St. Patrick's University Hospital

ID Number: AC0005

2018 Approved Centre Inspection Report Mental Health Act 2001)

St. Patrick's University Hospital
James's St
Dublin 8.

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
1 March 2017

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan, CEO

Registered Proprietor Nominee:
N/A

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

Inspection Date:
1 – 4 May 2018

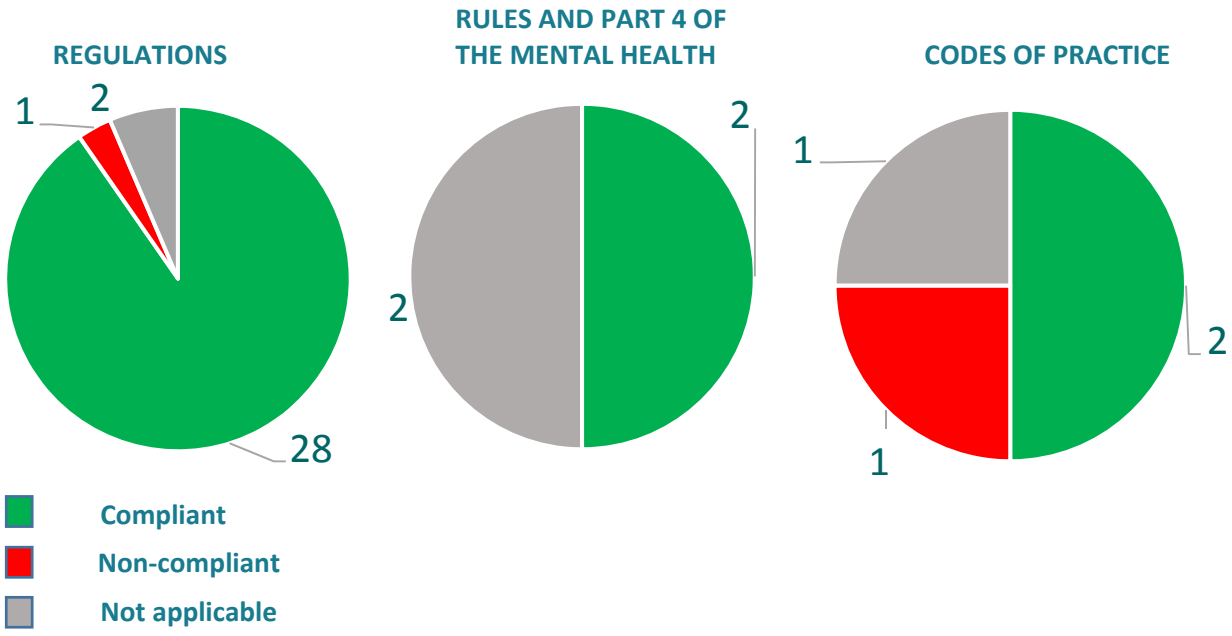
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
9 – 12 May 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
15 November 2018

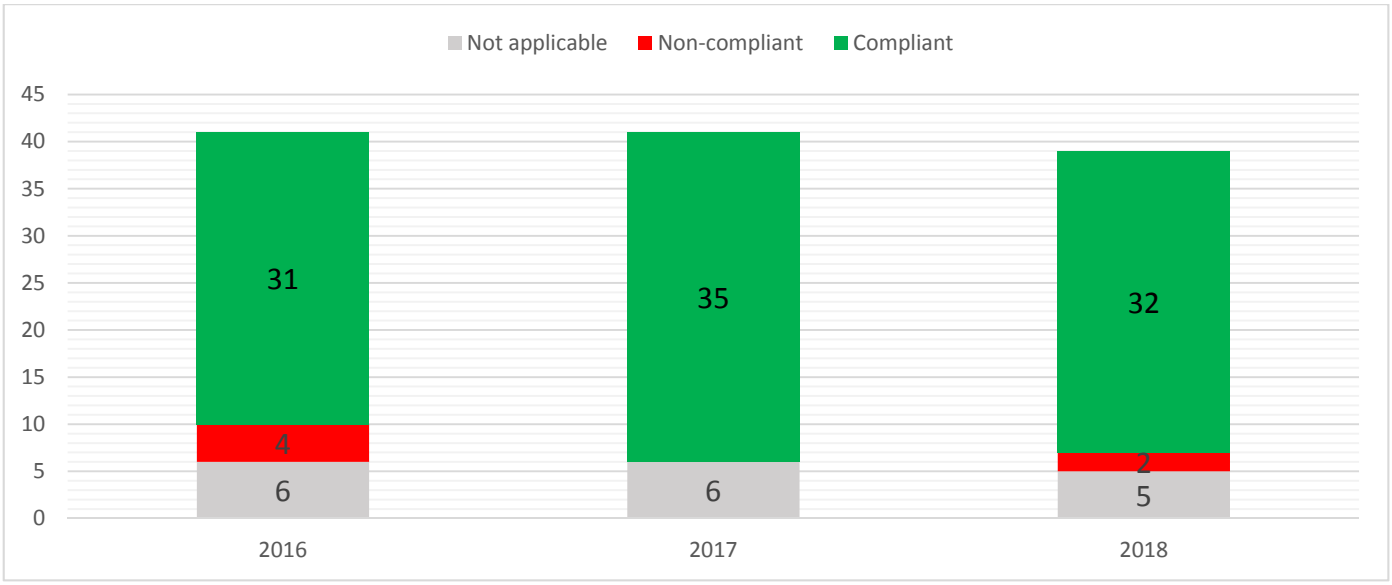
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

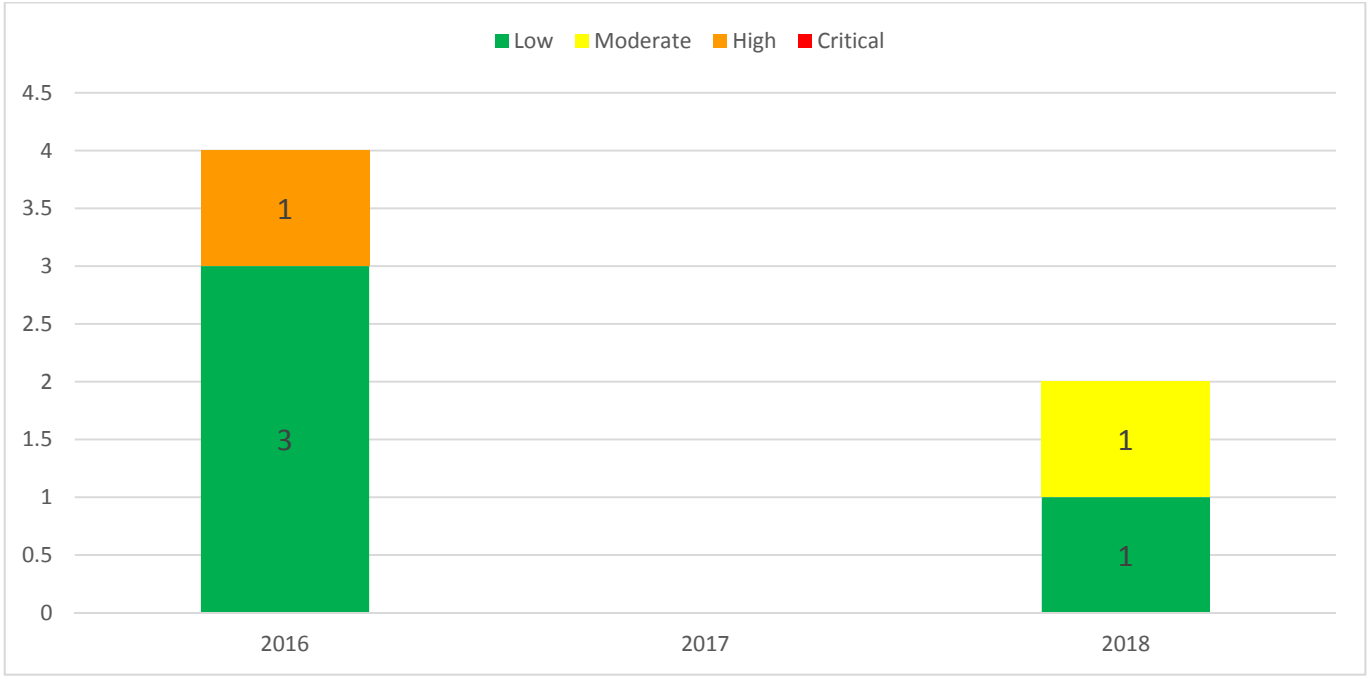
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



Please note: There were no areas of non-compliance in the 2017 inspection.

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".

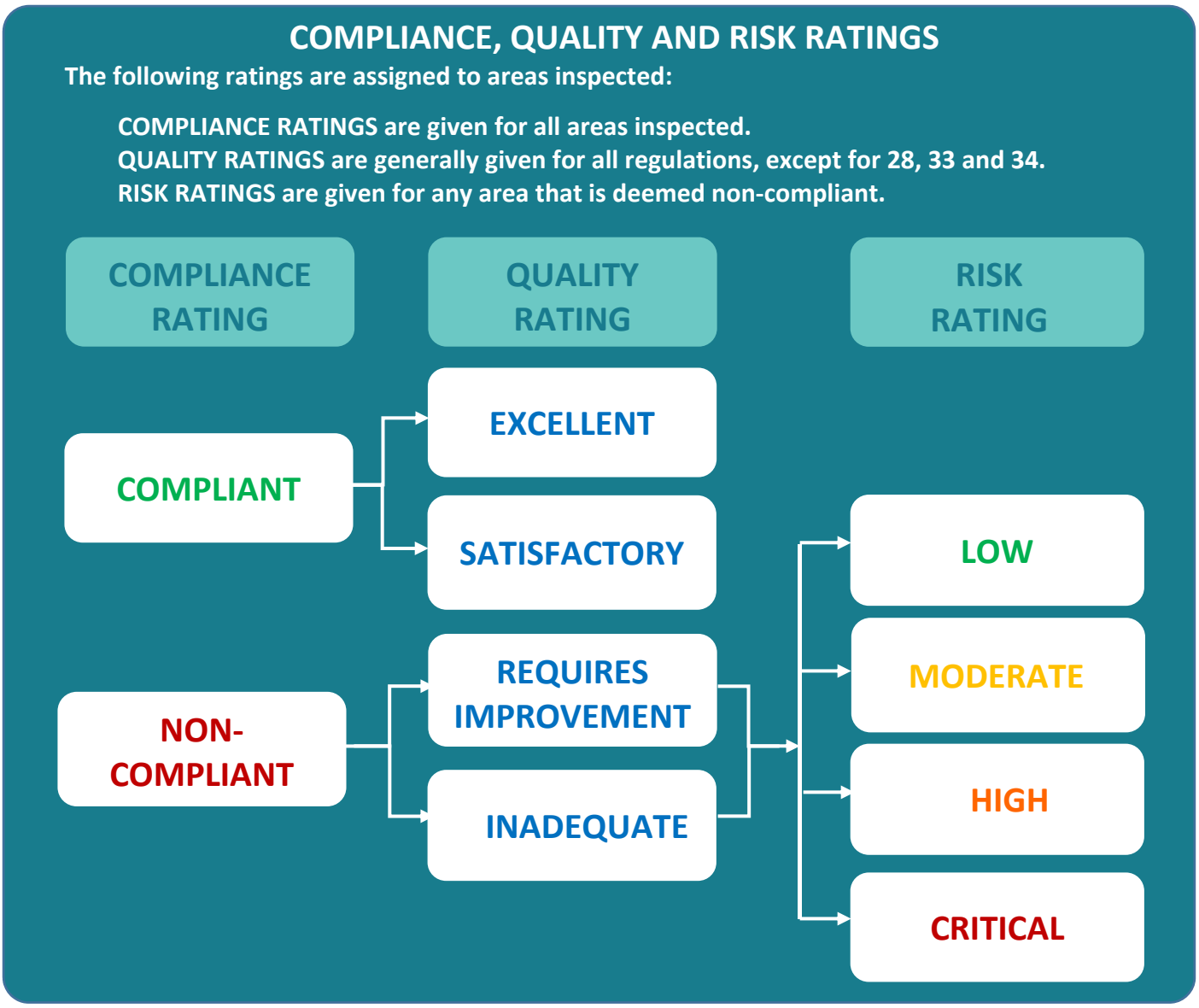
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

The approved centre was a 241-bed independent hospital and was part of the St. Patrick's Mental Health Service in central Dublin. It comprised eight wards: Dean Swift, including Special Care Unit (acute admissions); Stella, Grattan, Delaney, and Kilroot (general admissions); Vanessa (care of the elderly); Clara (eating disorders); and Temple (addictions service). The approved centre did not admit children.

The approved centre was non-compliant with only one regulation and one code of practice. There were 18 (58%) compliances with regulations that were rated excellent.

Safety in the approved centre

Food safety audits were carried out and the kitchen areas were clean. A system of using two patient identifiers was in place. Ligature points had not been minimised, which was not conducive to the safety and well-being of residents. Medication was ordered, prescribed, stored and administered in a safe manner. A comprehensive risk management policy was implemented. Staff were trained in Basic Life Support, fire safety, management of aggression and violence and the Mental Health Act.

Appropriate care and treatment of residents

Each resident had an individual care plan that was multi-disciplinary and developed with the resident. Therapeutic services and programmes were provided in line with the needs of residents, which were identified in their care plans. Physical health was assessed at admission and regularly thereafter. An early warning score system had been introduced which assisted registered psychiatric nurses in recognising individuals who are physically deteriorating, ensuring early intervention.

The approved centre complied with Part 4 of the Mental Health Act Consent to Treatment. Admission, transfer and discharge of residents was satisfactory. All residents' records were electronic, on-screen health records. Records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements.

Respect for residents' privacy, dignity and autonomy

The entrance/exit door of the special care unit was locked at all times to ensure the safety and welfare of the residents. Residents could access the enclosed garden area freely. The remainder of the approved centre was open. With regard to physical restraint, the clinical practice form was not signed by the consultant psychiatrist within the required 24-hour timeframe. Instead, in all three cases the clinical practice form was signed by the consultant psychiatrist 13-15 days after the physical restraint had occurred. Seclusion was not used**.** Respect for residents' privacy and dignity was apparent throughout the approved centre.

Residents could receive visitors in private or in the hospital coffee shop. CCTV was not used in the approved centre.

Responsiveness to residents' needs

The approved centre was well maintained internally and externally; however, one shower room was observed to have black mould on the ceiling and one bathroom was malodourous.

There was excellent information about the approved centre, residents medication and diagnosis provided to residents. There was a robust complaints procedure in place.

There was a good choice of food at mealtimes and healthy options were available. There was a wide range of recreational activities.

Governance of the approved centre

St. Patrick's University Hospital was part of St. Patrick's Mental Health Services. The hospital was built in 1746 and is governed by charter. The charter outlines the governance of the approved centre through a board of governors consisting of both ex officio and appointed members. The senior management team were responsible for the direct operation of the approved centre. A detailed clinical and corporate governance structure was in place.

The governance structure included a clinical governance committee, a risk and safety committee, a resuscitation committee, an infection control committee, a research ethics committee, a falls committee, a risk and safety committee, and a drugs and therapeutics committee.

The senior management team met fortnightly. Issues such as service development, health and safety, facilities, and risk management were discussed at these meetings and minutes evidenced a robust and active agenda with outcomes and actions allocated accordingly.

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The implementation of the e-swift system (an electronic records system). This system provided access and shared clinical information in real time across departments and service locations.

2. An early warning score system had been introduced which assisted registered psychiatric nurses (RPNs) in recognising individuals who are physically deteriorating, ensuring early intervention.

3. The introduction of the prompt assessment of needs, which provided early access to initial assessments for non-inpatient referrals from their own home, reducing waiting time.

4. The introduction of nurse prescribing among the team liaison nurse group.

5. The redesign of the approved centre's website, which included a new GP portal and media centre.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was an independent hospital and part of the St. Patrick's Mental Health Service. It was located in central Dublin. The original hospital structure was an 18th century listed building. A variety of extensions had been developed over the years. The approved centre was registered for up to 241 residents.

The approved centre comprised eight wards: Dean Swift, including Special Care Unit (acute admissions); Stella, Grattan, Delaney, and Kilroot (general admissions); Vanessa (care of the elderly); Clara (eating disorders); and Temple (addictions service). The approved centre did not admit children.

The approved centre was well maintained and decorated throughout. From the reception area in the hospital to all the wards, the décor and furnishings made for a respectful and relaxed environment to service-users. There was an exhibition space available to residents, which provided a new artist's exhibition several times per year. A wide range of therapeutic services were offered. Residents had access to a large garden and therapy garden within the approved centre grounds.

During the course of the inspection, the approved centre accommodated 233 residents. There were eight detained patients within the approved centre at the time of inspection. Residents were under the care of 13 consultant teams.

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

Resident Profile	
Number of registered beds	***241***
Total number of residents	**233**
Number of detained patients	8
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	2
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

St. Patrick's University Hospital was part of St. Patrick's Mental Health Services. The approved centre was formed in 1746 and is governed by charter. The charter outlines the governance of the approved centre through a board of governors consisting of both ex officio and appointed members. The senior management team were responsible for the direct operation of the approved centre. A detailed clinical and corporate governance structure was in place.

The governance structure included a clinical governance committee which was held weekly, a risk and safety committee which was held monthly, a resuscitation committee which was held every two months, an infection control committee which was held monthly, a research ethics committee which was held quarterly, a falls committee which was held every two months, a risk and safety committee which was held monthly, and a drugs and therapeutics committee which was held every two months.

The senior management team met fortnightly. The minutes from these meetings were provided to the inspection team. There was an active governance process involving senior management and, as appropriate, members of various disciplines within the approved centre. Issues such as service development, health and safety, facilities, and risk management were discussed at these meetings, which evidenced a robust and active agenda with outcomes and actions allocated accordingly.

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place.

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

- Clinical Director
- Director of Nursing
- Head of Social Work
- Director of Psychology
- Occupational Therapy Manager
- Director of Services
- Chief Executive Officer

All heads of discipline provided a clear overview of the governance within their respective departments. Each head of discipline was based in the approved centre. Defined lines of responsibility were evident in each department. Each head of discipline met with staff on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the senior management team. All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments. The medical, nursing and psychology departments had formal staff performance appraisals in place. The occupational therapy and social work department did not have staff performance appraisals but relevant heads of discipline stated that this process was informally facilitated or addressed through supervision.

All heads of discipline had received training on clinical risk management and each department maintained a risk register. All heads of discipline identified strategic aims for their teams and discussed potential operational risks with their departments. These were agenda items at senior management meetings. Key performance indicators assisted the approved centre to measure how well they were doing in relation to achieving set goals. Clear systems were in place to support quality improvement.

4.5 Use of restrictive practices

The entrance/exit door of the special care unit was locked at all times. This was a mechanism to ensure the safety and welfare of the residents. Residents could access the enclosed garden area freely.

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 22: Premises	✓		✓		✗	Low
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✓		✗	Moderate

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 20: Provision of Information to Residents
Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines
Regulation 26: Staffing
Regulation 27: Maintenance of Records
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.

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.

Six residents requested to meet with the inspection team. Residents were complimentary of staff and stated that they were helpful, supportive, informative, and kind. Residents expressed feeling safe in the approved centre. Residents stated that they were happy with the selection of therapeutic programmes and recreational activities available to them. Residents were also complimentary of the food and expressed having a good selection of food to choose from.

All residents were invited to complete a questionnaire about their experience in the approved centre. In total, two questionnaires were returned. Both residents reported that they understood what their individual care plan was.

Of those surveyed, each resident knew who their multi-disciplinary health care team members were. Both residents felt able to give feedback to staff, and to make complaints if they were not satisfied with any part of their stay in the approved centre.

Both residents felt that they had sufficient space for privacy. Finally, both residents stated that they had enough activities during the day.

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:

- Director of Psychology
- Chief Executive Officer
- Clinical Director
- Head of Social Work
- Director of Services
- Chief Pharmacist
- Occupational Therapy Manager
- Programme Manager for Clinical Governance
- Mental Health Act Administrator
- Director of ICT

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

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

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

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had five written policies in relation to food and nutrition. The nutritional care policy was last reviewed in May 2016. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The approved centre's menus were approved monthly by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. This resulted in recent introductions of healthier options including brown bread, more fruit and vegetables, and healthier desserts.

Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Fruit bowls were available to residents on all wards. There was a choice of hot meals at both lunchtime and teatime. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly, and fresh water was available from dispensers on each ward.

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

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had three written policies in relation to food safety. The catering department service plan and the food preparation zoning policy were last reviewed in July 2015. The waste management policy was last reviewed in September 2015. The policies combined included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in the main kitchen of the hospital and was transported to the ward areas of the approved centre. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

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

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Satisfactory**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. A record of residents wearing night clothes during the day, as indicated by their individual care plan, was maintained and monitored.

Evidence of Implementation: One resident was prescribed to wear night clothes during the day and this was specified in their individual care plan. Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents had an adequate supply of individualised clothing.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

(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 four written policies in relation to residents' personal property and possessions. The service-user property policy was last reviewed in September 2015. The policies combined included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept distinct from the resident's individual care plan (ICP). The checklist was updated on an ongoing basis in accordance with the approved centre's policy.

Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions. All residents had their own personal safe within their wardrobes. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

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

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 five policies in relation to the provision of recreational activities, and the recreational activities policy was last reviewed in May 2018. The policies combined included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Accessible and suitable information on the activities available to residents was provided in the information booklet that each resident received on admission. The timetable for activities was widely displayed on noticeboards including the electronic notice board in reception, and in the Eolas information centre.

Activities included TV, books, board games, arts and crafts, pottery, jewellery making, walking group, bingo, Tai Chi, yoga, a music group, gardening, movie nights, dancing, quizzes, and an internal and external gym and pool. A hairdresser was available by appointment in the approved centre once a week. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. The approved centre offered access to relaxation rooms, and external gardens, which included a pitch and putt course, a basketball court and a tennis court.

The approved centre had a dedicated occupational therapy department, which included a music room, art room, pool rooms, music rooms, a crafts room, a pottery room, a movie room, a computer room, library and an occupational therapy kitchen. There was an information centre, a family room, a hospital shop, and a hairdressing salon also available to residents. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at events were maintained in group records or in the 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 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 September 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 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. This was documented.

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

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in March 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 visits, as set out in the policy.

Monitoring: Restrictions on residents' rights to receive visitors was monitored and reviewed on an ongoing basis. Analysis was not completed to identify improvement, as the current restrictions were not deemed sufficient to justify documented analysis.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed at the hospital entrance and in each ward of the approved centre. Clinical files documented the names of visitors the resident did not wish to see and those who posed a risk to the resident. 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. It was possible for visits to take place in private bedrooms and other quiet areas. Visits also occurred in multifunctional rooms when they were not in use for other purposes.

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, and facilities such as the Wishing Well Family Room available was suitable for visiting children.

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 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 seven written operational policies and procedures in relation to resident communication. The Service User Access To Communication Facilities Policy was last reviewed in March 2017. The policies combined included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents had access to mail, fax, email, internet, and telephone if they wished. A computer room was available to residents seven days a week. Wi-Fi was also available throughout the approved centre.

In Dean Swift Ward, residents could use their own mobile phones or they could attend the computer room, following a risk assessment. Residents in special care wards did not have access to their own phones, but they were able to receive phone calls through the unit's cordless phone. There was a separate mobile handset available on all units, which residents could use in private. There were also two private phones attached to booths on the Delaney Ward.

Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. The Clinical Director/senior staff member designated by the Clinical Director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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 and procedures in relation to the implementation of resident searches. The policy was last reviewed in March 2017. 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 had been completed to identify opportunities for improvement of search processes.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches. The clinical file for one resident who was searched was inspected. Risk had been assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. The resident's consent was sought and documented, prior to the search taking place.

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

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

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

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

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had four written operational policies and protocols in relation to care of the dying. The care of the dying policy was last reviewed in September 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 interviewed were able to articulate the processes for end of life care, as set out in the policy.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Each resident had an ICP, ten of which were inspected. The ICP in the approved centre was part of the online electronic health records. A key worker was identified to ensure continuity in the implementation of a resident's ICP. 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 had been assessed at admission by the admitting clinician and an initial ICP was completed by the admitting clinician to address the immediate needs of the resident. All residents received an evidenced-based comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, and next of kin, as appropriate. Residents were requested to complete the Patient View and Opinions Form in advance of meeting the multi-disciplinary team, and family were involved in residents' ICPs with residents' consent.

The ICPs identified residents' assessed needs, appropriate goals, the care and treatment required to meet the identified goals including the frequency and staff responsibilities for implementing the care and treatment. The ICP identified the resources required to provide the care and treatment identified. The ICP included a risk management plan. However, three out of ten ICPs inspected did not have a preliminary discharge plan documented.

The ICP was reviewed by the MDT in consultation with the resident regularly. Residents had access to their ICPs and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews. All residents were asked to sign their ICP.

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

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 30 written policies in relation to the provision of therapeutic services and programmes. The Pathways to Wellness Programme Policy was last reviewed in June 2016. The policies combined 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 policies. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policies.

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: All therapeutic services and programmes provided by the approved centre were extensive, 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 services and programmes 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, and each ward had facilities to carry out group programmes or one to one sessions. Generally, therapeutic services and programmes needed were provided internally. 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 was because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

(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 four written policies and procedures in relation to the transfer of residents. The transfer to another approved centre or healthcare policy was last reviewed in January 2018. The policies combined included all of the requirements of the *Judgement Support Framework*.

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

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. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre to the other facility. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This communication included the reasons for transfer, the resident's care and treatment plan, including needs and risks, and the resident's accompaniment requirements on transfer.

The resident was assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident's needs. Relevant documentation was issued as part of the transfer, with copies retained, including a letter of referral with a list of current medications and a resident transfer form. 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 resident's clinical file.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two separate written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The physical examination and general health management policy was last reviewed in April 2018. The medical emergencies policy was last reviewed in September 2017. The policies and procedures included 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 policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

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

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator. Emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs, and each of the two clinical files inspected evidenced that both residents had received a six-monthly general health assessment.

Residents on antipsychotic medication did not have an annual assessment of prolactin levels. Adequate arrangements were in place for residents to access general health services and to be referred to other health services, as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Residents had access to national screening programmes appropriate to age and gender.

Information was provided to all residents regarding the national screening programmes available verbally through their GP, and in written form through primary care. There was a policy on tobacco use. Nicotine replacement therapy was available as a resource for staff to support residents in smoking cessation. Residents did not have access to comprehensive smoking-cessation programmes and supports.

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 **Excellent**

(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 two written operational policies and procedures in relation to the provision of information to residents. The Service User and Family Education Journey policy was last reviewed in March 2017, and the Accessing Interpreting and Translation Services policy was last reviewed in June 2017. The policies combined included all of the requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policies.

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

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

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 justification for restricting information regarding a resident's diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to

the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a series of operational policies in relation to resident privacy. The policy entitled ''Maintaining Service Users' Privacy when accessing St. Patrick's Mental Health Services'' was last reviewed in March 2017. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

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

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors unless there was an identified risk to residents. Where this risk was identified and toilet doors were not lockable, a clear process to safeguard resident privacy at all times was not in place. Locks had an override facility. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

Where residents shared a room, the bed screening ensured that their privacy was not compromised. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls; a cordless phone was available but most residents had their own mobile phones with the exception of the Dean Swift SCU unit.

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 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(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 series of written policies in relation to its premises, one of which was last reviewed in September 2015. The policies combined addressed all of the requirements of the *Judgement Support Framework*.

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

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 adequately lit and heated. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise/acoustics. All resident bedrooms were appropriately sized to address residents' needs. There was sufficient space for residents to move about, including outdoor spaces. Appropriate signage and sensory aids were provided to support resident orientation needs.

Hazards, including large open spaces, steps and stairs, slippery floor, hard and sharp edges, and hard or rough surfaces, had been minimised. Numerous potential ligature points were observed throughout the approved centre and continuous works were underway to minimise these. A continuous programme of review was underway in order to reduce ligature anchor points throughout the entire service.

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. There was a cleaning schedule implemented within the approved centre. The approved centre

was generally clean, hygienic, or free from offensive odours. There was, however, a male toilet which was malodorous and a shower room which was observed to have black mould growing on the ceiling.

Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed. Back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre. The approved centre had a designated sluice room, a designated cleaning room, and a designated laundry room. The approved centre provided assisted devices and equipment to address resident needs, and there were appropriately sized lifts where applicable. Remote or isolated areas of the approved centre were monitored, and the introduction of the SALTO system of controlled entry had removed the possibility of residents entering unstaffed areas.

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

a) **The premises were not clean and maintained in good decorative condition; one shower room was observed to have black mould on the ceiling, 22(1)(a).**
b) **The premises were not adequately ventilated; one bathroom was malodourous, 1(b).**

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

COMPLIANT

Quality Rating **Excellent**

(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 32 written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication, which were last reviewed in April 2018. The policies combined included all the requirements of the *Judgement Support Framework.*

Training and Education: All nursing, pharmacy, and medical 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. All 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, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's on-screen MPAR. A record was kept when medication was refused by the resident.

All entries in the electronic MPAR were colour coded to confirm administration of medication or not. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition. This was documented in the clinical file. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication was checked prior to administration, and expired medications were not administered. All medicines were administered by a registered nurse or registered medical practitioner and, any advice provided by the resident's pharmacist regarding the appropriate use of the product was adhered to.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a locked room. Medication refrigerators were kept locked. Refrigerators used for medication were used only for this purpose and a log was maintained of the refrigeration storage unit temperatures. An inventory of medications was conducted on a monthly basis by the pharmacy, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.

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

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in June 2016. The policy addressed all the requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

Quality Rating **Excellent**

(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 72 written policies and procedures in relation to the recruitment, selection and vetting of staff. All policies were in-date. The policies combined 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 relevant policies. Relevant staff interviewed were able to articulate the processes relating to staffing, as set out in the policies.

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

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

Opportunities were made available to staff by the approved centre for further education. The number and skill mix of staffing were sufficient to meet residents' needs. A written staffing plan was available within the approved centre. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Staff were trained in manual handling, infection control and prevention, dementia care, end of life care, resident rights, risk management, and treatment, incident reporting, and the protection of children and vulnerable adults.

All health care staff were trained in the following:

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

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Clara	CNM2	1	0
	RPN	2	1
Ward or Unit	*Staff Grade*	*Day*	*Night*
Dean Swift	CNM2	1	1
	CNM1	1	0
	RPN	7	5
Ward or Unit	*Staff Grade*	*Day*	*Night*
Delaney	CNM2/1	1	0
	RPN	4	2
Ward or Unit	*Staff Grade*	*Day*	*Night*
Grattan	CNM2/1	1	0
	RPN	4	3
Ward or Unit	*Staff Grade*	*Day*	*Night*
Kilroot	CNM2/1	1	0
	RPN	4	2
Ward or Unit	*Staff Grade*	*Day*	*Night*
Stella	CNM2/1	1	0
	RPN	4	2
Ward or Unit	*Staff Grade*	*Day*	*Night*
Temple	CNM2/1	1	0
	RPN	4	2

Ward or Unit	Staff Grade	Day	Night
Vanessa	CNM2/1	1	0
	RPN	5	3

Other Clinical Staff Providing Cover in the Approved Centre

Consultant psychiatrists	13
Psychologists	18
Registrars	18
Social workers	13
Occupational therapists	10
Pharmacists	6
Team liaison nurses	6
Cognitive behavioural therapists	6
Addictions therapists	8

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN)

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 27: Maintenance of Records

COMPLIANT

Quality Rating **Excellent**

(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 three written policies and procedures in relation to the maintenance of records, which were last reviewed in March 2017. The policies combined addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policies. 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 policies. 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: All residents' records were electronic, on-screen health records. Records 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' status at the time of inspection and the care and treatment being provided. Residents' access to their records was managed in accordance to the Data Protection Acts.

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. Staff had to receive clearance in advance of accessing on-screen health records, and staff only had access to the areas of the records relevant to them. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Each entry denoted the time automatically when records were accessed.

Electronic health records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use, through a password-protected mechanism.

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 rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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 September 2015. It 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 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 timeframes. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

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

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

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

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

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff accompanied and assisted patients to attend their Mental Health Tribunal and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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 **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in May 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. 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 and the details of the analysis were considered by senior management. Required actions had been 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 and based in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed on the noticeboard, and it was detailed within the service-user's information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made through noticeboards and information booklets. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

All complaints were handled promptly, appropriately and sensitively. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre's policy. This was documented in the complaints log.

The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints, apart from minor complaints were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented separately to other complaints. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process made available to them.

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

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 32: Risk Management Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in March 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All training was documented. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy.

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

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure

their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

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

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format, and were recorded on the Datix system. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The risk manager reviewed incidents for any trends or patterns occurring in the service.

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

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

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 in the reception area 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 three written operational policies and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The ECT Departmental Service Plan Policy was last reviewed in August 2017, the ECT Treatment Policy for In-Patients was last reviewed in February 2018, and the Management of Anaphylaxis Policy was last reviewed in June 2016. The policies 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 nurses involved in delivering ECT were trained in line with best international practice and had appropriate training and education in basic life support techniques. All nurses involved in delivering ECT attended the advanced cardiovascular life support course every two years.

Evidence of Implementation: The approved centre had a dedicated ECT suite, which included a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid response area.

Material and equipment for ECT were in line with best international practice, and there was documentary evidence that ECT machines were regularly maintained. The recovery room was spacious enough to accommodate the number of patients receiving ECT.

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant and named consultant anaesthetist had responsibility for ECT. Four registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one patient who was prescribed ECT was inspected. This indicated that the patient received appropriate information about the treatment, including details of likely adverse effects. The patient was also informed of his/her rights to an advocate and had the opportunity to raise questions at any time.

A written record of the assessments of capacity to consent to ECT was detailed in the patient's clinical file. It indicated that the patient was unable to give informed consent for ECT. ECT was administered in accordance with section 59(1)(b) of the Mental Health Act 2001. A *Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent* was completed and placed in the clinical file, and a copy was sent to the Mental Health Commission within five days.

The programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file, which also contained a pre-anaesthetic assessment and an anaesthetic risk assessment. The consultant psychiatrist in consultation with the patient reviewed progress and the need for continuation of ECT.

The ECT record which was completed after each treatment was placed in the clinical files, and the signature of the registered medical practitioners administering ECT was detailed. All pre and post ECT assessments were detailed and recorded in the clinical file. Copies of all cognitive assessments were placed in the clinical file. The ECT register was completed on conclusion of the ECT programme and a copy was placed in the patient's clinical file.

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

The inspection team examined the clinical files of four detained patients who were identified as being in continuous receipt of medication for a period in excess of three months. Two patients had consented to treatment, and there was a written record to this effect. The written record of consent recorded the following in both cases:

- The name 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 the discussion with the patient which had taken place on the nature and purpose of the medication, the effects of the medications, including the risks and benefits and any views expressed by the patient, and any supports provided to the patient in making the decision to consent.

Two patients were unable to consent to treatment and this was documented. In both cases, a *Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* had been appropriately completed. Each included details of the discussions with the patient on the nature and

purpose and the effects of the medication. Any views expressed by the patients were recorded. In each case, authorisation was provided by a second consultant psychiatrist. In both two cases, an assessment of the patient's ability to consent to treatment had been completed.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: There was two separate written policies in relation to the use of physical restraint. The management of aggression and violence policy which was last reviewed in September 2017, and the physical restraint policy, which was last reviewed in March 2018. The policies had been reviewed annually and included details of the following:

- The provision of information to residents regarding physical restraint.
- The individuals authorised to initiate and conduct physical restraint.
- The training requirements relating to physical restraint.

Training and Education: There was documented evidence to indicate that all staff involved in physical restraint had read and understood the policy.

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

Evidence of Implementation: Three episodes of physical restraint were inspected. These indicated the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others. Episodes of physical restraint were initiated after staff had first considered other interventions and following a risk assessment. Physical restraint was not prolonged beyond the period necessary in any case. Cultural awareness and gender sensitivity was demonstrated in all episodes of physical restraint.

All residents were informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. In all three episodes, the clinical practice form for physical restraint was completed by the person initiating and ordering the use of physical restraint no later than three hours after the episode, but the clinical practice form was not signed by the consultant psychiatrist within the required 24-hour timeframe. Instead, in all three cases the clinical practice form was signed by the consultant psychiatrist 13-15 days after the physical restraint had occurred.

In two episodes, there was no record that next of kin or representatives were informed of the use of physical restraint. In both episodes, a justification for not informing next of kin or representatives was not recorded in the clinical files.

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 of restraint with members of their 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 three episodes reviewed, the clinical practice form was not signed by the consultant psychiatrist within 24 hours of the episode, 5.7(c).**
b) **In two episodes, there was no record that, with the residents' consent, next of kin or representatives were informed of the use of physical restraint. In both episodes, a justification for not informing next of kin or a representative was not recorded in the clinical files, 5.9(a).**

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 three written policies in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The ECT Departmental Service Plan was last reviewed in August 2017, the ECT Treatment Policy for In-Patients was last reviewed in February 2018, and the Management of Anaphylaxis policy was last reviewed in June 2016. The policies addressed all policy-related criteria of this code of practice, 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. All nurses attended the advanced cardiovascular life support course, and a separate ECT training course every two years.

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. 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. Four registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed capable of consenting to receiving ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable the 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. The 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 the voluntary patient.

A programme of ECT for the voluntary patient was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the voluntary 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 file, 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 file, and the signature of the registered medical practitioners administering ECT was detailed. All pre and post ECT assessments were detailed and recorded in the clinical file. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission and re-admission assessment policy was last reviewed in April 2018, the transfer to another approved centre or healthcare facility was last reviewed in January 2018, and the discharge process policy was last reviewed in March 2018. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

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

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The decision to admit was made by the registered medical practitioner (RMP)/Consultant Psychiatrist. The resident was assigned a key-worker. The resident'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 using either the Falls Risk Assessment Score for the Elderly (FRASE) or the Astec Risk Assessment Tool (ARAT), and any other relevant information, such as work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the 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.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to the general practitioner/primary care/community mental health team, 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 compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 22: Premises

Report reference: Page 38 & 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. One shower room was observed to have black mould on the ceiling, 22(1)(a).	New	Corrective Action(s): Notwithstanding the fact that all other areas were considered clean and well maintained the shower room was cleaned and redecorated and a new enhanced extraction unit was fitted Post-Holder(s) responsible: Eamonn O' Reilly, Facilities Manager	Visual inspection	None	Cleaning and redecorating completed during the inspection process. New enhanced extraction unit was fitted post inspection See enclosed photograph
		Preventative Action(s): Complete environmental audits of all clinical areas including bathrooms and shower rooms Post-Holder(s) responsible: Paulina Beda, Clinical Audit Facilitator	Inspection of shower rooms in clinical areas is included in the annual Audit schedule	None	Ongoing continuous process
2. One bathroom was malodourous, 1(b)	New	Corrective Action(s): Facilities Manager has inspected the extraction system in this bathroom and an air freshing system has been added Post-Holder(s) responsible: Eamonn O' Reilly, Facilities Manager	Inspection of bathrooms in clinical areas is included in the annual Audit schedule	None	Ongoing continuous process

		Preventative Action(s): Maintain environmental audits of all clinical areas including bathrooms and shower rooms Post-Holder(s) responsible: Paulina Beda, Clinical Audit Facilitator	Inspection of bathrooms in clinical areas is included in the annual Audit schedule	None	Ongoing continuous process

Code of Practice: Use of Physical Restraint

Report reference: 64 & 65

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. In the three episodes reviewed, the clinical practice form was not signed by the consultant psychiatrist within 24 hours of the episode, 5.7(c).	New	Corrective Action(s): This matter has been brought to the attention of and discussed with the relevant Responsible Consultant Psychiatrist. Post-Holder(s) responsible: Prof. J. Lucey, Clinical Director SPMHS	The Clinical Director will confirm completion of this action to the Clinical Governance Committee once completed	None identified	November 1st 2018
		Preventative Action(s): This matter has been brought to the attention of and discussed with all Responsible Consultant Psychiatrist's. Post-Holder(s) responsible: Prof. J. Lucey, Clinical Director SPMHS	The Clinical Director will confirm completion of this action to the Clinical Governance Committee once completed	None identified	November 1st 2018
4. In two episodes, there was no record that, with the residents' consent, next of kin or representatives were informed of the use of physical restraint. In both episodes, a justification for not informing next of kin or a representative was not recorded in the clinical files, 5.9(a).	New	Corrective Action(s): This matter has been brought to the attention of and discussed with the relevant Clinical Nurse Manager 2. Post-Holder(s) responsible: Mr. J. Creedon, Director of Nursing	The Director of Nursing will confirm completion of this action to the Clinical Governance Committee once completed	None identified	November 1st 2018
		Preventative Action(s): This matter will be brought to the attention of and discussed with all Clinical Nurse Manager's in SPMHS. Post-Holder(s) responsible: Mr. J. Creedon, Director of Nursing	The Director of Nursing will confirm completion of this action to the Clinical Governance Committee once completed	None identified	November 1st 2018