Sycamore Unit, Connolly Hospital

ID Number: AC0032

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Sycamore Unit,
Connolly Hospital
Blanchardstown
Dublin 15

Approved Centre Type:
Psychiatry of Later Life

Most Recent Registration Date:
6 June 2016

Conditions Attached:
None

Registered Proprietor:
HSE

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

Inspection Team:
Karen McCrohan, Lead Inspector
Mary Connellan

Inspection Date:
11 – 15 June 2018

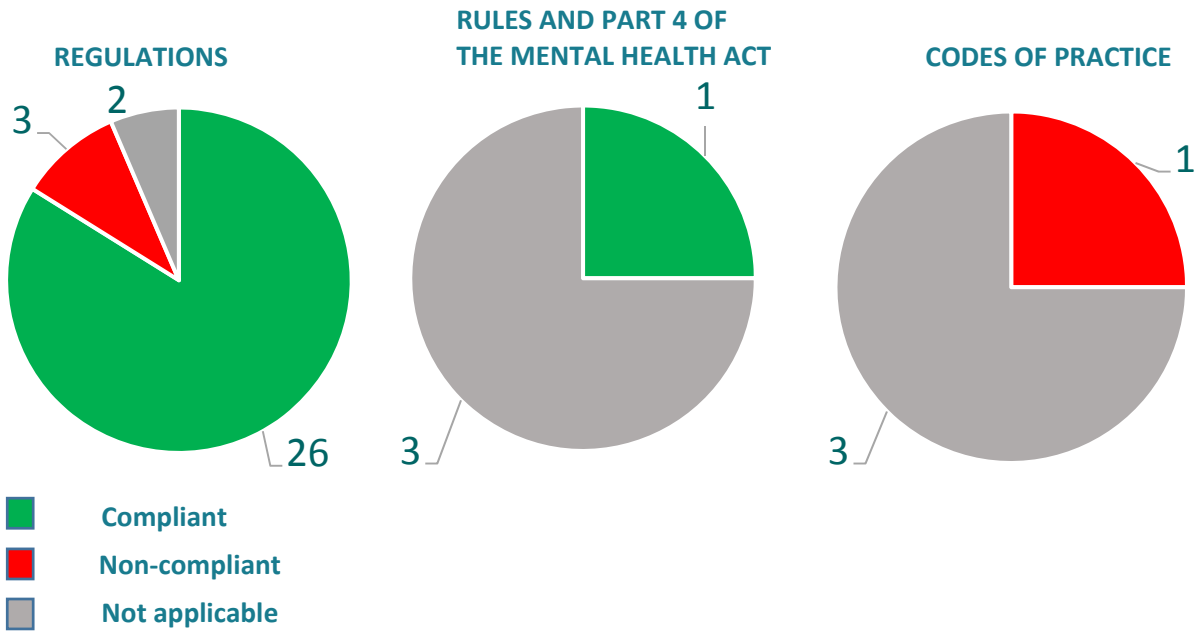
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
7 – 10 March 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
7 February 2019

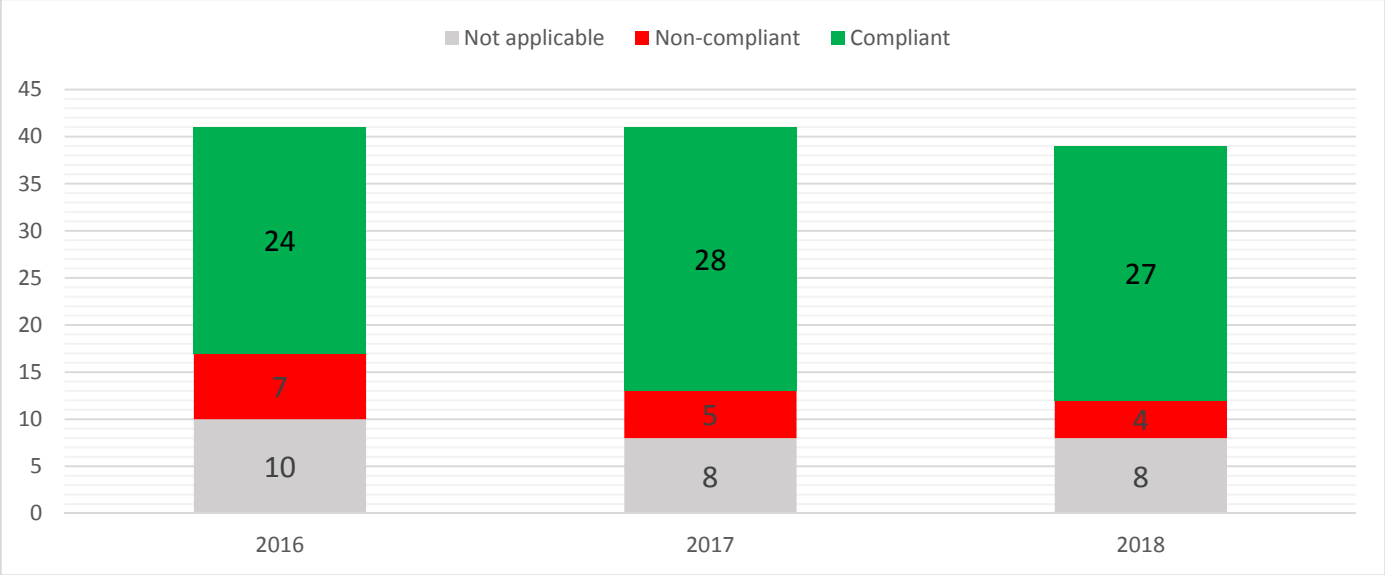
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

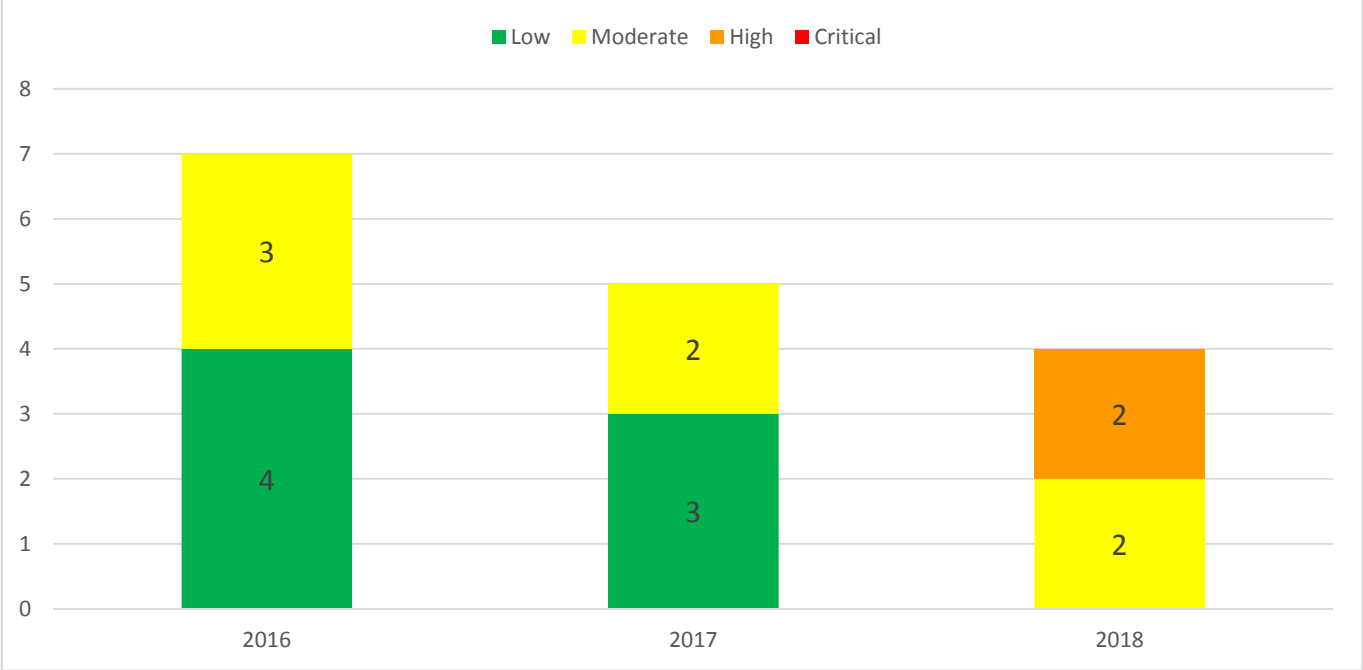
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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

Chart 2 – Comparison of overall risk ratings 2016 – 2018



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1.0 Introduction to the Inspection Process

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

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

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

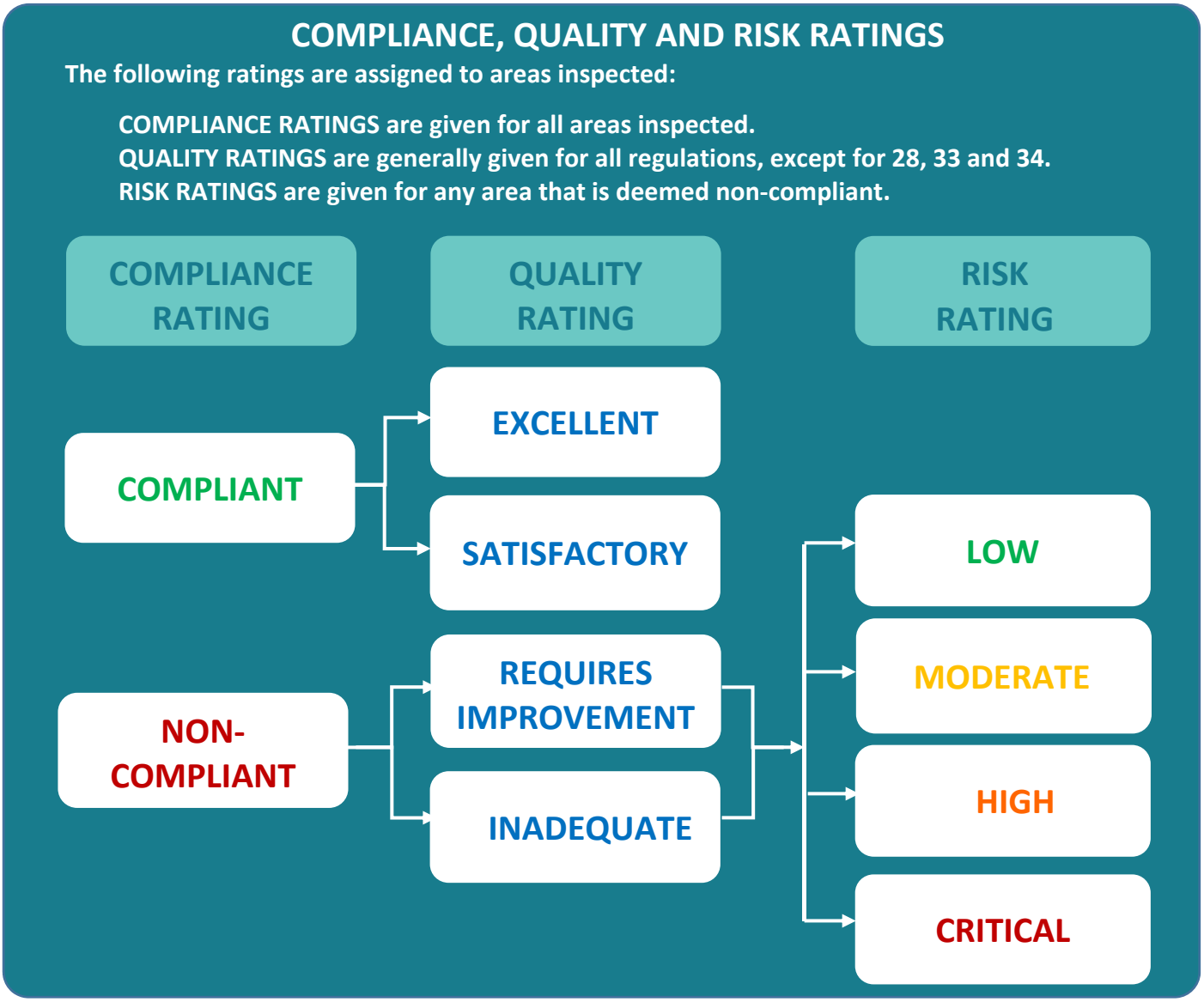
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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

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

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

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



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

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

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

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

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In Brief

Sycamore Unit was located on the grounds of Connolly Hospital Blanchardstown. It was a flat-roofed building, originally built in 1945. It consisted of a long corridor, with five dormitories and one single bedroom and as such was old-fashioned and institutional in style. The approved centre was registered for Psychiatry of Later Life, with a bed capacity of 25. All residents admitted to the Sycamore Unit had moderate or severe dementia, with variably diminished capacity, and were under the care of one multi-disciplinary team.

Sycamore Unit's compliance with regulations, rules and codes of practice has showed steady improvement over the previous three years: from 77% in 2016 to 84% in 2017 and now, in 2018, to 87%. It had no conditions to registration and had nine compliances rated as excellent. However, there were serious deficiencies in the provision of basic therapeutic and general health inputs.

Safety in the approved centre

Two personal identifiers were used when administering medication or other treatments. There were regular audits of food safety and kitchen areas were clean when inspected. Medication was ordered, prescribed, stored and administered in a safe manner.

All healthcare professionals were trained in fire safety, Basic Life Support, the Mental Health Act 2001 and Children First. However, not all staff had up-to-date training on the management of violence and aggression.

Ligature points were not minimised but this was considered unnecessary due to the resident profile. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

Appropriate care and treatment of residents

Each resident had a multi-disciplinary individual care plan that was regularly reviewed. Where possible residents were informed about their care plan and families also had input. The needs of residents identified as having special nutritional requirements were not regularly reviewed by a dedicated dietitian as direct access to a dietitian was not available.

The therapeutic services and programmes provided by the approved centre were evidence-based, but did not meet the assessed needs of residents, as documented in their individual care plans. Residents' physical needs were not always met. The approved centre did not have access to a dietitian, a physiotherapist, or an occupational therapist for seating assessments, as deemed necessary. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre did not always arrange for the service to be provided by an approved, qualified health professional in an appropriate location.

Residents' general health needs were not monitored and assessed at least every six months. Three residents on antipsychotic medication had not received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels.

End of life care was managed with respect to the residents' physical, psychological and spiritual needs. Families were accommodated so as to spend time with their relative.

Staff were not trained in line with the assessed needs of the resident group profile and of individual residents, or in accordance with the staff training plan. Staff were not appropriately trained in dementia care, end of life care, risk management, incident reporting or recovery approaches to mental health care and treatment.

Respect for residents' privacy, dignity and autonomy

Residents' property was safeguarded and where possible they retained control of their possessions. Visiting time was unrestricted and there were private areas set aside for visiting. Where it was necessary, staff assisted residents with phone calls and correspondence. Residents were accommodated in adequately sized dormitory style bedrooms, with four to six beds in each.

External doors were locked to maintain the safety of the residents who were at risk of wandering from the unit.

Responsiveness to residents' needs

Recreational activities were provided but there was limited access to occupational therapy. Access to religious practice was available and there was a chaplain who visited the unit. Information about the approved centre, residents' medication and diagnosis were available for residents and to their families if appropriate.

Residents had access to personal space and the approved centre was adequately lit, heated, and ventilated. There was appropriate signage and sensory aids to help residents find their way around the centre.

There were large spaces for residents to move about in, including the indoor dining area and outdoor garden areas. The day room, at the entrance of the approved centre, was considered too big for the resident cohort as it was very spacious and bare. While there was a television and chairs, the room lacked character and would have benefitted from additional furnishings to enhance the environment.

This has been identified by the inspectors for a number of years. The approved centre was in a good state of repair, internally and externally. The approved centre was clean, hygienic, and free from offensive odours. There were sufficient toilet and bathroom facilities, including wheelchair accessible facilities and assisted equipment to address resident needs.

Governance of the approved centre

Sycamore Unit came under two systems of governance; Connolly Hospital Blanchardstown (RCSI Hospital Group) and Dublin North City Mental Health Services (Community Healthcare Organisation 9). Connolly Hospital Blanchardstown had oversight of the maintenance of the premises, risk management and nursing and healthcare staff resources. Other issues, such as medical staffing, were managed by Dublin North City Mental Health Services.

While a governance structure was evident, the process of dual governance was somewhat fractured. Issues relating to the provision of identified needs such as routine physiotherapy and dietetics, continued to remain unresolved.

The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. Analysis of incident reports had been completed by the Connolly Hospital Risk Management Department to identify opportunities for improving risk management processes.

The process for escalating identified risks, such as occupational seating assessments, was unclear due to the complexity of the dual governance system.

Individual risk assessments were completed at resident admission, resident transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A falls quality improvement project had been initiated to minimise the residents' risk of falls.

2. Patient safety projects were completed on 'Enabling Well-being through Nature' and 'Dementia Green Care'.

3. The Speech and Language Therapist had facilitated education for staff and residents' relatives on communication and swallowing.

4. A new Sycamore Unit Information Booklet had been introduced.

5. The introduction of the 'Hello my name is…' initiative.

6. A new visitors' room was in operation.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

Sycamore Unit was located on the grounds of Connolly Hospital Blanchardstown. The approved centre was registered for Psychiatry of Later Life, with a bed capacity of 25. On the first day of the inspection, the Unit accommodated 21 residents. One resident was detained under the Mental Health Act 2001 and five residents were wards of court. All residents admitted to the Sycamore Unit had moderate or severe dementia, with variably diminished capacity, and were under the care of one multi-disciplinary team.

The approved centre was a flat-roofed building, originally built in 1945. It consisted of a long corridor, with five dormitories and one single bedroom. The personalised sleeping areas had a view of a colourful enclosed garden, which the residents, staff and visitors had access to. The approved centre also contained a functional multi-sensory Snoezelen room and a new visitors' room, which had tea and coffee facilities.

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

Resident Profile	
Number of registered beds	**25**
Total number of residents	**21**
Number of detained patients	1
Number of wards of court	5
Number of children	0
Number of residents in the approved centre for more than 6 months	18
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

Sycamore Unit came under two systems of governance; Connolly Hospital Blanchardstown (RCSI Hospital Group) and Dublin North City Mental Health Services (Community Healthcare Organisation 9). Connolly Hospital Blanchardstown had oversight of the maintenance of the premises, risk management and nursing and healthcare staff resources. Other issues, such as medical staffing, were managed by Dublin North City Mental Health Services.

On interview, the Heads of Discipline acknowledged that while a governance structure was evident, the process of dual governance was somewhat fractured. Issues relating to the provision of identified needs such as routine physiotherapy and dietetics, continued to remain unresolved. The inspection team were informed of plans to reconvene a working group to examine the governance of the Sycamore Unit, once the process of restructuring within CHO 9 has been completed. Advantages of the dual governance system were highlighted by senior frontline staff, examples included access to palliative care and acute hospital medical services.

Governance meeting minutes were provided to the inspection team. The minutes demonstrated that the governance process addressed both clinical and operational issues relating to the effective functioning of the approved centre. However, it was noted risk management issues were not routinely documented within the Sycamore Unit Management meeting minutes.

4.5 Use of restrictive practices

Access to the Sycamore Unit was controlled, by swipe or requested access, through the front entrance door. Controlled access was implemented in the Unit to ensure the safety of the residents, with due consideration of their diagnosis and level of cognitive functioning.

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 16: Therapeutic Services and Programmes	✓		✓		✗	High
Regulation 19: General Health	✓		✓		✗	High
Regulation 26: Staffing	✓		✓		✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	Low	✗	Moderate

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

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 10: Religion
Regulation 11: Visits
Regulation 14: Care of the Dying
Regulation 21: Privacy
Regulation 30: Mental Health Tribunals

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 Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As the approved centre did not use physical restraint, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

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

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

The inspection team met with eight residents' relatives during the inspection. These family members spoke highly of the care and treatment provided to the residents, acknowledging the dedication of the staff. However, some of the relatives felt that the residents would benefit from increased staffing levels and multi-disciplinary team input. The cleanliness of the Unit was commended by all.

7.0 Feedback Meeting

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

- Registered Proprietor Representative
- General Manager
- Executive Clinical Director
- Occupational Therapist Manager
- Senior Occupational Therapist
- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Area Lead Mental Health

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

The inspection team were informed that the multi-disciplinary team had identified a need for the use of Mechanical Means of Bodily Restraint on the Unit. The process for introducing Mechanical Restraint was clarified by the inspection team. Additionally, the complexities and challenges of the current dual governance system was acknowledged.

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 February 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 there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: A minimum of two resident identifiers appropriate to the residents' communication abilities, resident group profile, and individual residents' needs were used. The person-specific identifiers were detailed within residents' clinical files. To ensure that each resident was readily identifiable by staff, staff checked the identifiers when administering medications, undertaking medical investigations, and providing other health care services. An appropriate identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and yellow sticker alerts were applied to clinical files to alert staff to the presence of residents with the same or 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 **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to food and nutrition. The approved centre's Food and Nutrition 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 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 by a dietitian in Connolly Hospital to ensure nutritional adequacy in accordance with the residents' needs. The residents' meals were prepared and cooked in the main hospital's kitchen and transported to the approved centre.

Residents were provided with an assortment of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. There was a three-week menu cycle which included diabetic, healthy heart, low salt, and modified diet menus. All food was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. One resident reported that the soft diet menu of eggs and beans, which was being served most evenings, was repetitive. Hot and cold drinks were offered to residents regularly.

For residents with special dietary requirements, their nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The Malnutrition Universal Screening Tool, which was an evidence-based nutrition assessment tool, was used. The needs of residents, identified as having special nutritional requirements, were not regularly reviewed by a dedicated dietitian as direct access to a dietitian was not available. Residents, their representatives, family, and next of kin were educated about residents' diets and this education was delivered mainly by a speech and language therapist who was hired since last year's inspection.

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

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 two written policies in relation to food safety. The approved centre's Food Safety 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 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. This training was documented and evidence of certification was available, where appropriate.

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

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

The approved centre provided suitable and sufficient catering equipment. Hygiene was maintained to support food safety requirements and catering management staff visited the approved centre at least once a day. 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 **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. No residents were wearing nightclothes during the day at the time of the inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Clothes were laundered by an on-site laundry service in Connolly Hospital. 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 rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

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 a written operational policy in relation to residents' personal property and possessions, which was last reviewed in December 2017. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Personal property logs were monitored in the approved centre. Resident monies were audited twice a year by a clinical nurse manager. Documented analysis had been completed to identify opportunities for improving the processes relating to residents' personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safekeeping of residents' monies, valuables, personal property, and possessions. At the time of the inspection, there was a locked safe on the unit for small quantities of money. All larger sums of money were kept with patient accounts in the main hospital administration section. The access to and use of resident monies was overseen by two members of nursing staff.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan (ICP). Each resident had their own locker and wardrobe. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident's ICP. The checklist was updated on an ongoing basis, in accordance with the approved centre's policy.

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 **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in December 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 recreational activities, as set out in the policy.

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

Evidence of Implementation: The approved centre provided access for residents to appropriate recreational activities on weekdays and during the weekend. The information given to residents in relation to the available activities was user-friendly, accessible, and in line with residents' needs. The information included the types and frequency of recreational activities. Activities were developed, maintained, and implemented with family involvement mainly, and residents' preferences were taken into account.

Recreational activities provided by the approved centre were not adequately resourced. An occupational therapy assistant only worked in the approved centre sixteen hours a week. Nursing staff tried to facilitate additional recreational activities for residents where possible.

Opportunities were available for indoor and outdoor exercise and physical activity. Communal areas were suitable for recreational activities. The approved centre had a large enclosed sensory garden, which was accessible from bedroom dormitories and through the dining room. Records of resident attendance at events were maintained in group records or in clinical files.

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

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

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

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

Evidence of Implementation: Care and services provided were respectful of residents' religious beliefs and values. Residents' rights to practice religion were facilitated within the approved centre to a practicable extent. Residents had access to multi-faith chaplains. At the time of the inspection, most residents were Roman Catholic denomination and one resident was Church of Ireland. There were facilities available to support residents' religious practices. Residents had access to local religious services in Connolly Hospital and were supported to attend, if deemed appropriate following a risk assessment. Residents were facilitated to observe or abstain from religious practice in accordance with their desires.

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 in relation to visits. The policy was last reviewed in December 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: Documented analysis had been completed to identify opportunities for improving visiting processes.

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

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The approved centre's visiting room 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 **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in December 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: No residents had restrictions on their communication at the time of the inspection. Resident communication needs were monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to postal mail and telephone, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Staff opened postal mail on behalf of residents, with their consent where possible, in accordance with the approved centre's communication policy.

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

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in February 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.

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

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: Four residents had died since the last inspection. The end of life care provided was appropriate to each resident's physical, emotional, social, psychological, and spiritual needs, as documented in their relevant individual care plans. Religious and cultural practices were respected, as were the privacy and dignity of each resident.
Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care. Pain management was prioritised and managed during end of life care. DNAR orders and associated documentation were evidenced within the residents' clinical files. Support was given to other residents and staff following a resident's death. All deaths of residents were notified to the Mental Health Commission within the required 48-hour period.

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

Regulation 15: Individual Care Plan

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 December 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. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: Each resident had an ICP, seven of which were inspected. In two ICPs, a key worker was not named on the ICP. However, keyworkers were known to staff, residents and relatives as they were named at the residents' bed space.

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.

Most residents had been living in the approved centre for a number of years. However, for a recent admission, the resident had been assessed on admission by the admitting clinician and an ICP was completed by the admitting clinician to address the immediate needs of the resident.

Following an evidence-based comprehensive resident assessment, ICPs were developed by MDT members including medical staff, nursing staff and speech and language therapists. The occupational therapist attended review meetings occasionally but this was not always possible due to time constraints. One ICP, in relation to one new admission, was not developed by the multi-disciplinary team within the stipulated timeframe of seven days. Instead, the ICP was developed 13 days after the resident was admitted.

ICPs were drawn up without the participation of residents' family, which was not appropriate due to the nature of the resident profile and residents' condition. However, ICPs included a prompt for a family meeting.
The reviewed ICP's had appropriate goals, treatment and care requirements and necessary resources identified for each resident. All ICPs were developed, reviewed every six months, and updated by the

resident's MDT. The ICP was updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in December 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 therapeutic activities and programmes, as set out in the policy.

Monitoring: The overall range of services and programmes provided in the approved centre were not monitored on an ongoing basis to ensure that the assessed needs of residents were met. The occupational therapist had carried out a review of the therapeutic services and programmes and a detailed analysis, but this was not reflective of the range of services provided.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based, but did not meet the assessed needs of residents, as documented in their individual care plans. Residents' physical needs were not always met. The approved centre did not have access to a dietitian, a physiotherapist or an occupational therapist for seating assessments as deemed necessary. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre did not always arrange for the service to be provided by an approved, qualified health professional in an appropriate location.

A list of all therapeutic services and programmes provided in the approved centre was available to all residents. Adequate and appropriate resources were not available to provide therapeutic services and programmes. Therapeutic services and programmes were provided in a separate, dedicated room containing facilities and space for individual and group therapies. A record was maintained of participant engagement and outcomes achieved in therapeutic services and programmes. This record was within each resident's clinical file.

The approved centre was non-compliant with this regulation because a number of residents had unmet needs, these residents did not have access to the therapeutic service and programme required as documented in their individual care plan, 16 (1).

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in December 2017. The policy included the requirements of the *Judgement Support Framework* with the exception of a process for managing the transfer of involuntary residents.

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre in an emergency was examined. There was no documented communication between the approved centre and the receiving facility. The resident was risk assessed prior to the transfer and documented consent of the resident to their transfer was available. The resident's family was also informed of the transfer. The following information was issued, with copies retained as part of the transfer documentation, a letter of referral and the resident transfer form. The resident did not require any medication during the transfer process. A checklist contained within the patient transfer form 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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, monitoring, and evidence of implementation pillars.

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services and the response to medical emergencies. The policy was last reviewed in December 2017. The policy included the requirements of the *Judgement Support Framework* with the following exceptions:

- The referral process for residents' general health needs.
- The documentation requirements in relation to general health assessments.

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

Monitoring: While a systematic review had been undertaken, to ensure that six-monthly general health assessments of residents had occurred, not all of the assessments had been completed. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre did not have an emergency resuscitation trolley but staff had access at all times to an Automated External Defibrillator (AED), and applicable emergency equipment. The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Adequate arrangements were not in place for residents to access general health services and be referred to other health services. The clinical files inspected showed that not all residents received appropriate general health care interventions in line with their individual care plans. Residents with needs for physiotherapy, dietetic services and occupational seating assessments did not have access to those services.

Resident's general health needs were not monitored and assessed at least every six months. Of the clinical files inspected, two residents were overdue their six monthly general health checks. The remaining clinical files inspected showed that those residents had received a physical examination, and their blood pressure, body mass index, weight, and waist circumference was checked and recorded in the six-monthly general health assessment record. The following discrepancies were found on inspection:

- Nutritional status including diet, physical activity, and sedentary lifestyle status was not documented.
- Medication review (per prescriber guidelines) was not documented.

- Dental health assessments were not documented.

Three residents on antipsychotic medication had not received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels.

Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. National screening programmes were not applicable to this resident cohort.

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

a) Adequate arrangements were not in place for access by residents to general health services, and for their referral to other health services including dietetics, physiotherapy, and physical occupational therapy as required, 19, 1 (a).

b) Two residents had not received a six monthly general health assessment. The remaining six-monthly general health assessment records and associated tests were not fully complete. Three residents on antipsychotic medication had not received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels, at the time of the inspection, 19, 1 (b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of information to residents. The policy was last reviewed in January 2018. The policy 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 policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed, e.g. information on medication and housekeeping practices. Documented analysis had been completed to identify opportunities for improving the processes which resulted in the development of a new Sycamore Unit information booklet.

Evidence of Implementation: Residents were provided with a booklet on admission that included details of meal times; personal property arrangements; the complaints procedure; visiting times and 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 (MDT).

Due to the nature of the residents' condition, residents and their families were given written and verbal information on the residents' diagnosis, as appropriate. Information was provided to residents and their families on the likely adverse effects of treatments, including the risks and other potential side effects, as appropriate. The provision of this information to residents and their families was not routinely documented in clinical files.

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 the residents and their families' 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 through Connolly Hospital as required.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in December 2016. The policy 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 policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

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

Evidence of Implementation: Residents were called by their preferred name. The general demeanour of staff and the way staff addressed and communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. Residents were wearing clothes which respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. Rooms were not overlooked by public areas. All residents were accommodated in shared bedrooms and 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.

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 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in January 2018. The policy addressed the requirements of the *Judgement Support Framework* with the exception of the approved centre's utility controls and requirements.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed a hygiene audit but it had not completed a ligature audit. Documented analysis had not been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre's physical environment offered opportunity for residents to maintain and improve their mental and general health status. Residents had access to personal space and the approved centre was adequately lit, heated, and ventilated. There was appropriate signage and sensory aids to help residents find their way around the centre. Each bedroom had a photograph and first name of the resident outside the corridor. Bathrooms were well signposted, with pictures to support residents' orientation needs. Residents were accommodated in adequately sized dormitory style bedrooms, with four to six beds in each. Residents could control the heating in their rooms.

There were large spaces for residents to move about in, including the indoor dining area and outdoor garden areas. The day room, at the entrance of the approved centre, was considered too big for the resident cohort as it was very spacious and bare. While there was a television and chairs, the room lacked character and would have benefitted from additional furnishings to enhance the environment.
Hazards were minimised. Ligature points were not minimised but this was not deemed necessary due to the resident profile at the time of the inspection. The approved centre was in a good state of repair,

internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. A cleaning schedule was in place, and current national infection guidelines were followed. The approved centre was clean, hygienic, and free from offensive odours. There were sufficient toilet and bathroom facilities, including wheelchair accessible facilities and assisted equipment to address resident needs.

Clothes were sent to Connolly Hospital, Blanchardstown for laundry. There was a designated storeroom for excess laundry. The approved centre did not have a dedicated therapy and examination room. Furnishings throughout the approved centre supported residents' independence and comfort.

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

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in January 2018. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: All nursing, medical, and pharmacy staff had signed the signature log to indicate that they had read and understood the policy. 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 policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Nursing, medical and pharmacy staff had received training on the importance of reporting medication incidents, errors or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors and near misses. Analysis had not been completed by the drugs and therapeutics committee 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 was present within each resident's MPAR.

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. The pharmacist gave advice over the phone to the approved centre's staff, if requested, in relation to the appropriate use of the product.

Direction to crush medication was only accepted from the resident's medical practitioner. The medical practitioner did not provide a documented reason why the medication was to be crushed. The pharmacist was not consulted about the type of preparation to be used. The medical practitioner did not document in the MPAR that the medication was to be crushed. Instead, a blanket authorisation was given to crush medication in 20 of 21 MPARs. Authorisation was not provided on each individual prescription.

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 not conducted on a monthly basis. Medications 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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring and evidence of implementation pillars.

Regulation 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, safety statement, and procedures in relation to the health and safety of residents, staff and visitors. The Connolly Hospital Safety Statement was reviewed in September 2017. The approved centre's health and safety policy was last reviewed in January 2018. The policy and safety statement combined addressed the requirements of the *Judgement Support Framework,* with the following exceptions:

- Specific roles are allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- The monitoring and continuous improvement requirements implemented for the health and safety processes.

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

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written operational policies in relation to its staffing requirements. The approved centre's staffing policy was last reviewed in January 2018. The Connolly Hospital nursing policy for Staff Training and Development was last reviewed in 2015. The policies combined addressed the requirements of the *Judgement Support Framework,* with the following exceptions:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The roles and responsibilities in relation to staffing processes.
- The staff planning requirements to address the numbers and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- Staff performance and evaluation requirements.

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 relating to staffing, as set out in the policies.

Monitoring: There was no documented evidence to indicate that the implementation and effectiveness of the staff training plan was reviewed on an annual basis. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place, which identified the leadership and management structure, and the lines of authority and accountability of the approved centre's staff. Staff were recruited and selected in accordance with the HSE's policy 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, was maintained in the approved centre.

An appropriately qualified staff member was not on duty and in charge at all times. There was no registered psychiatric nurse on duty between 16:40-20:00 hrs. on six dates within a four-week period reviewed on inspection.

The number and skill mix of staffing was insufficient to meet resident needs. There were two registered general nurses on duty on May 30th when three registered general nurses were required. On May 19th, only one healthcare assistant was on duty when two healthcare assistants were required.

A written staffing plan was available within the approved centre which considered the assessed needs of the resident group profile of the approved centre. Annual staff training plans were completed for all staff, which identified the required training and skills development in line with the assessed needs of the resident group profile. All healthcare professionals were trained in
fire safety, basic life support, the Mental Health Act 2001 and Children First. However, not all staff had up-to-date training on the management of violence and aggression.

Staff were not trained in line with the assessed needs of the resident group profile and of individual residents, or in accordance with the staff training plan. Staff were not appropriately trained in dementia care, end of life care, risk management, incident reporting or recovery approaches to mental health care and treatment.

While there was a staff training folder, staff training logs were not maintained and kept up-to-date. Opportunities were made available to staff by the approved centre for further education. 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.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
	CNM	1	0
	RPN	1	1
	RGN	6	1
	HCA	4	2.5

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Registered General Nurse (RGN), Healthcare Assistant (HCA)

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

a) **The staffing policy did not include all policy required items relating to the recruitment, selection, and vetting of staff, 26 (1).**
b) **The skill mix of staff was not appropriate to the assessed needs of residents, 26 (2).**
c) **There was not an appropriately qualified staff member on duty and in charge of the approved centre at all times, 26 (3).**
d) **Not all staff had up-to-date mandatory training in PMAV, 26(4).**

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The privacy and confidentiality of resident record and content.

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

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

Evidence Of Implementation: All residents' records were secure, up to date, in good order, in a logical sequence with no loose pages, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents' current status and the care and treatment being provided. The records were physically stored together, where possible. All resident records were maintained using an identifier that was unique to the resident, but there were not two appropriate resident identifiers present on all documentation. In a number of cases, only the resident's name was recorded on clinical documentation, and a second identifier was not always used.

Only authorised staff made entries in residents' records, or specific sections therein. Hand-written records were legible. Three medical entries were written in blue ink, the reminder of hand-written records inspected were written in black indelible ink and were readable when photocopied. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. The 24-hour clock was not consistently used in each entry of residents' records.

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

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

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in January 2018. 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 in approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

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

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

Regulation 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 January 2018. 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. Private room facilities were provided for legal representatives and consultants. Staff accompanied and assisted patients to attend their Mental Health Tribunal as required, and tribunals were held in the boardroom of Connolly Hospital.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints, which was last reviewed in March 2018. The policies and procedures addressed requirements of the *Judgement Support Framework*, including the processes and procedures relating to 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.

The policy did not detail the confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.

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 policies. All staff interviewed were able to articulate the processes for making, handling and investigating complaints, as set out in the policies.

Monitoring: While there were no formal complaints, audit of the minor complaints log and related records had not been completed. Minor complaints data was not analysed, and while the Assistant Director of Nursing reviewed all minor complaints, details of the analysis were not provided to senior management to review and consider.

Evidence Of Implementation: There was a nominated person, a Patient Services Officer, responsible for dealing with all complaints available in the approved centre. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre's policy.
A consistent and standardised approach had been implemented for the management of all complaints. The resident information booklet had a complaints section but it did not detail the contact details of the complaints officer. However, the complaints procedure, including how to contact the complaints officer, was publicly displayed on a poster in the approved centre.

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

There were no formal complaints lodged since the last inspection. All minor complaints were handled promptly, appropriately and sensitively. 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. Minor complaints were documented separately to other complaints and a log of minor complaints was maintained in the 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 processes and monitoring pillars.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had three separate written documents and procedures in relation to risk management. The approved centre's risk management policy was last reviewed in January 2018. The Connolly Hospital Safety Statement was last reviewed in April 2018. The Sycamore Unit Evacuation Plan was last reviewed in 2015. The policy and associated documents combined included 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 the escalation of emergencies to management.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Training and Education: Not all relevant staff had received training in the identification, assessment and management of risk, and in health and safety risk management. Clinical staff were not trained in individual risk management processes. Management staff were trained in organisational risk management. Not 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 policies. All staff interviewed were able to articulate the risk management processes, as set out in the policies. Not all training was documented.

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

Hospital Risk Management Department 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 such as slips, trips, and falls to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes.

Clinical risks, corporate risks, and health and safety risks were identified, assessed, treated, reported, monitored, and recorded in the risk register. The process for escalating identified risks, such as occupational seating assessments, was unclear due to the complexity of the dual governance system.

Individual risk assessments were completed at resident admission, resident transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Ligature points were not minimised but this was considered unnecessary due to the resident profile. The requirements for the protection of children and vulnerable adults were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. Clinical incidents were reviewed by the MDT at their regular meeting. A record was not maintained of this review and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

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 prominently displayed in the approved centre.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

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 clinical file of one detained patient was inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. There was documented evidence that the responsible consultant psychiatrist had assessed the patients' capacity to consent to receive treatment. The result of the assessment was that the patient was deemed as not being capable of providing consent to treatment. The form 17 'Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) - Unable to Consent', contained in the clinical file of this patient evidenced the following:

- The names of the medications prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of discussions with the patient, including:
  - The nature and purpose of the medications.
  - The effects of the medications, including any risks and benefits.
  - Supports provided to the patient in relation to the discussion and their decision-making.
  - Approval by a consultant psychiatrist.
  - Authorisation by a second consultant psychiatrist.

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

11.0 Inspection Findings – Codes of Practice

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

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

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

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Discharge was not inspected against as no resident had been discharged since the last inspection.

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

Admission: The admission policy, which was last reviewed in February 2018, included the policy-related criteria for this code of practice with the exception of reference to referral letters in relation to planned admissions.

Transfer: The transfer policy, which was last reviewed in December 2017, included the policy-related criteria for this code of practice with the exception of the procedure for involuntary transfers.

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

Monitoring: Audits had not been completed on the implementation of and adherence to the admission and transfer policies.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental health illness or mental disorder. The admission assessment was completed and it included: a full physical examination, presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information; such as work situation, education, and dietary requirements. All assessments and examinations were documented within the clinical file, and the resident was assigned a key worker.

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

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

a) **The transfer policy did not include the procedure for involuntary transfers, 4.2.**
b) **Audits had not been completed on the implementation of and adherence to the admission and transfer policies, 4.19.**

Regulation 16: Therapeutic Services and Programmes

Report reference: Page 30

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. A number of residents had unmet needs, these residents did not have access to the therapeutic service and programme required as documented in their individual care plan, 16 (1).	New	Corrective Action(s): The provision of Therapeutic Services escalated to Hospital Executive. This will be discussed at Hospital Management Committee meeting for a permanent solution. Post-Holder(s) responsible: A.D.O.N. G.T.	From the communication after the Hospital Management Committee meeting.	Availability of Finance and Manpower resources.	Quarter 2 of 2019.
		Preventative Action(s): In the interim the Therapeutic services and programme record as per the Individual Care Plan of the service user will be made available from the Therapeutic Services within the hospital. Post-Holder(s) responsible: A.D.O.N. G.T.	Audit Quarterly.	Access to services may be difficult due to staffing availability.	Quarter 1 of 2019.

Regulation 19: General Health

Report reference: Page 32 & 33

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
2. Adequate arrangements were not in place for access by residents to general health services, and for their referral to other health services including dietetics, physiotherapy, and physical occupational therapy as required, 19, 1 (a).		Corrective Action(s): The provision of Therapeutic Services escalated to Hospital Executive. This will be discussed at Hospital Management Committee meeting for a permanent solution. Post-Holder(s) responsible: A.D.O.N.	From the communication after the Hospital Management Committee meeting.	Availability of Finance and Manpower resources.	Quarter 2 of 2019
	New	Preventative Action(s): In the interim the Therapeutic services and programme record as per the Individual Care Plan of the service user will be made available from the Therapeutic Services within the hospital. Post-Holder(s) responsible: A.D.O.N.	Audit Quarterly.	Access to services may be difficult due to staffing availability.	Quarter 1 of 2019.
3. Two residents had not received a six monthly general health assessment. The remaining six-monthly general health assessment records and associated tests were not fully complete. Three residents on antipsychotic medication had not	New	Corrective Action(s): Six monthly general health prompt\checklist will be available at the nurse's station for the medical and nursing staff to complete the assessments on time. Post-Holder(s) responsible: Consultant, C.N.M. and N.C.H.D.	Bi-annual audit.	Achievable.	Quarter 1 of 2019.

received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels, at the time of the inspection, 19, 1 (b).		Preventative Action(s): Induction to medical and nursing staff during changeover of staff. Follow up of audit findings at the Sycamore management meetings. Post-Holder(s) responsible: All M.D.T. staff.	Bi-annual audit.	Achievable.	Quarter 1 of 2019.

Regulation 26: Staffing

Report reference: Pages 42 & 43

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
4. The staffing policy did not include all policy required items relating to the recruitment, selection, and vetting of staff, 26 (1).	New	Corrective Action(s): Policy will be updated to remedy this anomaly. Post-Holder(s) responsible: Human Resource of the hospital.	Annual Auditing.	Achievable	Quarter 1 of 2019.
		Preventative Action(s): Audit findings. Post-Holder(s) responsible: C.N.M.	Annual Auditing.	Achievable	Quarter 1 of 2019.
5. The skill mix of staff was not appropriate to the assessed needs of residents, 26 (2).	New	Corrective Action(s): 1.5 W.T.E. of R.P.N. recruitment is in progress. Post-Holder(s) responsible: Human Resource of the hospital.	Quarterly Audit.	Achievability. Availability of staff.	Quarter 4 of 2019.
		Preventative Action(s): Careful rostering of available staff to achieve the skill mix until the recruitment of permanent staff is completed. Additional hours to cover identified vacancies offered to existing staff members to meet staffing requirements, and request to fill from agency staff is ongoing. Post-Holder(s) responsible: CNM/ADON.	Weekly by CNM and ADON.	Achievability. Availability of staff on a daily basis.	Ongoing.
6. There was not an appropriately qualified staff member on duty and in charge of the approved centre at all times, 26 (3).	New	Corrective Action(s): 1.5 W.T.E. of R.P.N. recruitment is in progress. Post-Holder(s) responsible: CNM/ADON	Quarterly Audit.	Achievability. Availability of staff.	Quarter 4 of 2019.

		Preventative Action(s): Careful rostering of available staff to achieve the skill mix until the recruitment of permanent staff is completed. Additional hours to cover identified vacancies offered to existing staff members to meet staffing requirements, and request to fill from agency staff is ongoing. Post-Holder(s) responsible: Human Resource of the hospital.	Weekly by CNM and ADON.	Achievability. Availability of staff on a daily basis.	Ongoing.
7. Not all staff had up-to-date mandatory training in PMAV, 26(4).	New	Corrective Action(s): Current staff are up to date with their training of PMAV. Post-Holder(s) responsible: Line Manager.	Bi-annually.	Achievable. Availability of adequate training programmes.	Completed.
		Preventative Action(s): Audit findings will be discussed at the Sycamore Management meetings and corrective actions will be implemented. Post-Holder(s) responsible: Line Managers.	Minutes of Sycamore Management meetings.	Achievable.	Ongoing.

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Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
8. The transfer policy did not include the procedure for involuntary transfers, 4.2.	Reoccurring	Corrective Action(s): Policy will be updated. Post-Holder(s) responsible: CNM	Annual audit.	Achievable	Quarter 1 of 2019.
		Preventative Action(s): Audit findings will ensure compliance. Post-Holder(s) responsible:	This will be monitored at the Sycamore Management meetings.	Achievable	Ongoing.
9. Audits had not been completed on the implementation of and adherence to the admission and transfer policies, 4.19.	Reoccurring	Corrective Action(s): Audit is complete. Post-Holder(s) responsible: CNM	Completed.	Achievable.	Completed.
		Preventative Action(s): Audit findings will ensure the compliance. The Sycamore Management committee will monitor the outcome of the audit findings. Post-Holder(s) responsible: MDT.	Quarterly Audit.	Achievable.	Ongoing.