St John of God Hospital

ID Number: AC0046

2018 Approved Centre Inspection Report (Mental Health Act 2001)

St John of God Hospital
Stillorgan
Co Dublin

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

Most Recent Registration Date:
17 May 2016

Conditions Attached:
None

Registered Proprietor:
St John of God Hospital Ltd.

Registered Proprietor Nominee:
Ms Emma Balmaine, Chief Executive

Inspection Team:
Martin McMenamin, Lead Inspector
Carol Brennan-Forsyth
Dr Enda Dooley, MCRN004155
Noeleen Byrne
Siobhán Dinan
Dr Susan Finnerty

Inspection Date:
15 – 18 May 2018

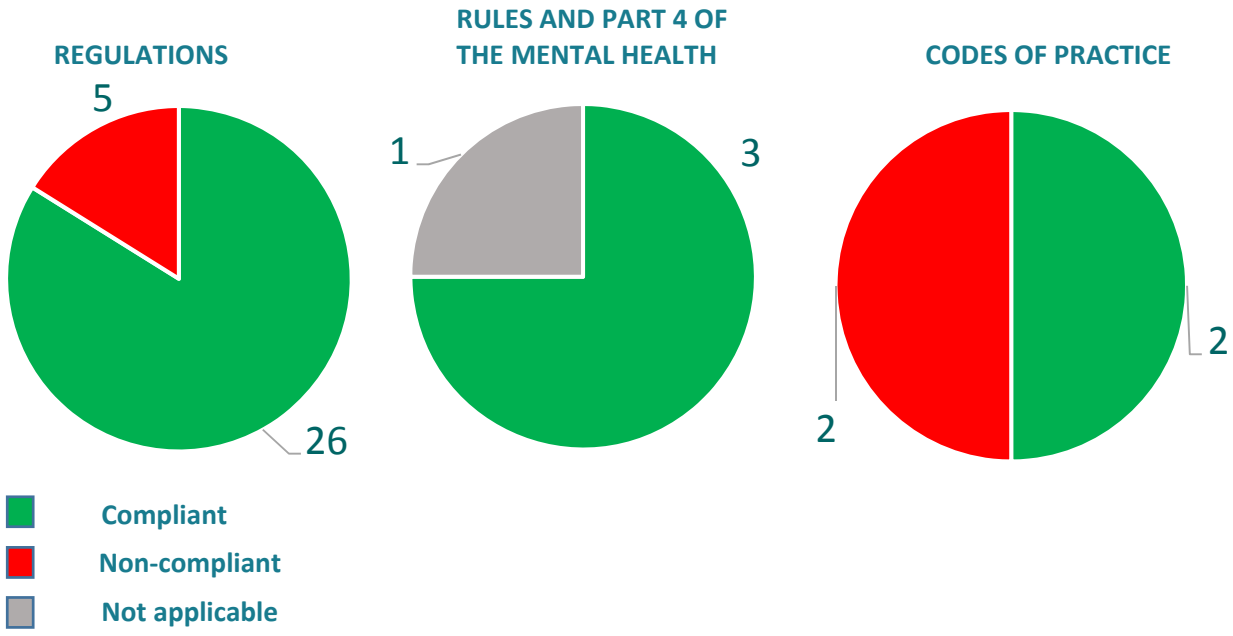
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
28 February – 3 March 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
15 November 2018

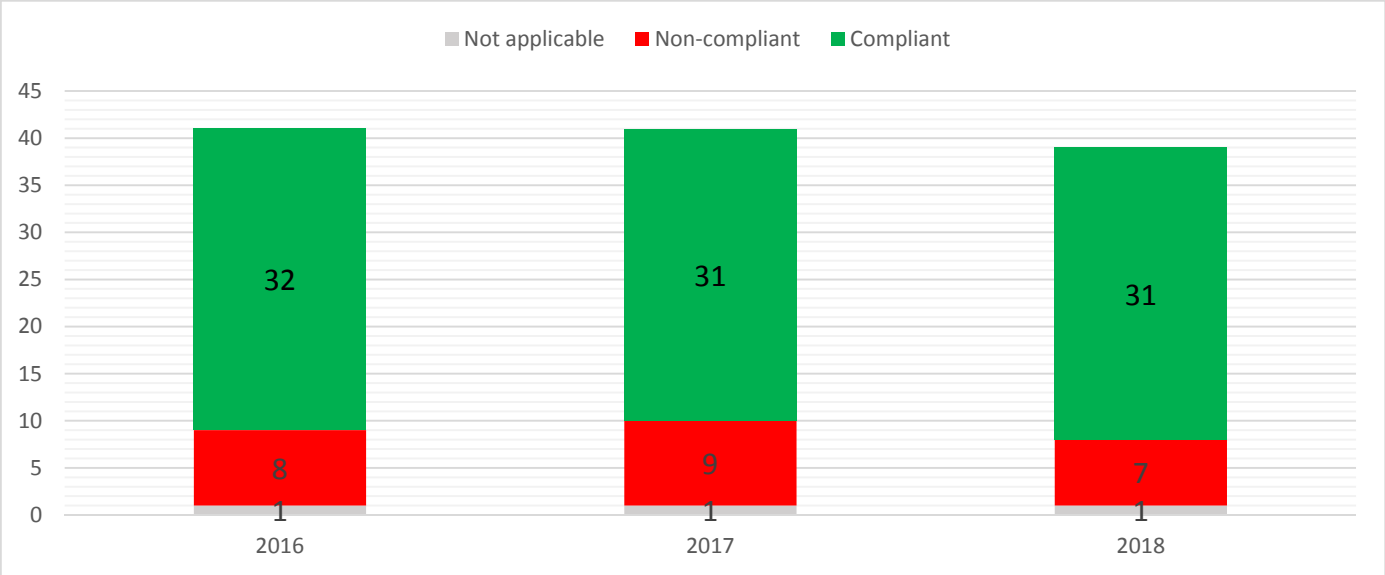
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

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

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018

Contents

1.0 Introduction to the Inspection Process

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

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

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

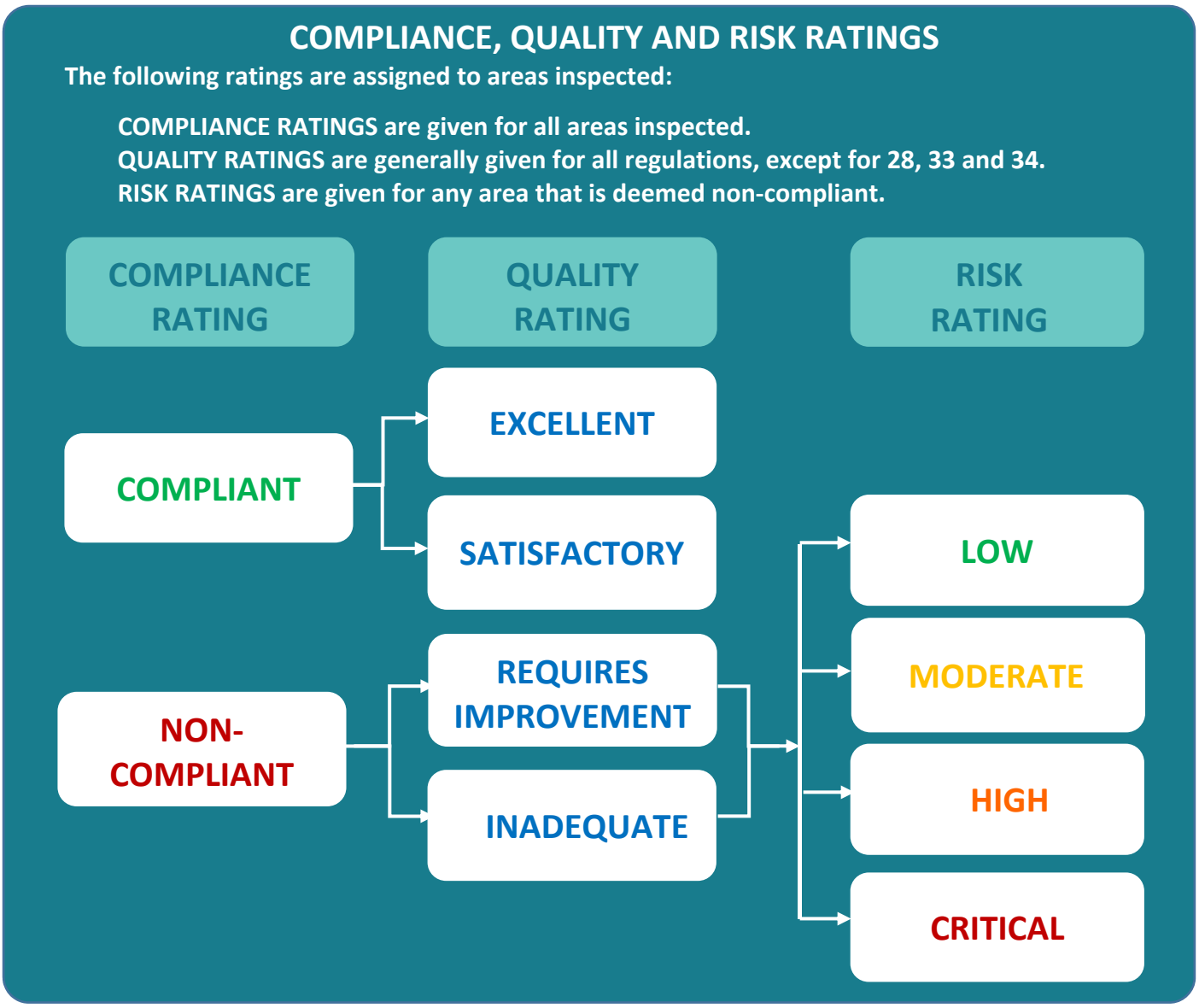
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In Brief

St John of God Hospital was an independent acute psychiatric hospital with 183 in-patient beds, located in Stillorgan, Co. Dublin. The approved centre provided a range of specialist services, including Addiction services, Dialectical Behaviour Therapy, Psychiatry of Later Life, eating disorders, and services for adolescents aged 14-17. On the first day of inspection, there were 161 residents, including 11 who were detained under the Mental Health Act (2001).

The approved centre was compliant with 82% of regulations, rules and codes of practice, an increase from 78% in 2017. There were 10 compliances with regulations rated as excellent, a decrease from 19 excellent ratings in 2017.

Safety in the approved centre

Pharmacy introduced new processes for dispensing for new admissions. Medication chart and prescription templates had been updated to align with Controlled Drugs Regulations 2017 and the implementation of a prescribing buddy system where each registrar was paired with a pharmacist to provide support and improve prescribing standards through active feedback and outcome monitoring.

A suicide reduction strategy and ligature minimisation plan was in evidence and processes for the safeguarding of residents had been introduced. A minimum of two person-specific resident identifiers appropriate to the resident group profiles were used.

Food safety audits had been completed periodically. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

Not all health care professionals were trained in fire safety, Basic Life Support, Management of violence and aggression, Mental Health Act 2001 and Children First.

Appropriate care and treatment of residents

Each resident had an individual care plan (ICP). A key worker was identified for each resident. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin where possible. In two cases, the ICP was drawn up by the multi-disciplinary team (MDT) after the required timeframe of seven days. Residents had access to their ICPs and were kept informed of any changes but four residents were not offered a copy of their ICP and no explanation for this was documented.

Therapeutic services and programmes provided by the approved centre were evidence-based, reflective of good practice guidelines and met the documented assessed needs of the residents. Adequate resources and facilities were available.

All residents had received a six-monthly general health assessment and those on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids, and electrocardiogram. Adequate arrangements were in place for residents to access general health services and for referral to other health services.

The approved centre was compliant with Part 4 of the Mental Health Act Consent to Treatment and with the Rules and Codes of Practice for ECT.

Respect for residents' privacy, dignity and autonomy

There were no blanket restrictions in use in the approved centre.

Secure facilities were provided in the general office of the hospital for the safekeeping of the residents' monies, valuables, personal property, and possessions, as necessary and residents were supported to manage their own property. The access to and use of resident monies was not consistently overseen by two members of staff and the resident or their representative, and not all financial entries were signed by the resident and staff, or by two staff members. Residents' clothing was clean and appropriate to their needs. The care and services provided within the approved centre were respectful of the residents' religious values and beliefs. There were no visiting restrictions implemented for a resident and there were no restrictions on residents' communication at the time of the inspection.

There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe a resident were incapable of recording or storing a resident's image.

Searches were implemented with due regard to the residents' dignity, privacy and gender.

Seclusion was carried out in accordance to the Rules Governing the Use of Seclusion. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint.

Responsiveness to residents' needs

The approved centre's menus were approved by the internal Catering Department in collaboration with outsourced dietitians, to ensure nutritional adequacy in accordance with the residents' needs.

A variety of wholesome and nutritious food, including portions from different food groups, was provided to residents. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.

Residents had access to a wide range of appropriate recreational activities, including indoor and outdoor exercise and physical activity. There was also a large coffee shop available to residents. Residents had access to a number of gardens throughout the hospital grounds.

Residents were provided with an information pack on admission that included details of the approved centre and their MDT. They were also provided with written and verbal information on diagnosis and medication. There was a robust complaints procedure in place.

Governance of the approved centre

There was a Board of Management for the approved centre. There were a number of standing committees including CGQSEC (Clinical Governance, Quality & Safety Executive Committee) to which the following sub-committees reported: Clinical Audit; Health and Safety; Consumer Council & Advocacy; Clinical Effectiveness and Quality Improvement; Risk Management; Patient Satisfaction and Complaints, as well as reviewing adverse incident reports. The Hospital Management Team met on a monthly basis and was chaired by the Chief Executive. The management team had standing items addressing incident management, health and safety, manpower planning, regulations, and operational and risk management.

A local incident management review group appraised adverse events and identified those that required escalation. The adoption of a dynamic risk management approach, together with the introduction of a risk reduction group, had assisted in standardising assessment and management of clinical risk while recognising the importance of clinical judgement in this process. The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy.

An additional dimension to the governance of the approved centre was the contracted services including the funding and management arrangements, between the Health Service Executive and Cluain Mhuire Community Mental Health Service, Saint John of God Community Services CLG (a community mental health service that is funded by the HSE). There were regular meetings and clear structured processes in place to address shared areas of care provision, but there was acknowledgement within the service that some of these processes, including communication and management arrangements, needed to be further improved.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The appointment of a Clinical Admissions Manager to the Admissions office within the hospital structure aimed at ensuring a smooth and efficient admission procedure.

2. The Psychology Department initiated a process of establishing a comprehensive quality assurance process in relation to therapeutic activities within the hospital. A sub-committee had been formed within the department to progress overall evaluation and audit of therapeutic programmes.

3. Pharmacy introduced new processes for dispensing for new admissions: dispensing for priority charts; medication returns from the wards; and for weekend leave prescribing and dispensing. Also introduced was the update of medication chart and prescription pad templates to align with Controlled Drugs Regulations 2017 and the implementation of a prescribing buddy system where each registrar was paired with a pharmacist to provide support and improve prescribing standards through active feedback and outcome monitoring.

4. Phlebotomy requests were sent electronically which allowed efficient planning for visiting the wards.

5. The mandatory training register for nursing staff was redesigned to promote compliance with all mandatory training requirements. In addition, time was released back to the CNM3s to engage in other tasks.

6. A review of storage of patients' property on St Peters suite was carried out. Individual patient property lockers were installed on the unit. This was positive for the residents in that they could manage personal property safely and nurses had more time to spend with patients.

7. The Pastoral Care Department introduced a quality initiative for the integration of a spiritual assessment tool for each patient on the Mental Health Information System (MHIS).

8. Occupational Therapy and Psychology Departments developed an integrated timetable for the Wellness and Recovery Programme in Carrigfergus ward. A resource centre was developed to include leisure materials and relaxation materials for use on the ward and information on community outlets.

9. The Occupational Therapy service in Ginesa suite undertook and completed an outdoor garden project with staff and young people on the unit, which resulted in a bright and colourful outdoor garden for them.

10. An independent Youth Advocacy Service for adolescents was introduced as an initiative between St John of God Hospital and Youth Advocate Programmes Ireland in providing for an independent advocacy service for young people and their families in the adolescent unit.

11. A dedicated Occupational Therapist was appointed to St Peters suite.

12. A dedicated clinical supervisor was employed (12hrs a week) and clinical supervision sessions had been introduced for nursing staff. This initiative supported nurses to develop their clinical skills and professional practice in response to service user/resident needs.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

St John of God Hospital was an independent acute psychiatric hospital with 183 in-patient beds. The not-for-profit approved centre was located on its own grounds in Stillorgan, Co. Dublin. The grounds were picturesque and spacious which provided residents with the opportunity to play golf and tennis and take a variety of scenic walks which had recently been restored. The approved centre comprised eight wards accommodating a range of specialist services, including Addiction services, Dialectical Behaviour Therapy, Psychiatry of Later Life, eating disorders, and services for adolescents aged 14-17. In total, eight multi-disciplinary teams worked in the approved centre. The referral pathway was through general practice and from other hospital and specialist services via an Admissions Department. The approved centre had facilities such as an occupational therapy kitchen, an art room, a relaxation area, a computer room, a hairdressing salon, a woodwork room, gym and an activities room. The Elvira room was dedicated for the use of adolescent residents and had access to an external garden.

On the first day of inspection, there were 161 residents, including 11 who were detained under the Mental Health Act (2001). The approved centre was a university teaching hospital, receiving a wide variety of students from various clinical disciplines (i.e. nursing, medical, psychology, pharmacy, and occupational therapy).

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

Resident Profile	
Number of registered beds	***183***
Total number of residents	**161**
Number of detained patients	11
Number of wards of court	1
Number of children	11
Number of residents in the approved centre for more than 6 months	4
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 hospital had established governance mechanisms in place to support the Board of Management's strategy and vision. A key sub-committee -the Clinical Governance, Quality and Safety Executive Committee (CGQSEC) oversaw a number of standing committees including: Clinical Audit; Health and Safety; Consumer Council & Advocacy; Clinical Effectiveness and Quality Improvement; Risk Management; Patient Satisfaction and Complaints, as well as reviewing adverse incident reports. The CGQSEC also acted as a conduit for feeding back issues from the Board and also identified items for escalation to the Board.

Additionally, the Hospital Management Team met on a monthly basis and was chaired by the Chief Executive. There was an organisational chart and clear governance structures and processes in place, which reflected the St John of God Hospital service. The management team had standing items addressing incident management, health and safety, manpower planning, regulations, and operational and risk management. Copies of the minutes of the senior management team meetings and the Clinical Governance, Quality & Safety meetings were provided to the inspection team.

A local incident management review group appraised adverse events and identified those that required escalation. The adoption of a dynamic risk management approach, together with the introduction of a risk reduction group, has assisted in standardising assessment and management of clinical risk while recognising the importance of clinical judgement in this process. A suicide reduction strategy and ligature minimisation plan was in evidence and processes for the safeguarding of residents were introduced including signage and updated policies on visits, child protection, and welfare.

An additional dimension to the governance of the approved centre was the contracted services including the communication and management arrangements, between the Health Service Executive and Cluain Mhuire Community Mental Health Service, Saint John of God Community Services CLG (a community mental health service that is funded by the HSE). Whilst there were regular meetings and clear structured processes in place to address these shared areas of care provision, there was acknowledgement within the service that some of these processes needed to be further improved.

4.5 Use of restrictive practices

There were no identified restrictive practices utilised.

5.0 Compliance

5.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 5: Food and Nutrition	✓		✓		✗	Moderate
Regulation 7: Clothing	✓		✓		✗	Low
Regulation 15: Individual Care Plan	✗	Low	✓		✗	Moderate
Regulation 21: Privacy	✓		✓		✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Low	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✗	Low	✗	High
Code of Practice on Admission, Transfer and Discharge to and from the approved Centre	✗	Low	✗	Low	✗	Low

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 6: Food Safety
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 12: Communication
Regulation 13: Searches
Regulation 14: Care of the Dying
Regulation 16: Therapeutic Services and Programmes
Regulation 17: Children's Education
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

6.0 Service-user Experience

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

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

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

The inspection team met 13 adults and 6 young people in total. Five of the young people met the inspectors as a group and three of them additionally asked to meet individually plus a further young person.

Residents interviewed were complimentary of staff. Most but not all, expressed satisfaction with the food and activities. Some residents expressed the view that the food was 'fantastic… there was too much…. salads are lovely'. For other residents, although there was a choice in food, 'there was not always an option' for some individual needs. One resident also expressed feeling 'uncomfortable' with the level of supervision in the dining room.

The majority of residents were happy with their care and with the working of the multi-disciplinary team. Some expressed the sentiment that with shared bedrooms 'it was hard to get space to yourself' and that they would 'like to have en suite bathrooms'. A number of residents also identified a need for an increase in the provision of television rooms.

A resident also suggested that the walk around the garden needed lighting in winter time and that they would like to see the fountain working again.

Thirty-seven residents completed the MHC 'Your Views' questionnaire.

Twenty-five per cent of residents felt that they did not understand what their individual care plan was, with almost forty per cent stating that they were never or only sometimes involved in setting their own goals in their care plans. Additionally, almost a fifth (19%) of residents stated that they did not know who their keyworker was and 11% of residents felt that they have inadequate space for privacy and that their privacy

and dignity were not respected. Twelve residents (32%) felt that there were not enough activities for them during the day.

Almost all residents stated that staff explained what was happening when they arrived in the ward, were happy with the way staff spoke with them during their stay and knew how to make a complaint if needed. Where any resident brought a matter to the attention of the inspectors during the inspection process, that query or concern was relayed on an anonymised basis to clinical/administrative staff, who undertook to follow it up.

7.0 Feedback Meeting

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

- Chief Executive Officer
- Clinical Director
- Deputy Director of Nursing
- Acting Head of Pharmacy
- Head of Psychology
- Head of Occupational Therapy
- Senior Social Worker
- Head of Operations, Quality and Data Protection
- Human Resources Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. Clarifications were provided to the inspectors by the approved centre staff in relation to labelling of medication, CCTV monitoring and garden access to residents of Ginesa suite. Also discussed was the recording of staff signatures in relation to policies.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in January 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. Relevant staff interviewed were able to articulate the processes for the identification of residents, as set out in the policy.

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

Evidence of Implementation: A minimum of two person-specific resident identifiers appropriate to the resident group profile, individual residents' needs, and their communication abilities were used. The preferred identifiers used for each resident were detailed within residents' clinical files, and were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

(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 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 food and nutrition, as set out in the policy.

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

Evidence of Implementation: The approved centre's menus were approved by the internal Catering Department in collaboration with outsourced dietitians, to ensure nutritional adequacy in accordance with the residents' needs. Dietitians employed by an external catering company were engaged in reviewing menu cycles with the goal of reducing the menu cycle from a seven-week cycle and to a four-week cycle, at the time of the inspection.

A variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid was provided to residents. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot and cold drinks were offered to residents regularly. Residents had access to the main hospital dining room and coffee shop. Residents had access to safe, fresh drinking water in easily accessible locations in the approved centre, and hot meals were served on a daily basis.

The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. In one case, the dietitian documented a St. Andrew's Nutritional Screening Instrument (SANSI) assessment of the resident, the findings of which indicated that the resident had a specific dietary requirement. This was documented by the dietitian, but on review of the clinical file, the resident's special dietary requirements were not evidenced in the resident's individual care plan.

The resident was not consistently provided with suitable menu options, and most of the menu was unsuitable for this person.

The approved centre was non-compliant with this regulation because not all residents were provided with food which took into account their special dietary requirements, 5 (2).

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in November 2015. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Appropriate hand-washing areas were provided for catering services. There was suitable and sufficient catering equipment in the approved centre. Catering areas and associated catering and food safety equipment were appropriately cleaned. Hygiene was maintained to support food safety requirements. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents clothing was clean and appropriate to their needs. At the time of the inspection, residents who might be without an adequate supply of their own clothing were not provided with an adequate supply of appropriate, individualised emergency clothing with due regard to their dignity and bodily integrity at all times.

The approved centre was non-compliant with this regulation because residents without an adequate supply of their own clothing were not provided with an adequate supply of appropriate individualised emergency clothing with due regard to their dignity and bodily integrity at all times.

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

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

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

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

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was not consistently overseen by two members of staff and the resident or their representative; not all financial entries were signed by the resident and staff, or 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 evidence of implementation pillar.

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. The occupational therapy information booklet given to residents, detailed accessible and user-friendly information on recreational activities, including the type and frequency of appropriate recreational activities. Weekly timetables were displayed on the approved centre's suites, and timetables were also displayed in each bedroom.

Residents had access to a range of appropriate recreational activities, including indoor and outdoor exercise and physical activity. Activities and facilities included: walking groups in outdoor areas; exercise groups; gym access, including exercise classes; outdoor gym equipment; a basketball court; a tennis court; pitch and putt; yoga; creative writing groups; music groups; and quiz groups. Recreational activities available on suites included television, newspapers, radio, board games, and arts and crafts. There was also a large coffee shop available to residents. Residents had access to a selection of gardens throughout the hospital grounds.

Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. The recreational activities provided by the approved centre were appropriately resourced. Communal areas were provided that were suitable for recreational activities on each suite. Documented records of attendance were retained in the clinical records.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

Monitoring: The implementation of the policy to support residents' religious practices was reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: The care and services provided within the approved centre were respectful of the residents' religious values and beliefs. On admission, residents received a spiritual assessment which was administered by medical or nursing staff. This assessment identified the resident's religious affiliations, if any. The spiritual assessment elicited whether the resident would like input from a healthcare chaplain or not. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented in each resident's clinical file.

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Facilities were available to support residents' religious practices, and included a Catholic Mass service which was held once daily Monday to Thursday, twice daily on Saturdays, and twice a day on Sundays. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. They had access to multi-faith chaplains. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits. The policy was last reviewed in January 2018. The policy included the requirements of the *Judgement Support Framework,* with the exception of the required visitor identification methods.

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

Monitoring: Documented analysis had not been completed to identify opportunities for improving visiting processes. While patient satisfaction surveys were documented, there was no specific analysis of visiting processes completed.

Evidence of Implementation: There were no visiting restrictions implemented for a resident at the time of the inspection. Appropriate and reasonable visiting times were publicly displayed. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting room/areas was suitable for visiting children, with appropriate furnishings and toys for children to play with.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **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 February 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Resident communication needs and restrictions on communication were monitored on an ongoing basis. A documented analysis had been completed to identify opportunities to improve communication processes.

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

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

(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 February 2016. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: A log of searches was maintained. Each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. A documented analysis was completed to identify opportunities for the improvement of search processes.

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical files and search forms in relation to three residents who underwent searches were inspected. Risk had been assessed prior to the search of each resident and their belongings in the search. Resident consent was sought and documented in all three cases. General written consent was sought for routine environmental searches.

The resident search policy and procedure was communicated to all residents. Residents were informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when searches were being conducted.

Searches were implemented with due regard to the residents' dignity, privacy and gender; at least one of the staff members who conducted the search was the same gender as the resident being searched. Search forms were completed for the three clinical files reviewed. Policy requirements were implemented when illicit substances were found as a result of a search.

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

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

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Systems analysis had been undertaken on two sudden deaths which had taken place since the last inspection.

Evidence of Implementation: No resident was in receipt of end of life care since the last inspection. The files of three resident deaths were reviewed. One had died in a general hospital and the other two deaths occurred whilst the individuals were on leave. No deaths occurred in the approved centre since the last inspection. Support was given to other residents and staff following each resident's death. All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

INSPECTION FINDINGS

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

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to 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: Each resident had an individual care plan (ICP), ten of which were inspected. A key worker was identified to ensure continuity in the implementation of a resident's ICP. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Residents were initially assessed at admission and an ICP was completed by the admitting clinician to address the immediate needs of resident. An ICP was developed by the MDT following a comprehensive assessment, within seven days of admission with the exception of two ICPs. Specifically, in two cases the ICP was authorised late, it was drawn up by the MDT after the required timeframe of seven days.

The ICP was a documented set of appropriate goals for each resident, specified the treatment and care required, and identified the resources required to provide the care and treatment specified. In one case the ICP was not reviewed by the MDT, instead the ICP was reviewed by nursing and medical staff only.

Residents had access to their ICPs and were kept informed of any changes. Four residents were not offered a copy of their ICP and no explanation for this was documented. The ICP of a child resident included their educational requirements.

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

a) **In two cases, the ICP was not drawn up by the MDT within the required timeframe of seven days.**
b) **Not all ICPs were developed by the full MDT.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

Monitoring: The range of services and programmes provided in the approved centre were monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: Therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents' individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents. All therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Adequate resources and facilities were available.

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

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

Regulation 17: Children's Education

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

INSPECTION FINDINGS

Processes: There was a written policy which was last reviewed in March 2018 in relation to the provision of education to child residents in the approved centre. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Individual providers of educational services on behalf of the approved centre were qualified in line with their role and responsibilities. Relevant staff were appropriately trained in the relevant legislation relating to working with children and their educational needs.

Monitoring: A daily record was kept of child residents' attendance at internal and external educational services. The record was kept within the classroom.

Evidence of Implementation: Child residents were assessed in terms of their individual educational requirements, with consideration of their needs and age on admission. Where appropriate to the needs and age of the child resident, the education provided by the approved centre was reflective of the required educational curriculum. Sufficient personnel resources were available to provide education to child residents in the approved centre in line with any requirements specified in their individual care plans. The teacher child ratio was 1:12 at the time of the inspection. Attendance by child residents at the approved centre's educational services was documented, including reasons for non-attendance.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was examined. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident's care and treatment plan, including needs and risks, and the resident's accompaniment requirements on transfer. These communication records with the receiving facility were documented, including their agreement to receive the resident in advance of the transfer.

The resident was risk assessed prior to the transfer. The following information was issued, with copies retained as part of the transfer documentation: a letter of referral, including a list of current medications, resident transfer form, and the required medication for the resident during the transfer process. A checklist was completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the residents' electronic clinical file.

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 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies. The policy was last reviewed in February 2018. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). The emergency equipment was checked daily. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, and each of the ten files inspected evidenced that all residents had received a six-monthly general health assessment, including an electrocardiogram and relevant blood tests.

The six-monthly general health assessment in 10 files reviewed documented an appropriate physical examination.

Residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids, and electrocardiogram. Adequate arrangements were in place for residents to access general health services and for referral to other health services, in locations such as St. Vincent's Hospital and St. Michael's Hospital. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing.

Residents had access to national screening programmes appropriate to their age and their gender by attending their own GP. Information was provided to all residents regarding the national screening programmes available through the approved centre.

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

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

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

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. The information documents provided by the approved centre were evidence-based, and were appropriately reviewed and approved prior to use.

Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs, and the medication sheets were generated by the St John of God Hospital pharmacy. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. The quality assessment was 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 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in February 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Audits were conducted on bathroom locks, cubicle curtains and shower curtains. A documented annual review (e.g. observational audit, walk-through 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. Service user-feedback resulted in findings which found 27% dissatisfaction with privacy. A documented 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, and the way in which staff interacted with residents was respectful. Staff knocked before entering residents' rooms. Where residents shared a room, the bed screening was adequate and it ensured that their privacy was not compromised.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. Locks had an override function. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Residents had their own phone or could use the public phone to make private phone calls.

Noticeboards in the general area of Ginesa Ward displayed identifiable resident information, specifically the full names of residents were displayed in a number of cases.

The approved centre was non-compliant with this regulation because resident's privacy was not protected at all times, with noticeboards detailing resident's full names in a number of cases.

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in February 2018. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment in place. Records were maintained. Appropriate signage and sensory aids provided supported resident orientation needs.

Accommodation for each resident in the approved centre assured their comfort and privacy and met their assessed needs. All bedrooms and communal rooms were appropriately sized to meet residents' needs. There was a sufficient number of toilets and showers for residents. The approved centre was clean, hygienic, free from offensive odours, and lighting, heating, and ventilation was adequate.

Residents in Carraig Dubh and Ginesa suites did not have access to any outdoor spaces unless accompanied by staff. There was no method provided for residents to directly control heating in the resident's own room.

Hazards were minimised in the approved centre. Ligature points were reduced to the lowest practicable level. Remote or isolated areas of the approved centre were monitored.

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

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures, including good prescribing practice guidelines, in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in April 2016. The guidelines document was last reviewed in February 2018. The policy and guidelines included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Each resident had an MPAR. All MPARs inspected evidenced a record of medication management practices, including a record of the following: two appropriate resident identifiers, medications administered, route of medication, dose of medication, and frequency of medication. A clear record of the date of initiation and discontinuation for each medication was recorded in each MPAR. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident were included in all cases.

All entries in the MPAR were written in black indelible ink. The generic name of creams and ointments was not always on the label of the products, but the MPAR detailed the generic name. Nurses were signing that they had administered ointments and creams when the resident was self-administering, and this was not coded as “self-administration under supervision”. In relation to medications for self-administration, one of the labels was illegible at the time of the inspection, and another label was not secure, it was falling off.

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

Medication dispensed or supplied to the resident was stored securely in a locked unit or fridge, where appropriate. The medication trolley remained locked at all times and secured in a locked room. Medication was appropriately stored, and medication storage areas were clean and tidy. Refrigerators used for medication were used only for this purpose and a log was maintained of the temperature.

A system of stock rotation was implemented, to avoid the accumulation of old stock, and an inventory of medications was conducted on a monthly basis.

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 evidence of implementation pillars.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had 12 written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in February 2018. The policies 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 policies. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in January 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process to cease monitoring a resident using CCTV in certain circumstances.

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

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

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe a resident were incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. The existence and usage of closed circuit television was disclosed to residents and or his or her representative at all times. The Mental Health Commission had been informed about the approved centre's use of CCTV.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The policy was last reviewed in November 2015. The policy and procedures addressed thirteen out of fifteen policy-related requirements of the *Judgement Support Framework*, including the following:

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

The policy and procedures did not address the following:

- 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.

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 relating to staffing, as set out in the policy.

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis as part of the function of the recently appointed training co-ordinator, and this was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents, and this was undertaken partly within the approved centre's manpower planning meetings. An occupational therapist position had been identified and filled for St. Peter's suite based on resident acuity.

Evidence of Implementation: Staff were recruited and selected in accordance with the approved centre's human resource and staffing policies. Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to undertake their role. A planned and actual staff roster was maintained, and it showed that an appropriately qualified staff member was on duty at all times. This was

documented. There were visiting healthcare professionals employed by the Cluain Mhuire Community Mental Health Service, who continued to meet with the catchment area patients when they were residents of the approved centre.

The number and skill mix of staffing was sufficient to meet resident needs. A written staffing plan was available within the approved centre and manpower planning meetings took place every two months to address staff planning needs. Where indicated, recruitment campaigns were initiated to address staffing needs.

Not all staff were trained in accordance with the assessed needs of the resident group profile and assessed needs of individual residents**,** as detailed in the staff training plan, which was based on a training needs analysis. Training included but was not limited to manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, dynamic risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults.

Staff training records were maintained for all categories of staff groups. Not all health care professionals were trained in the following:

- Fire safety.
- Basic Life Support.
- Management of violence and aggression (e.g. Therapeutic Crisis Intervention/Professional Management of Aggression and Violence [PMAV]).
- The Mental Health Act 2001.
- Children First

A copy of the Mental Health Act 2001 regulations and Mental Health Commission (MHC) rules and codes and all other MHC documentation and guidance were available to all staff in the approved centre.

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

Ward or Unit	Staff Grade	Day	Night
Ginesa Suite	CNM 2 1 CNM 1 1 RPN	Mon-Fri 5 staff until 14:00 then 4 staff until 21:00 Sat 3 staff all day 3 staff am & 4 staff in the evening	- - 2 (Plus twilight relief nurse 20:00-23:00)
Ward or Unit	**Staff Grade**	**Day**	**Night**
St. Camillus Suite	CNM 2 1 CNM 1 1 RPN	Mon/Thurs/Fri 5 staff in am and 3 staff in pm Sat / Sun 3 Staff all day	0 0 2
Ward or Unit	**Staff Grade**	**Day**	**Night**
St. Brigid's Suite	CNM 2 1 CNM 1 1 RPN	Mon-Fri 4 staff am and 3 staff in the pm Sat/Sun 3 staff all day	0 0 2
Ward or Unit	**Staff Grade**	**Day**	**Night**
St. Joseph's Suite	CNM 2 1 CNM 1 1 RPN	Mon-Fri 5 staff am & 4 staff in pm Sat/Sun 4 staff all day	0 0 2
Ward or Unit	**Staff Grade**	**Day**	**Night**
St. Peter's Suite	CNM 2 1 CNM 1 2 RPN	Mon-Fri 6 staff am & 5 staff in pm Sat/Sun 4 staff all day	0 0 3
Ward or Unit	**Staff Grade**	**Day**	**Night**
St. Paul's Suite	CNM 2 1 CNM 1 1 RPN	Mon-Fri 5 staff am & 4 staff in pm Sat/Sun 4 staff (HCAs as required in support of close observations)	0 0 2
Ward or Unit	**Staff Grade**	**Day**	**Night**
Carrig Fergus Suite	CNM 2 1 CNM 1 1 RPN	Mon-Fri 5 staff am & 4 staff in pm Sat/Sun 4 staff all day	0 0 2
Ward or Unit	**Staff Grade**	**Day**	**Night**
Carrig Dubh Suite	CNM 2 1 CNM 1 1 RPN	Mon-Fri 4 staff all day Sat/Sun 4 staff all day	0 0 2

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

Other Clinical Staff Providing Cover in the Approved Centre

Consultant Psychiatrist	10 WTE
Non-consultant Hospital Doctors	13 WTE

Nursing	145 WTE
Occupational Therapists	11 WTE
Art Therapists	1.0 WTE
Social Workers	9 WTE
Pastoral Care	1.64 WTE
Pharmacy	7 WTE
Psychology	11 WTE
Addiction Counsellors	4 WTE

Consultant Geriatrician (Sessional)
Speech & Language Therapist (Sessional)
Gym instructor (Sessional)
Dietitian (Sessional)
HCAs when required for 1:1 support.

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

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

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in November 2015. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. The records of transferred and discharged residents were included in the review process insofar as was practicable. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: A record was initiated for every resident assessed or provided with care and/or services by the approved centre and were in electronic format. Residents' access to their records was managed in accordance to the Data Protection Acts.

All residents' records inspected were secure, up to date, in good order and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents' current status and the care and treatment being provided. Records were developed and maintained in a logical sequence. All resident records were maintained using an identifier that was unique to the resident, and there were two appropriate resident identifiers recorded on all documentation.

Only authorised staff made entries in residents' records, or specific sections therein. Where student nurses or clinical training staff made entries on residents' records, this was countersigned by a registered nurse or clinical supervisor. Where a member of staff made a referral or consulted with another member of the health care team, this person was clearly identifiable by their full name and title.

Hand-written records were legible and written in black indelible ink. Entries in resident records inspected were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. The 24-hour clock was consistently detailed in each entry of residents' records.

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

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. The operating policies and procedures required by the regulations were all reviewed within the required three-year time frame, and obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

The operating policies and procedures were communicated to all relevant staff, were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines. The format of the operating policies and procedures was standardised to include: the title of the policy and procedure; the reference number and revision of the policy and procedure; the document owner; approvers; reviewers; the scope of the policy and procedure; the date at which the policy would be implemented or effective from; the scheduled review date (the document was re-dated after each review); and the total number of pages in the policy and procedures.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in November 2015. The policy and procedures included all of the requirements of the *Judgement Support Framework*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals. The Mental Health Act Administrator kept a running spreadsheet of each tribunal and actioned any issues as they arose.

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

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Audits of the complaints log and related records had been completed. Audits were documented and the findings acted upon. Complaints data was analysed. Details of the analysis were considered by senior management. Required actions were identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre's policy. The complaints procedure, including how to contact the nominated person was publicly displayed, and it was detailed within the resident information booklet. Complaints details were also available on the approved centre's website, and in a complaints leaflet.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms. All complaints were handled promptly, appropriately and sensitively.

Timeframes for a response and outcome of complaint were identified. A timeframe of five working days was in place to respond to the complainant following the initial receipt of the compliant, thirty days was the investigation period for complaints, and a period of six months was given for the required resolution of complaints. Where timeframes were not achieved or further investigation time was required in relation to the complaint, this was communicated to the complainant.

Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's ICP. The registered proprietor ensured that the quality of the service and care and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented separately to other complaints. The complainant's satisfaction or dissatisfaction with the investigation findings was documented in the complaints log held by the nominated complaints individual.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had 25 written policies in relation to risk management and incident management procedures. The risk management and procedures policy was last reviewed in February 2018. The policies addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

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

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

Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed at admission, at resident transfer, at resident discharge, and in conjunction with medication requirements or medication administration, in advance of resident seclusion and specialised treatment such as electro-convulsive therapy. These risk assessments were completed with the aim of identifying individual risk factors. Structural risks, including ligature points, were removed or effectively mitigated.

Residents and/or their representatives were involved in the individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the MDT at their regular meeting. A record was maintained of this review and recommended actions.

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

The approved centre was compliant with this regulation. The quality assessment was 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 outside each of the wards of the approved centre.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy was last reviewed in February 2018. The policy addressed all policy-related criteria of this rule, including ECT protocols developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice and had appropriate training and education in Basic Life Support techniques.

There were no involuntary patients receiving ECT at the time of inspection, and therefore this rule was inspected against two pillars only.

The approved centre was compliant with this rule.

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of seclusion, dated May 2017. It addressed all of the elements of this rule, including the following:

- Those authorised to carry out seclusion.
- The provision of information to the patient.
- Ways of reducing seclusion rates.

Training and Education: All staff involved in the use of seclusion had signed the signature sheet, indicating that they had read and understood the policy.

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

Evidence of Implementation: The clinical files of three voluntary patients who had been placed in seclusion were inspected. In all cases, seclusion was initiated by a registered medical practitioner (RMP) and/or registered nurse. The consultant psychiatrist was notified of the use of seclusion as soon as was practicable, and this was recorded in clinical files. Where seclusion was initiated by a registered nurse, an assessment, including a risk assessment, was completed prior to seclusion taking place. The episodes of seclusion were recorded in the clinical files and seclusion register by the registered medical practitioner. The seclusion register was signed by the responsible consultant psychiatrist within 24 hours.

Voluntary patients in seclusion had access to adequate toilet and washing facilities. Seclusion facilities were furnished, maintained, and cleaned to ensure respect for residents' dignity and privacy. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

In each episode, seclusion was used only in rare and exceptional circumstances, in the best interests of each patient, and after all other interventions to manage the patient's unsafe behaviour had first been considered by the service. Cultural awareness and gender sensitivity were exhibited in each episode of seclusion. In all cases, the implementation and use of CCTV to monitor each patient in seclusion was appropriate, and viewing of CCTV was restricted to designated personnel. Patients were informed of the reasons for, duration of, and circumstances leading to the discontinuation of seclusion, and next of kin

were informed in two cases. Next of kin were not informed in one case and the reasons for this were documented in the clinical file.

In each episode of seclusion, a registered nurse directly observed each patient for the first hour. A written record of each patient in seclusion was made by a registered nurse every 15 minutes, and each patient's level of distress and behaviour were documented. Nursing reviews and medical reviews in relation to seclusion took place, and were completed within the stipulated timeframe by registered medical practitioners.

All uses of seclusion were clearly recorded in the clinical files and on the seclusion register. In all episodes of seclusion inspected, patients were informed of the ending of seclusion and the reasons for ending seclusion were recorded in the clinical files. Each episode of seclusion was reviewed by the multi-disciplinary team, and documented in the clinical file within two working days after the episode of seclusion.

The approved centre was compliant with this rule.

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

There were 11 detained, i.e. involuntary patients in the approved centre at the time of the inspection. The clinical file of one detained patient was inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. There was documented evidence that the responsible consultant psychiatrist had assessed the patient's capacity to consent to his/her treatment. The result of the assessment was that the patient was deemed as not being capable of providing consent to his/her treatment due to a lack of capacity to consent.

The *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult)- Unable to Consent*, contained in the clinical file of this patient evidenced the following:

- The names of the medications prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of discussions with the patient, including:
  - The nature and purpose of the medications.

- The effects of the medications, including any risks and benefits.
- Supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist.
- Authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001.

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating HIGH

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.

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually and was last reviewed in July 2017. The policy addressed all of the policy-related criteria of this code of practice including the following:

- The provision of information to the resident.
- Those who can initiate and implement physical restraint.
- Child protection processes where a child was physically restrained, including details of appropriate training for staff in relation to child protection.

Training and Education: There was no documented evidence to indicate that all staff involved in physical restraint had read and understood the policy.

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

Evidence of Implementation: The files of two adult residents and one child resident, who each had been physically restrained once since the last inspection, were inspected. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour. In all cases, the restraint order did not extend beyond the maximum period of 30 minutes.

All residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. In the case of the child resident, however, there was no documented evidence to indicate that their parent/guardian were informed of the child's physical restraint as soon as possible.

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

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

a) **In the case of the child resident, there was no documented evidence to indicate that the parent (s)/guardian (s) were informed of the child's physical restraint as soon as possible, 11.1.**
b) **There was no documented evidence to indicate that all staff involved in physical restraint had read and understood the policy.**

Admission of Children

COMPLIANT

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had one written policy and protocols in place in relation to the admission of a child, which was last reviewed in September 2017. The policy included all of the policy related criteria of this code of practice including:

- The requirement for each child to be individually risk-assessed.
- Procedures in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training relating to the care of children.

Evidence of Implementation: The approved centre had a children's ward facility, which was age-appropriate and a programme of activities appropriate to age and ability was provided. There were eleven children in the approved centre on the first day of the inspection. Appropriate accommodation was designated, including age and gender-segregated sleeping and bathroom areas. Observation arrangements, including the assignment of a designated staff member, was provided as considered clinically appropriate.

Provisions were in place to ensure the safety of the child, and to ensure the right of the child to have his/her views heard. Children had their rights explained and information about the ward and facilities were provided in a form and language that they could understand. Consent for treatment was obtained from one or both parents. Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre.

All staff having contact with children had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Children had access to age-appropriate advocacy services: The Youth Advocacy Programme (YAP), had commenced in August 2017.

The approved centre was compliant with this code of practice.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. It was last reviewed in February 2018. The policy addressed all of the policy-related criteria of this rule, and it detailed ECT protocols developed in line with best international practice, which addressed:

- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice and had appropriate training and education in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had responsibility for ECT management, and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical files of two voluntary patients who were receiving ECT were examined. The consultant psychiatrist assessed both patients' capacity to consent to receiving treatment, and this was documented in each patient's clinical file. Both patients were deemed capable of consenting to receiving ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable each patient to make a decision on consent. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side effects. Information was provided both orally and in writing, in a clear and simple language that each patient could understand. Each patient was informed of his/her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia. The consultant psychiatrist administered a capacity assessment on both patients.

A programme of ECT for each of the two patients was prescribed by the responsible consultant psychiatrist and recorded in the clinical files. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with each patient and/or next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical files, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine.

The ECT record which was completed after each treatment was placed in the clinical files, and the signature of the registered medical practitioner administering ECT was detailed. All pre and post ECT assessments were detailed and recorded in the clinical files. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical files.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **LOW**

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. The admission policy was last reviewed in April 2018, the transfer policy in January 2017, and the discharge policy in July 2017. All policies combined included all of the policy-related criteria of the code of practice.

Training and Education: There was no documentary evidence of staff signatures to indicate that all 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, discharge, and transfer policy.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident's family member/carer/advocate were involved in the admission process, with the resident's consent. The resident received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information such as work situation, education, and dietary requirements. The resident received a full physical examination.

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

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

A preliminary discharge summary was sent to the general practitioner/primary care/Community Mental Health Team (CMHT) within three days. A comprehensive discharge summary was issued within 14 days, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was non-compliant with this code of practice because there was no documentary evidence that all relevant staff had read and understood the admission, transfer, and discharge policies, 9.1.

Regulation 5: Food and Nutrition

Report reference: Page 20

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. Not all residents were provided with food which took into account their special dietary requirements, 5(2).	New	Corrective Action(s): All teams will be reminded that specific dietary requirements must be noted, included and carried forward in individual care plans. Post-Holder(s) responsible: Consultant Psychiatrists and Clinical Nurse Managers on each Suite	Minute at CGQSEC meeting and Clinical Nurse Managers Meeting	Non-attendance at meetings and information not disseminated from meetings.	16 October 2018
		Preventative Action(s): Audits to check compliance Post-Holder(s) responsible: Health Promotion Nurse & Nurse Practice Development Manager	Audits scheduled	Delay in completion of audits	As per annual audit schedule

Regulation 7: Clothing

Report reference: page 22

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
2. Residents without an adequate supply of their own clothing were not provided with an adequate supply of appropriate individualised emergency clothing with due regard to their dignity and bodily integrity at all times.	New	Corrective Action(s): This matter was addressed during the inspection and acknowledged as rectified by the inspector before the end of the inspection process. Post-Holder(s) responsible: Head of Accommodation Services	This action has been completed already	Already achieved	Completed
		Preventative Action(s): Check stock on a regular basis Post-Holder(s) responsible: Head of Accommodation Services	Stock take records	None	Ongoing

Regulation 15: Individual Care plan

Report reference: Page 30-31

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. In two cases the ICP was not drawn up by the MDT within the required timeframe of seven days.	New	Corrective Action(s): All Department Heads will be emailed regarding the importance of ensuring that all ICPs are reviewed as per policy, within 7 days Post-Holder(s) responsible:Clinical Director	Read receipt will be attached to the email	Achievable	31.10.2018
		Preventative Action(s): Weekly audit of ICP will continue Post-Holder(s) responsible: As above	Weekly audit	Achievable	Ongoing
4. Not all ICPs were developed by the full MDT.	New	Corrective Action(s): All MDTs will be emailed to remind staff of the importance of ensuring that the full MDT should attend each patients care plan review. Post-Holder(s) responsible:Clinical Director	Read receipt will be attached to the email	Achievable	31.10.2018
		Preventative Action(s): Bi-Annual quality audit of the MDT care plans will be adjusted to ensure the presence of multiple members of the MDT will be taken into account Post-Holder(s) responsible: Chair of Clinical Effectiveness & Quality Improvement Committee	Bi-annual audit	Achievable	Ongoing on bi-annual basis

Regulation 21: Privacy

Report reference: page 40

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
5. Resident's privacy was not protected at all times, with noticeboards detailing resident's full names in a number of cases.	New	Corrective Action(s): Suite in question instructed to ensure that full names are not listed on this noticeboard. Post-Holder(s) responsible: Clinical Nurse Manager II, Adolescent Suite	CMNII will check regularly	None	Immediate
		Preventative Action(s): Regular checks by the CNMII Post-Holder(s) responsible: Clinical Nurse Manager II, Adolescent Suite	As above	None	Ongoing

Regulation 26: Staffing

Report reference: Pages 47 - 50

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
6. Not all relevant staff had up-to-date mandatory training in basic life support, fire safety, PMAV, 26 (4). 7. Not all relevant staff had up-to-date mandatory training in the Mental Health Act, 2001, 26(5). 8. Not all staff were trained in Children first.	Reoccurring	Corrective Action(s): To ensure all relevant staff are up to date with Mandatory Training Post-Holder(s) responsible: Training / Human Resources Manager and All Heads of Depts.	New Training Officer in place since February 2018 with total focus on staff training. Continuous monitoring and recording of staff training records. Arranging and scheduling training courses as required Monthly reports issued to Management. Reminders sent to staff to complete training 2019 Training Schedule to be issued by Dec 2018 to enable planned training over the year	Staff shortages may prevent relevant staff from attending training courses Patient emergencies can prevent relevant staff from attending courses at short notice Lack of IT skills for some support staff to complete online training Staff returning from maternity leave, sick leave, and career break have to wait for next scheduled course.	Ongoing action Plan to be 100% compliant in all mandatory training by end of 2018
		Preventative Action(s): As above Post-Holder(s) responsible: As above	Training Officer will monitor and submit monthly reports to the Management Team via the Human Resources Manager	None	Ongoing

Codes of Practice: Use of Physical Restraint

Report reference: Pages 70

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
9. In the case of a child resident there was no documented evidence to indicate that the parent(s)/ Guardian(s) were informed of the child's physical restraint as soon as possible, 11.1.	Reoccurring	Corrective Action(s): All check lists for Physical restraints to be fully completed immediately after an episode of Physical restraint which includes contacting NOK. Post-Holder(s) responsible:CNM2s on each suite and CNM3	Documentation to be checked by ward manager and notification sent to CNM3 on a monthly basis	none	To commence immediately
		Preventative Action(s) CNM3 to receive reports from CNM2s on all physical restraints within the hospital on a monthly basis and documentation to be checked to ensure that the checklist for the code of practice is completed. Post-Holder(s) responsible: As above	Monthly reports returned to CNM3	none	Immediately
10. There was no documented evidence to indicate that all staff involved in physical restraint had read and understood the policy.	Reoccurring	Corrective Action(s): Nursing staff complete individual induction booklets which show a record of the policies read and understood. The physical restraint policy is included in this. Other departments must have a procedure in place to ensure that this policy is read and understood and subsequently signed off. Post-Holder(s) responsible: CNM2s, DDON, NPDM	Induction booklets to be checked for sign-off on relevant policies	none	ongoing
		Preventative Action(s): As above Post-Holder(s) responsible: As above plus Heads of Department	All staff involved in Physical restraint must be made aware of the policy	High staff turnover	ongoing

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 74-75

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
11. No documentary evidence that all relevant staff had read and understood the admission, transfer, and discharge policies, 9.1.	Reoccurring	Corrective Action(s): Check that policies are signed off Post-Holder(s) responsible: Clinical Heads of Department and Admissions Staff	Sign-off records can be checked to ensure compliance	Staff on maternity leave, career break, sick leave	31 October 2018
		Preventative Action(s): As above Post-Holder(s) responsible: As above	As above	As above	Ongoing