compliant with this code of practice.**

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 August 2015, included all of the policy-related criteria for this code of practice.

**Transfer:** The transfer policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

**Discharge:** The discharge policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

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

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

#### Evidence of Implementation:

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

**Admission:** Admission was on the basis of mental illness or mental disorder. An admission assessment was completed, and included the following: the presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, current mental health state, risk assessment, any other relevant information, and a full physical examination. Resident's family member/carer/advocate were involved in the admission process, with resident consent.

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

**Discharge:** The discharge plan included the estimated date of discharge and there was documented communication with the relevant general practitioner/primary care team and/or CMHT. There was no reference to early warning signs of relapse and risks. The discharge assessment did not address psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs, and informational needs. There was no documentary evidence that discharge was coordinated by a key worker. There was no documentary evidence that a comprehensive discharge summary was issued within 14 days. There was no documentary evidence that a comprehensive discharge summary was issued containing the required elements, including the following: diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues,

follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

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

- a) The discharge plan did not contain a reference to early warning signs of relapse and risks.
- b) The discharge assessment did not address psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs, and informational needs.
- c) Discharge was not coordinated by a key worker.
- d) There was no documentary evidence that a comprehensive discharge summary was issued containing the required elements.

## Appendix 1: Corrective and Preventative Action Plan – Selskar House - 2018 Inspection Report

### Regulation 15: Individual Care Plan

Report reference: Page 30

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
<p>1. One ICP was not reviewed and by the resident's MDT within six months</p>	<p><i>New</i></p>	<p>Corrective Action(s): This ICP was updated by the MDT upon identification that it was 4 days overdue.</p> <p>Post-Holder(s) responsible: MDT</p>	<p>ICPs are audited by an auditor external to the unit on a quarterly basis. Any non compliance will be brought to the attention of the MDT.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>4<sup>th</sup> June 2018</p>
		<p>Preventative Action(s): Preventative Action(s): A flagging system is now in place which provides the MDT with 2 weeks advance notice that a ICP review is due. CNM2s ensure reviews are scheduled prior to review date.</p> <p>Post-Holder(s) responsible: CNMIIIs &amp; MDT</p>	<p>ICP's are audited by an auditor external to the unit on a quarterly basis. Any non compliance will be brought to the attention of the MDT.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>
<p>2. One ICP did not specify the treatment and care required for an identified mental health need and goal.</p> <p>3. One ICP did not identify the resources for an identified mental health need and goal.</p>	<p><i>New</i></p>	<p>Corrective Action(s): This ICP was updated to specify the treatment &amp; care required for the identified mental health need and goal.</p> <p>This ICP was updated to identify the resources required to meet the identified mental health need and goal.</p> <p>Post-Holder(s) responsible: MDT</p>	<p>ICPs are audited by an auditor external to the unit on a quarterly basis. Any non compliance will be brought to the attention of the MDT.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>4<sup>th</sup> June 2018</p>

		<p>Preventative Action(s): A flagging system now in place which will prevent ICP's from not being reviewed within the 6 month timeframe. Our ICP template once completed within the 6 month timeframe specifies treatment, care, mental health needs, goals and resources.</p> <p>Post-Holder(s) responsible: CNMIIs &amp; MDT</p>	<p>ICPs are audited by an auditor external to the unit on a quarterly basis. Any resultant failings in the flagging system or any other non compliance will be brought to the attention of the MDT.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>
<p>4. One ICP was not discussed, agreed where practical and drawn up with the participation of the resident.</p>	<p><i>New</i></p>	<p>Corrective Action(s): This ICP was reviewed, discussed and agreed with the resident in so far as was practical in June 2018.</p> <p>Post-Holder(s) responsible: MDT</p>	<p>ICPs are audited by an auditor external to the unit on a quarterly basis. Any resultant non compliance will be brought to the attention of the MDT.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>4<sup>th</sup> June 2018</p>
		<p>Preventative Action(s): The flagging system now in place will prevent ICPs not being reviewed within the 6 month timeframe. Our ICP template once completed within the 6 month timeframe documents discussions with and participation of residents or provides rationale for why not.</p> <p>Post-Holder(s) responsible: MDT</p>	<p>ICPs are audited by an auditor external to the unit on a quarterly basis. Any non compliance will be brought to the attention of the MDT.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>

## Regulation 19: General Health

Report reference: 33 & 34

Area(s) of non-compliance	Specific	Measureable	Achievable / Realistic	Time-bound	
<p>5. The six-monthly general health assessment of two residents did not document the following: family/personal history, BMI, weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health. 1(b)</p>	<p>New</p>	<p>Corrective Action(s): Six monthly physicals of these two residents was completed in June 2018 and included review of the following: Family/personal history, BMI, weight, waist circumference, blood pressure, smoking status, nutritional status, medication review or dental health.</p> <p>The physical assessment form has been updated to capture all the above required information.</p> <p>Post-Holder(s) responsible: General Practitioner/SHO</p>	<p>As part of the audit schedule in Selskar House Regulation 19; General Health and all of the requirements within this regulation will be audited on an bi annual basis for each resident.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>June 2018</p>
	<p>Preventative Action(s): Preventative Action(s): A flagging system using a communication whiteboard identifies when residents 6 month physicals are due. These dates are now placed in the unit diary and communicated daily as required with the Medical Officer.</p>	<p>As part of the audit schedule in Selskar House Regulation 19; General Health and all of the requirements within this regulation will be audited on an bi annual basis for each resident.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>	

		<p>The updated physical examination form capturing all required information is now in use.</p> <p>Post-Holder(s) responsible: CNM's &amp; Medical Officer</p>			
<p>6. For residents on antipsychotic medication, there was not an annual assessment of ECG or prolactin. 1(b)</p>	<p>New</p>	<p>Corrective Action(s): ECG and prolactin levels have been completed for residents on antipsychotic medication.</p> <p>Post-Holder(s) responsible: SHO</p>	<p>As part of the audit schedule in Selskar House, Regulation 19:General Health and all of the requirements within this regulation will be audited on an bi annual basis for each resident.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>June 2018</p>
		<p>Preventative Action(s): All residents on anti psychotic medication are identified on the communication whiteboard as requiring annual assessment of ECG &amp; prolactin. When due, this will be communicated to the Medical Team by CNMIs.</p> <p>Post-Holder(s) responsible: CNMIs &amp; Medical Officer</p>	<p>As part of the audit schedule in Selskar House Regulation 19; General Health and all of the requirements within this regulation will be audited on an bi annual basis for each resident.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>

## Regulation 20: Provision of Information to Residents

Report reference: 35 & 36

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
<p>7. The registered proprietor did not ensure that residents were provided with suitable verbal and written information on diagnosis. 20 1 (c)</p>	<p><i>New</i></p>	<p>Corrective Action(s): Information both written and verbal regarding diagnosis is now available to residents and families.</p> <p>Post-Holder(s) responsible: CNMIIs/Medical Team</p>	<p>Regulation 20: Provision of information will be monitored monthly by an auditor external to the unit using Nursing Metrics. Any non compliance will be brought to the attention of the MDT via the CNMIIs.</p>	<p>No barriers, actions are achievable and realistic.</p>	
		<p>Preventative Action(s): On admission and on a regular basis through the care planning process, residents and family members will be offered information both written &amp; verbal on diagnosis. Provision of information regarding diagnosis will be evidenced in the ICP documentation with tick box confirmation.</p> <p>Post-Holder(s) responsible: CNMIIs &amp; MDT</p>	<p>Regulation 20: Provision of information will be monitored monthly by an auditor external to the unit using Nursing Metrics. Any non compliance will be brought to the attention of the MDT via the CNMIIs.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>

<p>8. The registered proprietor did not ensure that residents were provided with information on indications for use of all medications to be administered to the resident, including any possible side effects. 21 1(e)</p>	<p><i>New</i></p>	<p>Corrective Action(s): A folder has been developed which provides information on all commonly used medications, side effects and indications for use. It is made available to residents and family members as required.</p> <p>Post-Holder(s) responsible: Medical Team</p>	<p>Regulation 20: Provision of information will be monitored monthly by an auditor external to the unit using Nursing Metrics. Any non compliance will be brought to the attention of the MDT via the CNMIIs.</p>	<p>No barriers, actions are achievable and realistic.</p>	
		<p>Preventative Action(s): Residents and their families will be made aware of the availability of this folder at point on admission and ongoing during the care plan process.</p> <p>Offer of this information will be evidenced using a tick box on care planning documentation.</p> <p>Post-Holder(s) responsible: MDT</p>	<p>Regulation 20: Provision of information will be monitored monthly by an auditor external to the unit using Nursing Metrics. Any non compliance will be brought to the attention of the MDT via the CNMIIs.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>

## Regulation 21: Privacy

Report reference: 37

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
<p>9. Resident's privacy and dignity was not appropriately respected at all times. A resident's diagnosis was displayed on a sign on their bedroom door.</p>	<p>New</p>	<p>Corrective Action(s): Sign removed from bedroom door.</p> <p>Post-Holder(s) responsible: CNMII</p>	<p>Daily monitoring by nurse in charge.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>June 2018</p>
		<p>Preventative Action(s): A memo had been issued to all staff reiterating the importance of maintaining the residents' dignity, privacy &amp; confidentiality.</p> <p>Post-Holder(s) responsible: CNMIIs</p>	<p>Daily monitoring by nurse in charge.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>

## Regulation 22: Premises

Report reference: 38 & 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
10. Premises were not maintained in good structural and decorative condition. 1(a)	New	<p>Corrective Action(s): Schedule now in place to eliminate chips in the walls and painting is to commence.</p> <p>Post-Holder(s) responsible: Service Management/Technical Services</p>	<p>The CNMIIs will liaise with service management and inspect works once completed.</p>	<p>There have been on going delays in accessing maintenance. Service Management to address same.</p> <p>Achievable with negotiation with Technical Services.</p>	<p>October 2018</p>
		<p>Preventative Action(s): Meeting sought with Estates to agree regular maintenance SLA and to ensure that wall defects and painting completed to expected standard.</p> <p>Post-Holder(s) responsible: Service Management</p>	<p>Regulation 22 Premises; will be monitored on an ongoing basis using the Best Practice Guidelines Premises Checklist. Areas of non compliance will be addressed. Premises audit last completed October 2018.</p>	<p>There have been on going delays in accessing maintenance. Service Management to address same.</p> <p>Achievable with negotiation with Technical Services.</p>	<p>Monitoring is ongoing</p>
11. Premises were not adequately ventilated. Two toilets in the approved centre were malodourous 1(b)	New	<p>Corrective Action(s): Schedule in place to rectify toilet deficiency.</p> <p>Post-Holder(s) responsible: Service Management &amp; Technical Services</p>	<p>The CNMIIs will liaise with service management and inspect works once completed.</p>	<p>There have been on going delays in accessing maintenance. Service Management to address same.</p> <p>Achievable with negotiation with Technical Services.</p>	<p>October 2018</p>

		<p>Preventative Action(s): A programme of maintenance in conjunction with as required remedial works will be put in place to ensure the maintenance requirements are addressed in a timely manner.</p> <p>Post-Holder(s) responsible: Service Management and Technical Services</p>	<p>Regulation 22 Premises; will be monitored on an ongoing basis using the Best Practice Guidelines Premises Checklist. Areas of non compliance will be addressed. Premises audit last completed October 2018.</p>	<p>There have been on going delays in accessing maintenance. Service Management to address same.</p> <p>Achievable with negotiation with Technical Services.</p>	<p>Monitoring is ongoing</p>
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## Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

Report reference: 40 & 41

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
<p>12. A clear record of the date of initiation for each medication was not present on three MPARs.</p> <p>13. A clear record of the date of discontinuation for each medication was not present on two MPARs.</p> <p>14. Allergies and reactions were not recorded on six MPARs reviewed</p> <p>15. The generic name of a medication was not written on one MPAR</p>	<p><i>New</i></p>	<p>Corrective Action(s): These three MPARs have now amended to display date of initiation.</p> <p>These two MPARs have now been amended to ensure date of discontinuation for each medication are recorded.</p> <p>These six MPARs were amended to ensure allergies and reactions were recorded.</p> <p>This MPAR was amended to use the generic name of the medication.</p> <p>Post-Holder(s) responsible: Medical Team</p>	<p>MPARs will be monitored on a monthly basis using Nursing Metrics and deficits in prescribing standards brought to the attention of medical team.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Completed June 2018</p>
			<p>Preventative Action(s): Preventative Action(s):</p> <p>A Memo was issued to the Medical team members by the Consultant to ensure that each MPAR evidenced, date of initiation, date of discontinuation, allergy and reaction status and generic name of medication.</p>	<p>MPARs will be monitored on a monthly basis using Nursing Metrics and deficits in prescribing standards brought to the attention of medical team.</p>	<p>No barriers, actions are achievable and realistic.</p>

		Post-Holder(s) responsible: Consultant Psychiatrist			
16. There was no signed order by a medical practitioner to crush medication in seven MPARs.	New	Corrective Action(s): These 7 MPAR's have now been amended to record that medications are to be crushed.  Post-Holder(s) responsible: SHO	MPARs will be monitored on a monthly basis using Nursing Metrics and deficits in prescribing standards brought to the attention of medical team.	No barriers, actions are achievable and realistic.	Completed June 2018
		Preventative Action(s): Preventative Action(s): A Memo was issued to the Medical team members by the Consultant to instruct that where medications are to be crushed this must be recorded on the MPAR.  Post-Holder(s) responsible: Consultant Psychiatrist	MPARs will be monitored on a monthly basis using Nursing Metrics and deficits in prescribing standards brought to the attention of medical team.	No barriers, actions are achievable and realistic.	Monitoring is ongoing
17. The policy had not been amended to reflect the changes in the Mental Health Act 2015.	New	Corrective Action(s): Policy has been amended to reflect changes in MHA and will be presented for approval by EMT in October.  Post-Holder(s) responsible: SECH PPGG	Approval of this policy will be monitored as part of overall monitoring of Regulation 29.	No barriers, actions are achievable and realistic.	For Approval Oct 25 <sup>th</sup> 2018

		<p>Preventative Action(s):</p> <p>All policies are reviewed at a minimum of 3 yearly or more frequently where regulatory frameworks require so.</p> <p>The chair will ensure changes in legislation will be reflected in local policies within an appropriate timeframe.</p> <p>Post-Holder(s) responsible:</p> <p>SECH PPGG Chairperson</p>	<p>The process for policy review is monitored to ensure that required amendments are made and approved by EMT in a timely manner.</p> <p>Monitoring data is available on an excel spreadsheet and updated by the chair.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>
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## Regulation 26: Staffing

Report reference: 43 & 44

Area(s) of non-compliance	Specific	Measureable	Achievable / Realistic	Time-bound
<p>18. The approved centre was non-compliant with this regulation because not all staff were up to date with fire safety, management of violence and aggression, BLS and the MHA training.</p>	<p>Corrective Action(s): A schedule of training has been co ordinated through each Head of Discipline in order to ensure compliance with mandatory requirements:</p> <ul style="list-style-type: none"> <li>• Fire training – on site training in March 2018 and again in November 2018.</li> <li>• BLS –on site trainer now in place, training ongoing.</li> <li>• TMVA – 5 day training prioritised for all staff in Selskar Unit.</li> <li>• MHA 2001 – training continues to be promoted in this regard and IT facilities are in situ.</li> </ul> <p>Post-Holder(s) responsible: HOD's</p>	<p>Heads of Discipline will monitor compliance on an ongoing basis.</p>	<p>Ensuring all staff have all mandatory training in date at all times with staff shortages and turnover s challenging, though we will continue to action towards full compliance.</p>	<p>Schedule had been completed June 2018</p>
	<p>Preventative Action(s): Preventative Action(s): Each Head of Discipline will conduct an annual audit to review training uptake and establish action plans to ensure staff have up to date mandatory training. All attendance at training will be recorded and updated on training database. Training Records are available digitally to the HOD to assist in monitoring training compliance</p> <p>Post-Holder(s) responsible: HOD's</p>	<p>Heads of Discipline will monitor compliance on an ongoing basis.</p>	<p>Ensuring all staff have all mandatory training in date at all times with staff shortages and turnover s challenging, though we will continue to action towards full compliance.</p>	<p>Monitoring is ongoing</p>

## Regulation 27: Maintenance of records

Report reference: 45 & 46

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
<p>19. Resident records were not developed and maintained to a logical sequence. 27 (1).</p>	<p><i>New</i></p>	<p>Corrective Action(s): Records are now maintained in sequential fashion. Post-Holder(s) responsible: All MDT members</p>	<p>A review of documentation will take place as part of the quarterly ICP audits to ensure compliance.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>September 2018</p>
		<p>Preventative Action(s): A Memo has been issued to MDT members to ensure the filing of health care documents are carried out in a logical sequence.  Post-Holder(s) responsible: Service Management</p>	<p>A review of documentation will take place as part of the quarterly ICP audits to ensure compliance.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>
<p>20. Records were not maintained in good order and had several loose pages.27 (1)</p>	<p><i>New</i></p>	<p>Corrective Action(s): Loose pages were re inserted. Post-Holder(s) responsible: CNMIIs</p>	<p>A review of documentation will take place as part of the quarterly ICP audits to ensure compliance.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>September 2018</p>

		<p>Preventative Action(s): Reinforced progress pages have been sourced and are now in use.</p> <p>Post-Holder(s) responsible: CNMIIs</p>	<p>A review of documentation will take place as part of the quarterly ICP audits to ensure compliance.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>
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## Rules: The Use of Mechanical Restraint

Report reference: 56

Area(s) of non-compliance	Specific	Measureable	Achievable / Realistic	Time-bound
21. The review date in one episode of the use of mechanical restraint was overdue.	<p>Corrective Action(s): Review of mechanical restraint that was overdue was completed.</p> <p>Post-Holder(s) responsible: Consultant Psychiatrist</p>	<p>As part of the Selskar House audit schedule, the review of mechanical restraint will be monitored quarterly.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>June 2018</p>
	<p>Preventative Action(s): Preventative Action(s):</p> <p>There is now a flagging system in place using the communication whiteboard which highlights when reviews are due. CNMIIs will schedule upcoming reviews in the diary and alert medical team.</p> <p>Post-Holder(s) responsible: Medical team and CNMIIs.</p>	<p>As part of the Selskar House audit schedule, the review of mechanical restraint will be monitored quarterly.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing</p>

## Codes of Practice: Admission, Transfer and Discharge

Report reference: 60 & 61

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
<p>22. The discharge assessment did not address psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs, and informational needs.</p> <p>23. Discharge was not coordinated by a key worker</p> <p>24. There was no documentary evidence that a comprehensive discharge summary was issued containing the required elements.</p>	<p><i>Reoccurring</i></p>	<p>Corrective Action(s):</p> <p>The MDT are unable to revisit this discharge assessment of this resident for a specific reason. Comprehensive discharge letters had been sent to receiving care facility.</p> <p>Post-Holder(s) responsible: MDT</p>	<p>As part of Selskar Auditing Schedule, auditing of all discharges will take place and areas where the Code of Practice has not been adhered to will be addressed.</p>	<p>The MDT are unable to revisit this discharge assessment of this resident for a specific reason.</p> <p>A corrective action cannot take place.</p>	<p>Discharge letters were sent to receiving facility in May 2018.</p>
		<p>Preventative Action(s): Future discharge assessment documentation will be completed in full including: psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs, and informational needs.</p> <p>A key worker will co ordinate all future discharges.</p> <p>A comprehensive discharge summary containing all the required elements will be issued to receiving facility and a copy of this will be retained in the healthcare record.</p> <p>Post-Holder(s) responsible: CNMII &amp; Medical Team</p>	<p>As part of Selskar Auditing Schedule, auditing of all discharges will take place and areas where the Code of Practice has not been adhered to will be addressed.</p>	<p>No barriers, actions are achievable and realistic.</p>	<p>Monitoring is ongoing post each discharge.</p>