Ashlin Centre
ID Number: AC0094

2019 Approved Centre Inspection Report (Mental Health Act 2001)
Ashlin Centre
HSE North Dublin Mental Health Services
Beaumont Road
Dublin 9

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

Most Recent Registration Date:
16 May 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Anne Marie Donohue, General Manager Mental Health Services, CHO DNCC

Inspection Team:
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Inspection Date:
19 – 21 February 2019

Previous Inspection Date:
19 – 22 June 2018

Inspection Type:
Unannounced Annual Inspection

Date of Publication:
Tuesday 20 August 2019

2019 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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 2017 – 2019
**Contents**

1.0 Inspector of Mental Health Services – Review of Findings .......................................................... 5
2.0 Quality Initiatives ................................................................................................................................ 10
3.0 Overview of the Approved Centre ........................................................................................................ 11
  3.1 Description of approved centre ........................................................................................................ 11
  3.2 Governance ........................................................................................................................................... 11
  3.3 Reporting on the National Clinical Guidelines .................................................................................. 12
4.0 Compliance ................................................................................................................................................ 13
  4.1 Non-compliant areas on this inspection ............................................................................................... 13
  4.2 Areas of compliance rated “excellent” on this inspection ....................................................................... 13
  4.3 Areas that were not applicable on this inspection ................................................................................. 14
5.0 Service-user Experience ......................................................................................................................... 15
6.0 Feedback Meeting .................................................................................................................................... 16
7.0 Inspection Findings – Regulations ........................................................................................................... 17
8.0 Inspection Findings – Rules .................................................................................................................... 60
9.0 Inspection Findings – Mental Health Act 2001 ..................................................................................... 63
11.0 Inspection Findings – Codes of Practice ............................................................................................. 65
Appendix 1: Corrective and Preventative Action Plan .................................................................................. 69
Appendix 2: Background to the inspection process .................................................................................... 86
1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The Ashlin Centre was a purpose-built facility located in the grounds of Beaumont Hospital. The approved centre provided for the acute in-patient needs of the North Dublin Mental Health Service (NDMHS). The Ashlin Centre comprised two units, which could accommodate 46 residents at full capacity. The Joyce unit was a 38-bedded general adult and rehabilitation and recovery admissions unit, while the Sheehan unit was an 8-bedded unit for Psychiatry of Old Age (POA). There were twelve multi-disciplinary teams (MDTs) between the two units.

Compliance with regulations, rules and codes of practice have decreased since 2017. In 2017, compliance was 69%, in 2018, it was 82% and, in 2019 on this inspection, compliance was 66%. Five compliances with regulations were rated as excellent.

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

**Condition 1:** To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Finding on this inspection:** The approved centre was not in breach of Condition 1; however, the approved centre was non-compliant with Regulation 15: Individual Care Plan at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically. Hygiene was maintained to support food safety requirements.
- Quarterly audits of Medication Prescription and Administration Records (MPARs) had been undertaken to determine compliance with the policy and procedures and the applicable legislation and guidelines.
- The approved centre was free from hazards and the risk from ligature anchor points was mitigated.
However:

- Two MPARs did not detail a record of all medications administered to the resident and a clear stop date for each medication was not recorded in two MPARS inspected. Micrograms were not written in full on two occasions within two MPARS; abbreviations were used instead.
- Not all health care staff were trained in the following: fire safety, Basic Life Support, the management of violence and aggression, the Mental Health Act 2001 and Children First. The mandatory training of medical staff was particularly poor.

**Appropriate care and treatment of residents**

- The approved centre provided therapeutic services and programmes that were evidence-based. The programmes were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans (ICPs). Adequate resources and facilities were available. Five occupational therapy groups ran weekly and the approved centre had a dedicated full-time social worker who worked with residents on a one-to-one basis as required.
- Adequate arrangements were in place for residents to access general health services at the adjoining hospital, and be referred to other health services, as required. Residents had access to smoking-cessation programmes and supports.
- Admission, transfer and discharge procedures met the requirements of the relevant code of practice.

However:

- Although residents’ general health needs were monitored and assessed at least every six months, staff did not record three residents’ Body Mass Index and four residents’ waist circumference. There was no documented evidence that residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids and prolactin levels.
- Ten ICPs were inspected. Despite having a condition with regard to Regulation 15: Individual Care Plan (see above), compliance with the regulation and quality of ICPs was poor. The findings of the inspectors did not tally with the findings of the ICP audit submitted to the Mental Health Commission one month before the inspection.
  - Four ICPs inspected were not developed by the residents’ MDT.
  - One ICP inspected was not developed within seven days of admission.
  - One ICP was not recorded in one composite set of documents.
  - There was no evidence of resident involvement in three ICPs inspected.
  - Three ICPs inspected did not contain specific and appropriate goals for the residents.
  - Two ICPs did not adequately identify the care and treatment provided.
  - Three ICPs did not identify the resources required to provide the care and treatment identified.
Respect for residents’ privacy, dignity and autonomy

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, and locks had an override function. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.
- Resident bedrooms were appropriately sized to address the residents’ needs. Spaces were adequate for all residents to move about freely and there were five internal gardens.
- There was adequate private space for residents to meet their visitors.
- The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

However:

- The privacy screening panels on the residents’ bedroom doors could only be opened or closed by a member of staff with a specific key. During the inspection, most of the privacy screening panels on the residents’ bedroom doors were left open by default.
- The two observation panels on the double doors leading to the seclusion facilities were fitted with transparent glass. At the time of the inspection, these observation panels were loosely covered with A4 paper and it was still possible see into the seclusion facilities.
- The seclusion facilities were dirty and cluttered. Despite the fact that the seclusion room had not been used in four days, the inspectors found that the floors, walls and observation mirror were all dirty. Various items such as pillows and paper towelling were scattered across the floor.
- The premises was not adequately ventilated; a malodour was emanating from a number of the facilities such as the visitors’ female toilet, one resident’s toilet, the therapy kitchen, and the seclusion room.
- The approved centre was not maintained in a good state of repair, internally and externally:
  - In the gardens, some of the plant boxes were rotting, and the black plastic underlay was visible and tangled in areas where woodchip surfacing had worn away. The gravel on one of the pathways had worn away rendering the path uneven.
  - There was peeling paint in one bedroom and two different doorframes in one corridor were damaged.
  - A broken shelf was observed in one en suite, which had sharp plastic edges.
  - The lino in the property room was ripped and the ceiling tiles in the quiet room were discoloured.
  - During the resident interviews, one resident reported that the exercise equipment was broken.
  - The activity kitchen and bathroom facilities were dirty. This included a discoloured toilet bowl, and old tea and coffee spillages on the floors and tables.
  - The sink and the oven in the therapy kitchen was dirty.
  - On flushing the female visitors’ toilet, water constantly splashed onto the toilet seat.
  - In the high observation sitting room, the upholstery of many chairs was ripped.
- The property storeroom in one of the wards was untidy, had a large amount of miscellaneous items, and was not conducive to safely storing residents’ property.
Human Rights

There was a breach of human rights in the lack of privacy and dignity afforded to residents because of the inadequacy of screening in bedrooms and the seclusion room and the uncleanliness and poor maintenance of the approved centre.

Responsiveness to residents’ needs

- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and on Saturdays. Activities included colouring, origami, drawing, pool, music, books, TV, DVDs, jigsaws, board games, table tennis, art, crafts, a music group and yoga. Outdoor activities included access to a cross trainer, a gardening group and racket ball, as well as an outdoor walking group facilitated by health care assistants.
- The approved centre had a dedicated music room, project room, hair and beauty room, activity kitchen, two group rooms, a games room, and a quiet room within an activities corridor.
- An information booklet about the approved centre was available and residents could obtain written information about their diagnosis and medication.
- There had been four formal complaints since the last inspection. All complaints were handled promptly, appropriately and sensitively, were dealt with by the nominated person and recorded in the complaints log.
- The approved centre provided residents with a variety of wholesome and nutritious food. There was at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance.

Governance of the approved centre

- The Ashlin Centre was part of Dublin North City and County Community Healthcare, and was managed by the North Dublin Mental Health Service (NDMHS). The NDMHS governance processes encompassed four core monthly meetings: the Management Team Meeting, Quality and Patient Safety Committee, Compliance Meeting and Working Group.
- Clinical audits and policies were developed and managed by two specific working groups.
- 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. Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register.
- While not all staff were up-to-date on their mandatory training, some improvements within the service were noted.
However:

- The inspectors found an absence of strong governance and management structures locally within the Ashlin Centre:
  - Seclusion facilities were observed to be dirty, cluttered and malodorous.
  - The two property rooms within the Joyce unit were disorganised and untidy and there was evidence of deviation from the approved centre’s personal property and possessions policy.
  - Despite having a condition on Regulation 15: Individual Care Plan, the ICP committee did not have a chair and the committee had not met in months.
  - Staff within the approved centre were not aware of an established clinical audit working group.
- There were limited internal processes to facilitate communication within the approved centre.
- There was no local quality and patient safety or business meeting within the approved centre.
- While there was no formal review of incidents for trends or patterns occurring in the service at the time of the inspection, there were plans in progress to address this.

Staff resources, non-compliance with mandatory training and the National Recruitment Service’s recruitment times were cited as three key operational risks within the governance questionnaires.
The following quality initiatives were identified on this inspection:

1. Implementation of a Tobacco Free Campus.
2. Development of resident information leaflets on the Joyce Day Ward.
3. Revision of the seclusion care plan documentation template.
4. Facilitation of additional activity groups such as yoga and ‘Coping with Anxiety and Cravings’.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Ashlin Centre was a purpose-built facility located in the grounds of Beaumont Hospital. The approved centre provided for the acute in-patient needs of the North Dublin Mental Health Service (NDMHS). NDMHS provided mental health services to its population of 264,520 plus 3,177 people from Dublin North City, namely part of Killester in Dublin 5. This is a mixed urban and rural area, which extends from the north city areas of Raheny and Artane to the northern county boundary at Balbriggan.

The Ashlin Centre comprised two units, which could accommodate 46 residents at full capacity. The Joyce unit was a 38-bedded general adult and rehabilitation and recovery admissions unit, while the Sheehan unit an 8-bedded unit for Psychiatry of Old Age (POA). The Joyce unit was on the ground floor, while the newly renovated Sheehan unit had been relocated to the first floor. There were twelve multi-disciplinary teams between the two units.

All accommodation comprised single bedrooms, with en suite facilities. The approved centre had an activities corridor, which incorporated an art room, games room, activities kitchen and associated therapeutic rooms. There were five gardens, four serving the Joyce unit and one for the Sheehan unit.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>46</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>34</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>9</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>11</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

The Ashlin Centre was part of Dublin North City and County Community Healthcare, and was managed by the North Dublin Mental Health Service (NDMHS). The NDMHS governance processes encompassed four core monthly meetings: the Management Team Meeting, Quality and Patient Safety Committee, Compliance Meeting and Working Group. These minutes evidenced regular discussion on key issues such as finance, governance, compliance and quality and patient safety. Clinical audits and policies were developed and managed by two specific working groups.

However, the findings from the inspection indicated an absence of strong governance and management structures locally within the Ashlin Centre. For example, the seclusion facilities were observed to be dirty,
cluttered and malodorous, despite the fact that the facilities had not been used in four days. The two property rooms within the Joyce unit were disorganised and untidy and there was evidence of deviation from the approved centre’s personal property and possessions policy. Despite having a condition on Regulation 15: Individual Care Plan (ICPs), the ICP committee did not have a chair and the committee had not met in months. Staff within the approved centre were not aware of an established clinical audit working group. Furthermore, there were limited internal processes to facilitate communication within the approved centre. While there was evidence of a monthly discharge committee, there was no local quality and patient safety or business meeting within the approved centre.

In terms of risk management, 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. Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. While there was no formal review of incidents for trends or patterns occurring in the service at the time of the inspection, there were plans in progress to address this.

There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment. The numbers and skill mix of staffing within the approved centre were sufficient to meet resident needs. While not all staff were up-to-date on their mandatory training, some improvements within the service were noted.

The Mental Health Commission’s Governance Questionnaire was issued to the approved centre. Completed questionnaires were returned by the Executive Clinical Director, Clinical Director, Area Director of Nursing, Assistant Director of Nursing, Occupational Therapy Manager, Principal Psychology Manager and the Principal Social Worker. The Heads of Discipline outlined regular engagement with staff and clear reporting systems. Visits to the approved centre, by the heads of disciplines, ranged from daily to quarterly and all disciplines reported engaging in clinical supervision, with the exception of nursing. Staff resources, non-compliance with mandatory training and the National Recruitment Service’s recruitment times were cited as three key operational risks within the governance questionnaires.

3.3 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.
4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>High</td>
<td>✓</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Relating to the Admission of Children</td>
<td>X</td>
<td>Moderate</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
</tbody>
</table>

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.

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As no involuntary patient had received ECT since the last inspection, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

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 six residents during the inspection. The residents were complimentary of the care and treatment provided and the residents spoke positively of staff. The quality of the food was regarded as good, while one resident requested more vegetarian meal options. Residents stated that the facilities were spacious and comfortable. While residents spoke positively of the therapeutic and recreational activities provided, a few residents reported that they would benefit from additional activities particularly in the evenings. One resident highlighted that opportunities to exercise within the approved centre were limited due to the size of the internal courtyards and the fact that the exercise equipment was broken.
6.0 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:

- General Manager - Registered Proprietor Nominee
- Executive Clinical Director
- Clinical Director
- Assistant Director of Nursing (x2)
- Psychology Manager
- Social Worker
- Occupational Therapist (x2)
- Clinical Nurse Manager III
- Clinical Nurse Manager II (x2)

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. Any relevant information provided by the service to the inspection team at the feedback meeting was reflected within the report.
7.0 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

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 March 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 resident group profile and individual residents’ needs were used. The preferred person-specific identifiers used were appropriate to the residents’ communication abilities, and were detailed within residents’ clinical files. The identifiers were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. A sticker alert was used to assist staff in distinguishing between residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 5: Food and Nutrition

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in March 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A systematic review of menu plans had been undertaken 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: To ensure nutritional adequacy in accordance with the residents’ needs, the approved centre’s menus were last approved by a dietitian in late 2017. Four-week menu cycles were developed at this time.

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Irish Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot and cold drinks were offered to residents regularly.

Residents had access to a safe supply of fresh drinking water from water coolers and jugs of water which were available on all units. 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 Instrument, an evidence-based nutrition assessment tool was used. Residents’ special dietary needs were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 6: Food Safety

(1) The registered proprietor shall ensure:
   (a) the provision of suitable and sufficient catering equipment, crockery and cutlery
   (b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and
   (c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:
   (a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
   (b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
   (c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in March 2018. The policy included a the requirements of the Judgement Support Framework with the following exceptions:

- Food preparation, handling, storage, distribution, and disposal controls.
- Adhering to the relevant food safety legislative requirements.
- The management of catering and food safety equipment.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety/hygiene commensurate with their role. The training was documented but evidence of certification was not available.

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

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. All food was prepared in St. Ita’s site in Portran and delivered daily to the approved centre. There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 7: Clothing

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 January 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. A record of residents wearing nightclothes during the day, as indicated by their ICP, was kept and monitored.

Evidence of Implementation: No resident was nursed in night clothes at the time of the inspection. Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. The living skills room had a washing machine and dryer for residents use, but residents were encouraged, in the first instance, to send their clothes home with their family. 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

(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 January 2017. The policy addressed all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept separate from the resident’s individual care plan (ICP). The checklist was updated on an ongoing basis, in accordance with the approved centre’s policy. An accurate record had not been maintained of all property, specifically in relation to one resident. The storage location of some of the resident’s property was not clearly documented on their property checklist. This carried the potential risk of the resident’s property being misplaced.

Facilities were provided for the safekeeping of the residents’ monies, valuables, personal property, and possessions, as necessary. One resident’s personal property and possessions was not safeguarded adequately when the approved centre assumed responsibility for them. The property storeroom in one of the wards was untidy, had a large amount of miscellaneous items, and was not conducive to safely storing residents’ property. This was addressed during the inspection.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff and the resident or their representative.
The approved centre was non-compliant with this regulation for the following reasons:

a) An accurate record had not been maintained of all property, specifically in relation to one resident, 8 (3).

b) There was not adequate provision for the safe-keeping of all personal property and possessions, 8 (6).
Regulation 9: Recreational Activities

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, and the recreational activities policy was last reviewed in October 2016. The policy included the requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities relating to the provision of recreational activities within the approved centre.
- The facilities available for recreational activities, including the identification of suitable locations for recreational activities within and external to the approved centre.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and on Saturdays, but not on Sundays. Information on the activities available to residents was provided in the information booklet that each resident received on admission. Activities timetables were displayed on noticeboards in corridors around the approved centre.

Activities included colouring, origami, drawing, pool, music, books, TV, DVDs, jigsaws, and board games. The activities corridor also had a group room which contained a table tennis table. There were also group activities including an art group, craft group, music group, and yoga.

Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. The approved centre offered access to a cross trainer, a gardening group, and racket ball, as well as an outdoor walking group facilitated by health care assistants.

The approved centre had a dedicated music room, project room, hair and beauty room, activity kitchen, two group rooms, a games room, and a quiet room within an activities corridor. A sitting room and therapy room were available on the Sheehan unit. A sitting room and a quiet room were available on the high observation unit.

Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Records of resident attendance at events were maintained in group records or in the clinical files.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 10: Religion

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 January 2017. The policy included the requirements of the Judgement Support Framework with the exception of identifying residents’ religious beliefs.

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: Residents’ rights to practice religion were facilitated within the approved centre. Residents were supervised to attend religious services in Beaumont hospital on a Sunday. If a resident was unable to attend, and wished to see a chaplain, the service arranged a chaplain visit within the approved centre. Residents had access to multi-faith chaplains, if required. They were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
## Regulation 11: Visits

(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 May 2018. The policy included all of the requirements of the Judgement Support Framework.

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

**Monitoring:** Restrictions on residents’ rights to receive visitors was monitored and reviewed on an ongoing basis. Analysis was completed to identify opportunities to improve visiting processes. This was documented.

**Evidence of Implementation:** Appropriate and reasonable visiting times were publicly displayed in the approved centre. Clinical files documented the names of visitors the resident did not wish to see and those who posed a risk to the resident. A separate visiting area, in the main reception, was provided where residents could meet visitors in private. This area included two visitor’s rooms, which were suitable for visiting children and families. No visitors were permitted onto the ward area of either Joyce Unit or the High Observation area. Visitors were permitted onto the Sheehan unit and the unit had a designated visitor’s room.

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 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

(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 policies in relation to resident communication. The policy was last reviewed in May 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: No current resident had any impediment on free communication. Documented analysis had been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents could use mail, fax, internet, and telephone if they wished. Residents had access to their own personal phones. A provision was in place to facilitate private communication. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. The Clinical Director, or senior staff member designated by the clinical director, only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

As there had been no searches since the last inspection, the approved centre was not inspected under the monitoring and evidence of implementation pillars for this regulation or quality assessed under this regulation.

The approved centre was compliant with this regulation.
Regulation 14: Care of the Dying

(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. The care of the dying policy was last reviewed in March 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 end of life care, as set out in the policy.

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

The approved centre was compliant with this regulation.
Regulation 15: Individual Care Plan

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

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. 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: The ICPs of ten residents were inspected. Nine of the ICPs inspected were a composite set of documents stored in the clinical file. One ICP was not identifiable and was interrupted. The same ICP was amalgamated with progress notes. Each resident was assessed at admission and an initial care plan was completed by the admitting clinician to address the immediate needs of the resident.

In one ICP inspected, there was no evidence that the ICP was developed within seven days of admission. In four ICPs, the members of the MDT were not present in the ICP development meetings, but the full MDT were available and accessible to the resident if deemed necessary. A key worker was identified in all 10 ICPs inspected to ensure continuity in the implementation of residents’ ICPs.

Three of the ICPs inspected did not contain specific, accurate, and appropriately defined goals for the residents. Instead, goals included phrases such as ‘to return home’ and ‘to maintain good physical health’. Two ICPs did not adequately identify the care and treatment provided. Three ICPs did not identify the resources required to provide the care and treatment identified, instead they referred to the resource as the MDT.

Residents had access to their ICPs and were kept informed of any changes. There was no evidence of resident involvement in three ICPs. It was not always recorded or evident whether the resident had been offered a copy of their ICP and any reviews. When a resident declined or refused a copy of their ICP, the reason was not evident within in documentation inspected.

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

a) Four ICPs inspected were not developed by the residents’ MDT.
b) One ICP inspected was not developed within seven days of admission.
c) One ICP was not recorded in one composite set of documents.
d) There was no evidence of resident involvement in three ICPs inspected.
e) Three ICPs inspected did not contain specific and appropriate goals for the residents.
f) Two ICPs did not adequately identify the care and treatment provided.
g) Three ICPs did not identify the resources required to provide the care and treatment identified.
Regulation 16: Therapeutic Services and Programmes

(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 January 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

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

Five occupational therapy groups ran weekly. Adequate resources and facilities were available. The approved centre had a dedicated full-time social worker who worked with residents on a one-to-one basis as required. Therapeutic services and programmes were provided in separate dedicated rooms. There were group rooms, activities rooms, an occupational therapy kitchen, and a games room. There was a defined therapeutic area which included dining facilities. Residents who were not in the high dependency area were encouraged to attend the therapeutic area.

Where a resident required a therapeutic service or programme that was not provided internally such as physiotherapy and speech and language therapy, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in January 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

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

The resident was risk assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident’s needs. A documented justification as to why the resident’s consent to being transferred was not received from the resident, and this was recorded. The following information was issued, with copies retained as part of the transfer documentation: a letter of referral, including a list of current medications, and the resident’s transfer Form 10. Copies of all records relevant to the transfer process were retained in the resident’s clinical file. A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education and evidence of implementation pillars.
Regulation 19: General Health

(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, which was last reviewed in May 2018. The policies and procedures included the requirements of the Judgement Support Framework with the following exceptions:

- The resource requirements for general health services, including equipment needs.
- The incorporation of general health needs into the resident individual care plan.

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

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

Evidence of Implementation: Staff in the approved centre had access to an emergency trolley and to an Automated External Defibrillator. The emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Residents had access to national screening programmes appropriate to their age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre which included breast check, cervical screening, retina check (diabetics only), and bowel screening. Residents had access to smoking-cessation programmes and supports.

Adequate arrangements were in place for residents to access general health services at the adjoining hospital, and be referred to other health services, as required. The clinical files inspected showed that residents received appropriate general health care interventions in line with their individual care plans. Resident’s general health needs were monitored and assessed at least every six months. All clinical files inspected evidenced that each of the residents had received a physical examination.

Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, but not less than every six months. The six-monthly general health assessment records
included most of the requirements. However, three residents’ Body Mass Index and four residents’ waist circumference were not recorded.

For residents on antipsychotic medication, all received an annual assessment of their heart function through an electrocardiogram. There was no documented evidence that residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids and prolactin levels.

Full records were not available demonstrating residents’ completed general health checks and associated results, including records of any clinical testing. While blood results were maintained on an electronic system, known as the PIPE system, these results were not always evident within the clinical file. The complexity of obtaining blood results from the PIPE system was acknowledged as an issue by staff.

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

a) The six-monthly general health assessment records and associated tests were not fully completed; residents’ Body Mass Index and waist circumference was not checked and recorded in one case, 19 (b).

b) There was no documented evidence that residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids and prolactin levels, 19 (b).
Regulation 20: Provision of Information to Residents

(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, which was last reviewed in January 2017. The policy included the requirements of the Judgement Support Framework, with the exception of the process for managing the provision of information to residents’ representatives, family, and next of kin, as appropriate.

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

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. The information booklet had been updated twice since the last inspection, but a documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with a handbook on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents’ rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. A copy of the resident booklet was placed in each resident’s bedroom. The booklet had been updated in January 2019. Residents were also provided with details of their multi-disciplinary team (MDT).

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a resident’s diagnosis was documented in the clinical file.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. The content of medication
information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services 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 processes, training and education, and monitoring pillars.
Regulation 21: Privacy

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 October 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.
- The approved centre’s process for addressing a situation where resident privacy and dignity is not respected by staff.

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

Monitoring: A documented annual review had 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 in which staff addressed and spoke with residents was respectful. 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. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

Residents’ privacy was not appropriately respected at all times as the privacy screening panels on the residents’ bedroom doors could only be opened or closed by a member of staff with a specific key. During the inspection most of the privacy screening panels on the residents’ bedroom doors were opened by default. The two observation panels on the double doors leading to the seclusion facilities were fitted with transparent glass. At the time of the inspection, these observation panels were loosely covered with A4 paper. This had the potential for a breach in privacy, as it was still possible to view the seclusion facilities.

The residents’ dignity was not respected at all times because the seclusion facilities were dirty and cluttered. Despite the fact that the seclusion room had not been used in four days, the floors, walls and observation mirror were all observed to be dirty. Various items such as pillows and paper towelling were scattered across the floor.

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

- Seclusion facilities were dirty and cluttered.
- The observation panel on the double doors leading into the seclusion facility did not have appropriate privacy screening as it was loosely covered with A4 paper.

NON-COMPLIANT
Quality Rating Requires Improvement
Risk Rating HIGH
c) Residents and their bedrooms were viewable through the open observation panels on the bedroom doors. Residents were unable to close the privacy screening without assistance from staff.
Regulation 22: Premises

(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.


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in August 2016. 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 separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit and heated. The premises was not adequately ventilated; a malodour was emanating from a number of the facilities such as the visitors female toilet, one resident’s toilet, the therapy kitchen, and the seclusion room. The ground floor heating is controlled for each individual room by computer system at reception and as per request by each resident. The first floor rooms have controls in each room. Appropriate signage and sensory aids were provided to support residents in finding their way around the building.

Ligature point risks were minimised to the lowest practicable level. Resident bedrooms were appropriately sized to address the resident needs. Spaces were adequate for all of the residents to move about freely. There were five internal gardens, four serving the Joyce unit and one for the Sheehan unit. There was a sufficient number of toilets and showers for residents. Remote and isolated areas of the approved centre were monitored.

The approved centre was not maintained in a good state of repair, internally and externally. In the gardens, some of the plant boxes were rotting, and the black plastic underlay was visible and tangled in

NON-COMPLIANT
Quality Rating Requires Improvement
Risk Rating HIGH
areas where woodchip surfacing had worn away. The gravel on one of the pathways had worn away rendering the path uneven. There was peeling paint in one bedroom and two different door frames in one corridor were damaged. A broken shelf was observed in one en suite, which had sharp plastic edges. The lino in the property room was ripped and the ceiling tiles in the quiet room were discoloured. During the resident interviews, one resident reported that the exercise equipment was broken.

The activity kitchen, seclusion room, and bathroom facilities were not adequately cleaned. This included a discoloured toilet bowl and old tea and coffee spillages on the floors and tables. The seclusion room was dirty and cluttered. The sink and the oven in the therapy kitchen required cleaning. On flushing the female visitors’ toilet, water constantly splashed onto the toilet seat.

The approved centre did not provide suitable furnishings to support resident independence and comfort. In the high observation sitting room, the upholstery of many chairs was ripped.

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

a) The premises were not adequately clean and hygienic. The activity kitchen, seclusion room, and bathroom facilities were dirty, 22 (1)(a).

b) The approved centre did not have adequate and suitable furnishings. The upholstery of armchairs in the high observation unit sitting room was torn, 22 (3).

c) The premises was not maintained in good structural and decorative condition as the gardens were not adequately maintained; there was peeling paint in one bedroom and another en suite had a broken shelf. Two door frames were damaged within the approved centre, lino in the property room was ripped, and the ceiling tiles in the quiet room were discoloured, 22 (1)(a).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

(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.


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 2016. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- The process for self-administration of medication.
- The process for medication reconciliation.

Training and Education: No medical 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. All nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

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

Evidence of Implementation: Each resident had an MPAR. Ten MPARs were inspected and each evidenced a record of medication management practices, including a record of two resident identifiers, and details of dosage, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included on each MPAR.

All entries in the MPAR were legible, and written in black indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently, where there was a significant change in the resident’s care or condition. This was documented in the resident’s clinical file. Micrograms were not written in full on two occasions within two MPARS, abbreviations were used instead.

Two MPARs did not detail a record of all medications administered to the resident and a clear stop date for each medication was not recorded in two MPARS inspected. All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members prior to administration. The use of appropriate resident identifiers, good hand-hygiene techniques, and cross-infection control techniques were observed during the administration of medication. 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.
Medication was stored in the appropriate environment, as advised by the pharmacist. Refrigerators used for medication were used only for this purpose, and a daily log was completed of fridge temperatures. Food and drink was not stored in areas used for the storage of medication. The medication trolley remained locked at all times and secured in a locked room.

In accordance with Regulation 23(1), the approved centre was non-compliant as the registered proprietor did not ensure that there were suitable practices relating to the prescribing and administration of medicines for the following reasons:

   a) Two MPARs did not detail a record of all medications administered to the resident.
   b) The stop date for each discontinued medication was missing in two MPARs inspected.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors, which was last reviewed in January 2016. The health and safety policy was last reviewed in September 2019. The policy addressed the requirements of the Judgement Support Framework with the exception of details of the specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

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

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

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

The approved centre was compliant with this regulation.
Regulation 25: Use of Closed Circuit Television

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:
   (a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
   (b) it shall be clearly labelled and be evident;
   (c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
   (d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
   (e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

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

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had not been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence Of Implementation: There were clear signs in prominent positions where CCTV cameras were located. CCTV was used in the seclusion room only which was located in the high dependency area of the approved centre. A resident was monitored solely for the purpose of ensuring his/her health, safety, and welfare. The cameras were incapable of recording or storing a resident’s image in any format, and they did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. The Mental Health Commission had been informed about the approved centre’s use of CCTV.

The approved centre was compliant with this regulation. The quality 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 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The staffing policy was last reviewed in May 2018. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- The ongoing staff training requirements and frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.
- The required qualifications of training personnel.

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

Monitoring: The implementation and effectiveness of the staff training plan were not 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: The organisational chart in place identified the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment.

Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times. The number and skill mix of staffing was sufficient to meet resident needs. A written staffing plan was available within the approved centre, but it did not take into consideration the assessed needs of the resident group profile of the approved centre through the following: size and layout of the approved centre, level of acuity of psychiatric illness, age profile of residents, the length of stay of residents, challenging behaviour exhibited by residents, the level of dependency and need for supervision of the residents, and the number of beds available.
Staff were trained in manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, and residents’ rights. However, staff were not trained in risk management, incident reporting, and the protection of children and vulnerable adults.

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

The table below highlights the percentages of staff per department who were trained in each of the five mandatory pillars.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (48)</td>
<td>42 88%</td>
<td>31 65%</td>
<td>40 83%</td>
<td>48 100%</td>
<td>48 100%</td>
</tr>
<tr>
<td>Consultant Psychiatrist (17)</td>
<td>12 71%</td>
<td>12 71%</td>
<td>9 53%</td>
<td>17 100%</td>
<td>10 59%</td>
</tr>
<tr>
<td>Medical (23)</td>
<td>11 48%</td>
<td>6 26%</td>
<td>2 9%</td>
<td>23 100%</td>
<td>6 26%</td>
</tr>
<tr>
<td>Occupational Therapist (3)</td>
<td>2 66%</td>
<td>3 100%</td>
<td>3 100%</td>
<td>3 100%</td>
<td>3 100%</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>0 0%</td>
<td>0 0%</td>
<td>1 100%</td>
<td>0 0%</td>
<td>1 100%</td>
</tr>
<tr>
<td>Psychology (4)</td>
<td>0 0%</td>
<td>4 100%</td>
<td>3 75%</td>
<td>4 100%</td>
<td>4 100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joyce Unit</td>
<td>CNM 2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sheehan Unit</td>
<td>CNM 2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNM 3 (Sheehan &amp; Joyce)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>ADON (Sheehan &amp; Joyce)</td>
<td></td>
<td>On call</td>
</tr>
<tr>
<td>Day Ward</td>
<td>CNM 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Ward or Unit  | Staff Grade
-------------|------------------
Sheehan and Joyce | Social Worker 1 WTE  
                      | Occupational Therapist 2.2 WTE  
                      | Psychologist 4 visiting

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Whole time equivalent (WTE).

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

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, or management of violence and aggression, 26(4).
b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).
Regulation 27: Maintenance of Records

(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.


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, which was last reviewed in June 2018. The policy included the requirements of the Judgement Support Framework with the exception of the process for making a retrospective entry in residents’ records.

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

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

Evidence of Implementation: Records were stored securely in the nurses’ station which was kept locked at all times. All records were up to date, in good order, and constructed, maintained, and used in accordance with the Data Protection Act. All resident records were stored together where possible, and a record was initiated for every resident in the approved centre. Resident records were reflective of the residents’ current status and the care and treatment being provided. Records were maintained using two appropriate resident identifiers.

Entries were factual, consistent, and accurate and each entry recorded the date and time using the 24-hour clock. Entries made by student nurses were countersigned by a registered nurse. Hand written records were legible and written in black ink. Resident records were developed and maintained in a logical order. They were accessible to authorised staff only. Documentation relating to food safety, health and safety, and fire inspections was 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 met did not meet all criteria of the Judgement Support Framework under the processes and training and education pillar.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
Regulation 29: Operating Policies and Procedures

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 January 2017. It included all of the requirements of the Judgement Support Framework.

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

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

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

The operating policies and procedures required by the regulations were not reviewed within the specified three-year time frame. This included the Regulation 18: Transfer of Residents, Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines and Regulation 24: Health and Safety policy. The operating policies and procedures were appropriately approved, and incorporated relevant legislation, evidence-based best practice and clinical guidelines.

Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. The format of the operating policies and procedures was standardised but the policies did not include the following: a reference and version number, the document owner and the total number of pages in the policy and procedure.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that three written operational policies and procedures of the approved centre were reviewed at least every 3 years. This included Regulation 18: Transfer of Residents, Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines and Regulation 24: Health and Safety policy.
Regulation 30: Mental Health Tribunals

(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 2016. 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 not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided a private tribunal room and adequate resources to support the Mental Health Tribunals process. Staff attended their Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in April 2018. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

Evidence Of Implementation: There was a nominated person responsible for dealing with all complaints available and based in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed on noticeboards, and it was detailed within the service user’s information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made through noticeboards and information booklets. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.
There had been four formal complaints since the last inspection. All complaints were handled promptly, appropriately and sensitively. The quality of the service or care and treatment of a resident did not appear to be adversely affected by reason of the complaint being made. All complaints were dealt with by the nominated person and recorded in the complaints log.

Minor complaints were documented separately. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process was made available to them. However, there was no record of the complainant’s satisfaction or dissatisfaction with the complaint investigation findings.

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

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 32: Risk Management Procedures

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

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

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. The audit did not measure actions taken to address risks identified against the time frames identified in the register. Analysis of incident reports had not been completed to identify opportunities for improving risk management processes.

Evidence Of Implementation: The person with responsibility for risk was identified and known by staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. All incidents were reviewed by either the assistant director of nursing during the day or the night clinical nurse manager 3. All serious incidents were reviewed by the clinical director; these were also discussed at North Dublin Mental Health Service’s Quality and Patient Safety Committee meeting. However, there was no forum for risks to be discussed locally within the approved centre. At the time of the inspection, there was no process for formally reviewing incidents for trends or patterns. The service was working on establishing a process to address this issue.
Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint and seclusion, and at resident admission and transfer. These risk assessment were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were removed or effectively mitigated. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format.

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

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
8.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 69: The Use of Seclusion

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. The policy was last reviewed in January 2019. The policy included all of the guidance criteria of this code pursuant to Section 69 of the Mental Health Act 2001, including who may implement seclusion, the provision of information about seclusion to the resident, and the ways of reducing rates of seclusion use.

Training and Education: There was a written record which indicated that not all staff involved in seclusion had read and understood the policy.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings, which did not endanger patient safety. The seclusion room was not cleaned to ensure respect for residents’ dignity as the facilities were observed to be dirty, cluttered and malodorous. Items such as pillows, rolls of paper towelling, unused commode trays and a bag of clothing were found on the floor of the seclusion facilities. In the seclusion room, there was visible dirt and dust on the floor, walls and door window. Dried food was visible on the seclusion room’s observation mirror. The last episode of seclusion was four days prior to the inspection.

The clinical files of three residents who had been in seclusion, on one occasion, each were inspected. In all three episodes, seclusion was only implemented in the resident’s best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified on the use of seclusion within the appropriate time frame. In one seclusion episode, there was no evidence that the seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours.

Cultural awareness and gender sensitivity were demonstrated. Residents were informed of the reasons, for, duration of, and circumstances leading to discontinuation of seclusion. Each resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. Each resident was informed of the ending of seclusion. The reason for ending seclusion was recorded on the clinical file.
in each case. Each episode of seclusion was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days after the episode of seclusion.

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

a) The seclusion room was dirty, cluttered and malodorous which indicated that the seclusion facilities were not cleaned to ensure respect for resident dignity, 8.2.

b) In one seclusion episode, there was no evidence that the seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours, 3.5.

c) Not all staff involved in seclusion had signed a policy log to indicate that they had read and understood the policy, 10. 2(b).
9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
Part 4 Consent to Treatment

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 files of two detained (i.e. involuntary) patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication for over three months were examined. Both patients were assessed as being unable to consent to receiving treatment and this was documented within their clinical files.

A Form 17: Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent had been appropriately completed in both cases. It included details of the discussions with the patient on the nature and purpose and the effects of the medication. Any views expressed by the patients were recorded. Authorisation was provided by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
11.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
Use of Physical Restraint

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in January 2019. The policy addressed all of the policy-related relevant items of this code of practice, including the provision of information to the resident, those who can initiate and who may implement physical restraint, and child protection process were a child is physically restrained.

Training and Education: All staff involved in physical restraint had signed the policy log to indicate that they had read and understood the policy.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: The files of three residents who each had been physically restrained once since the last inspection were reviewed. In all three episodes, physical restraint was used in rare and exceptional circumstances only, and staff had first considered all other interventions to manage the resident’s unsafe behaviour. The use of physical restraint was based on a risk assessment of each resident. In one episode of physical restraint, the clinical practice form was not signed by the consultant psychiatrist within 24 hours.

In all episodes of physical restraint, cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint. Each of the three residents had received a medical exam, by a registered medical practitioner within three hours after the start of the physical restraint episode. In one episode of physical restraint, the episode of physical restraint was not reviewed by members of the multi-disciplinary team and documented in the clinical file.

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

a) In one episode of physical restraint, the clinical practice form was not signed by the consultant psychiatrist within 24 hours, 7.2.

b) In one episode of physical restraint, the episode of physical restraint was not reviewed by members of the multi-disciplinary team and documented in the clinical file, 9.3.
Admission of Children

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of children, which was last reviewed in January 2016. It addressed the requirement for each child to be individually risk-assessed and the procedures for identifying the person responsible for notifying the Mental Health Commission (MHC) of the child admission. The policy also detailed procedures in relation to family liaison, parental consent, and confidentiality.

Training and Education: Staff had received training in relation to the care of children, which was called Children First.

Evidence of Implementation: One child was admitted since the last inspection, following an assessment by the Child and Adolescent Mental Health Service (CAMHS) team, but there was no CAMHS bed available. The approved centre was not suitable for the admission of children.

The clinical file inspected indicated that provisions were in place to ensure the safety of the child, to ensure their rights to have their views heard, and to respond to the child’s particular needs as a young person in an adult setting. Staff having contact with the child had undergone Garda vetting, and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff.

Appropriate accommodation was available for the child in the approved centre, including age and gender segregated sleeping and bathroom areas. The child was admitted into a single bedroom, with a dedicated staff member and the approved centre provided a dedicated regime of activities. Gender sensitivity was demonstrated. The child had their rights explained and was provided with information about the available facilities in a form and language that they could understand. The clinical file recorded the child’s understanding of the explanation given to them on their rights.

Advice from the Child and Adolescent Mental Health Service was available when necessary. Consent for treatment was obtained from one or both parents. Educational requirements did not apply because the admission period was of short in duration, four days during the summer time. The Mental Health Commission was notified of the child’s admission to an approved centre for adults within the required 72-hour time frame.

The approved centre was non-compliant with this code of practice as it was not suitable for the admission of children as it is an adult centre and there were no suitable or dedicated facilities for the treatment and care of children, 2.5 (b).
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in November 2016, the transfer policy was last reviewed in January 2016, and the discharge policy was last reviewed in January 2014. The policies combined included all of the policy related criteria of the code of practice.

Training and Education: Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies. Specifically, medical staff had not signed.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, and discharge 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 illness or mental disorder. The resident was assigned a key-worker. The resident received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

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

There was appropriate MDT input into discharge planning. A preliminary discharge summary was issued within three days. A comprehensive discharge summary was issued within 14 days to relevant personnel. The discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was non-compliant with this code of practice because not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 8: Residents' Personal Property and Possessions

<table>
<thead>
<tr>
<th>Reason ID: 10000166</th>
<th>An accurate record had not been maintained of all the property, specifically to one resident, 8 (3).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Identify the resident and record all property correctly</td>
</tr>
<tr>
<td></td>
<td>Updated property record maintained in residents file</td>
</tr>
<tr>
<td></td>
<td>Yes Please note/re: below time bound - this has been Completed</td>
</tr>
<tr>
<td></td>
<td>09/07/2019</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ensure all property records are completed correctly</td>
</tr>
<tr>
<td></td>
<td>Monthly Audit</td>
</tr>
<tr>
<td></td>
<td>Yes Please note - this has commenced and is ongoing</td>
</tr>
<tr>
<td></td>
<td>09/07/2019</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000167</th>
<th>There was not adequate provision for the safe-keeping of all personal property and possessions, 8 (6).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All patients property is now stored safely. Store rooms tidied and maintained.</td>
</tr>
<tr>
<td></td>
<td>Key Worker checks property against property records. CNM2 inspects storeroom weekly</td>
</tr>
<tr>
<td></td>
<td>Yes Note/Time Bound below: This has been completed</td>
</tr>
<tr>
<td></td>
<td>09/07/2019</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Labelled storage box assigned to each resident in storeroom</td>
</tr>
<tr>
<td></td>
<td>Weekly schedule in place for tidying and maintaining store rooms</td>
</tr>
<tr>
<td></td>
<td>Yes Commenced and ongoing</td>
</tr>
<tr>
<td></td>
<td>09/07/2019</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
</tr>
</tbody>
</table>
### Regulation 15: Individual Care Plan

**Reason ID : 10000168** Four ICPs inspected were not developed by the residents' MDT.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT to review the four ICPs</td>
<td>ICP Audit</td>
<td>Yes Note/Time Bound below - This has been completed</td>
<td>09/07/2019</td>
<td>MDTs</td>
<td></td>
</tr>
</tbody>
</table>

**Preventative Action**

Training for MDT staff on completing ICPs

| ICP Audits Monthly ICP Checklist | Yes Note: Commenced and on going | 09/07/2019 | Heads of Disciplines |

**Reason ID : 10000169** One ICP inspected was not developed within seven days of admission.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDTs to ensure all ICPs are developed within seven days of admission</td>
<td>ICP Audit</td>
<td>Yes Note: This has been completed</td>
<td>09/07/2019</td>
<td>MDTs</td>
<td></td>
</tr>
</tbody>
</table>

**Preventative Action**

Training for MDT staff on completing ICPs

| ICP Audits Monthly ICP Checklist | Yes Note: Commenced and on going | 09/07/2019 | Heads of Disciplines |

**Reason ID : 10000170** One ICP was not recorded in one composite set of documents.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICP to be identified and recorded in one composite set of documents</td>
<td>ICP Audit</td>
<td>Yes Note: This has been completed</td>
<td>09/07/2019</td>
<td>MDT</td>
<td></td>
</tr>
</tbody>
</table>

**Preventative Action**

Training for MDT staff on completing ICPs

| ICP Audits Monthly ICP Checklist | Yes Note: Commenced and on going | 09/07/2019 | Heads of Disciplines |

**Reason ID : 10000171** There was no evidence of resident involvement in three ICPs inspected.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three ICPs to be identified and residents to be</td>
<td>ICP Audit</td>
<td>Yes Note: Completed</td>
<td>09/07/2019</td>
<td>MDT</td>
<td></td>
</tr>
</tbody>
</table>

**Preventative Action**

Training for MDT staff on completing ICPs

<p>| ICP Audits Monthly ICP Checklist | Yes Note: Commenced and on going | 09/07/2019 | Heads of Disciplines |</p>
<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Training for MDT staff on completing ICPs</th>
<th>ICP Audits Monthly</th>
<th>ICP Checklist</th>
<th>Yes</th>
<th>Note: Commenced and on going</th>
<th>09/07/2019</th>
<th>Heads of Disciplines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason ID: 10000172</td>
<td>Three ICPs inspected did not contain specific and appropriate goals for the residents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Three ICPs to be identified, specific and appropriate goals to be developed for the resident</td>
<td>ICP Audit</td>
<td>Yes</td>
<td>Note: Completed</td>
<td>09/07/2019</td>
<td>MDT</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Training for MDT staff on completing ICPs</td>
<td>ICP Audits Monthly</td>
<td>ICP Checklist</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
<td>09/07/2019</td>
<td>Heads of Disciplines</td>
</tr>
<tr>
<td>Reason ID: 10000173</td>
<td>Two ICPs did not adequately identify the care and treatment provided.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Two ICPs to be identified, care and treatment to be identified.</td>
<td>ICP Audit</td>
<td>Yes</td>
<td>Note: Completed</td>
<td>09/07/2019</td>
<td>MDT</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Training for MDT staff on completing ICPs</td>
<td>ICP Audits Monthly</td>
<td>ICP Checklist</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
<td>09/07/2019</td>
<td>Heads of Disciplines</td>
</tr>
<tr>
<td>Reason ID: 10000174</td>
<td>Three ICPs did not identify the resources required to provide the care and treatment identified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Three ICPs to be identified and the resources required</td>
<td>ICP Audit</td>
<td>Yes</td>
<td>Note: Completed</td>
<td>09/07/2019</td>
<td>MDT</td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Training for MDT staff on completing ICPs</td>
<td>ICP Audits Monthly ICP Checklist</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
<td>09/07/2019</td>
<td>Heads of Disciplines</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td></td>
</tr>
<tr>
<td>to provide care and treatment identified.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 19: General Health

**Reason ID: 10000175**

The six-monthly general health assessment records and associated tests were not fully completed; residents' body mass index and waist circumference was not checked and recorded in one case, 19 (b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Identify patients who did not have body mass index and waist circumference recorded and rectify.</td>
<td>Recorded in General Health Assessment</td>
<td>Yes  Note: Completed</td>
<td>09/07/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ensure all required information on General Health Assessment template is complete</td>
<td>Audit each 6 monthly physical health template following each assessment</td>
<td>Yes  Note: Commenced and on going</td>
<td>09/07/2019</td>
</tr>
</tbody>
</table>

**Reason ID: 10000176**

There was no documented evidence that residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids and prolactin levels, 19 (b).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Identify patients who did have this recorded and rectify</td>
<td>Record of completed tests in General Health Assessment</td>
<td>Yes  Note: Completed</td>
<td>09/07/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ensure all required information on General Health Assessment template is completed</td>
<td>Audit each 6 monthly physical health template following each assessment</td>
<td>Yes  Note: Commenced and on going</td>
<td>09/07/2019</td>
</tr>
</tbody>
</table>
### Regulation 21: Privacy

#### Reason ID: 10000180

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seclusion Room deep cleaned and tidied</td>
<td>Hygiene Audit</td>
<td>Yes</td>
<td>Note: Completed</td>
<td>09/07/2019</td>
</tr>
</tbody>
</table>

#### Preventative Action

| Measurable | Hygiene Audit | Yes | Note: Completed | 09/07/2019 | CNM2 |

#### Reason ID: 10000181

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation panel glass now covered with opaque frosting</td>
<td>Completion of work checked by ADoN</td>
<td>Yes</td>
<td>Note: Completed</td>
<td>09/07/2019</td>
</tr>
</tbody>
</table>

#### Preventative Action

| Measurable | N/A | Yes | 09/07/2019 | ADoN |

#### Reason ID: 10000182

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation panels locked as default setting</td>
<td>6 hourly check of panels to ensure they are closed</td>
<td>Yes</td>
<td>Note: Completed and on going</td>
<td>09/07/2019</td>
</tr>
</tbody>
</table>

#### Preventative Action

| Measurable | Privacy Audit. Daily Checklist. | Yes | Note: Commenced and on going | 09/07/2019 | CNM2 |
### Regulation 22: Premises

#### Reason ID: 10000177

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean all the facilities</td>
<td>Areas checked for cleanliness by CNM2 and Senior OT</td>
<td>Yes</td>
<td>Note: Completed</td>
<td>09/07/2019</td>
<td>CNM2 adn Senior OT</td>
</tr>
</tbody>
</table>

#### Preventative Action

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised cleaning programme for all areas set up with cleaning contractors</td>
<td>Monthly Hygiene Audit</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
<td>09/07/2019</td>
<td>CNM2 and Senior OT</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000178

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gardens to be maintained. All damage to be repaired and/or replaced.</td>
<td>Monthly Hygiene Audit</td>
<td>Yes</td>
<td></td>
<td>31/08/2019</td>
<td>Maintenance Manager</td>
</tr>
</tbody>
</table>

#### Preventative Action

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Enviromental and Maintenance Checklist. Regular garden upkeep and maintenance schedule</td>
<td>Monthly Hygiene Audit</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
<td>31/08/2019</td>
<td>CNM2 and Maintenance Officer</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000179

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The approved centre did not have adequate and suitable furnishings. The upholstery of armchairs in the high observation unit sitting room was torn, 22 (3).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrective Action</td>
<td>Damaged furniture to be replaced. New furniture ordered.</td>
<td>Monthly Hygiene Audit, Monthly Environmental Checklist</td>
<td>Yes</td>
<td>31/08/2019</td>
<td>CNM2</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Monthly Environmental and Maintenance Checklist</td>
<td>Monthly Hygiene Audit</td>
<td>Yes Note: Commenced and on going</td>
<td>31/08/2019</td>
<td>CNM2</td>
</tr>
</tbody>
</table>
**Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines**

<table>
<thead>
<tr>
<th>Reason ID : 10000183</th>
<th>Two MPARs did not detail a record of all medications administered to the resident.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>MPAR to detail all required information</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td></td>
<td>Audit of MPAR and Metrics Audit</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Provide training to all nursing staff on recording of administration of medications</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000184</th>
<th>The stop date for each discontinued medication was missing in two MPARs inspected.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>MPAR to detail all required information</td>
</tr>
<tr>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td></td>
<td>Audit of MPAR. Metrics Audit</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Provide training to all medical staff on completing MPARS</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Reason ID: 10000185**

Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, or management of violence and aggression, 26(4). Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All relevant staff to be identified and assigned training.</td>
<td>Training needs analysis updated and focused training plan to identify training deficits. Metrics Audit.</td>
<td>Yes Note: Commenced and on going</td>
<td>31/10/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Training database maintained. Liaise with training providers.</td>
<td>Monthly review of staff training</td>
<td>Yes Note: Commenced and on going</td>
<td>31/10/2019</td>
</tr>
</tbody>
</table>
### Regulation 29: Operating Policies and Procedures

**Reason ID : 10000187**

The registered proprietor did not ensure that three written operational policies and procedures of the approved centre were reviewed at least every 3 years. This included Regulation 18: Transfer of Residents, Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines and Regulation 24: Health and Safety policy.

<table>
<thead>
<tr>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Policies to be reviewed</td>
<td>Audit of Policies</td>
<td>Yes Note: Completed</td>
<td>08/07/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Subcommittee's of PPPG committee now in place, will take responsibility for maintaining and updating policies for each Approved Centre.</td>
<td>Policy committee to complete policy review date template</td>
<td>Yes Note: Commenced and on going</td>
<td>08/07/2019</td>
</tr>
</tbody>
</table>
**COP Relating to Admission of Children under the Mental Health Act 2001.**  
**Reason ID : 10000162**  
The approved centre was not suitable for the admission of children as it is an adult centre and there were no suitable or dedicated facilities for the treatment and care of children, 2.5 (b).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No children will be admitted to the approved centre, as it is not an age appropriate facility. This is dependent on availability of CAMHS beds. Transfer to the Child Unit is expedited. Children admitted have a 1:1 nurse and Headspace Toolkit is available.</td>
<td>Audit, post admission of a child</td>
<td>Not achievable or realistic as CAMHS service do not have an out of hours service for emergencies.</td>
<td>12/07/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No children will be admitted to the approved centre as it is not an age appropriate facility. This is dependent on availability of CAMHS beds. Transfer to the Child Uniot is expedited. Children admitted have a 1:1 nurse and</td>
<td>Audit post admission of child</td>
<td>Not achievable or realistic as CAMHS service do not have an out of hours service for emergencies.</td>
<td>12/07/2019</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>Headspace Toolkit is available.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Code of Practice on the Use of Physical Restraint in Approved Centres

**Reason ID : 10000163**

In one episode of physical restraint, the clinical practice form was not signed by the consultant psychiatrist within 24 hours, 7.2.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
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<th>Achievable/Realistic</th>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant to be made aware of the requirement</td>
<td>Physical Restraint Audit</td>
<td>Yes</td>
<td></td>
<td>09/07/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training on completion of clinical practice form on Physical Restraint for medical staff</td>
<td>Training Records</td>
<td>yes</td>
<td></td>
<td>30/08/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

**Reason ID : 10000164**

In one episode of physical restraint, the episode of physical restraint was not reviewed by members of the multi-disciplinary team and documented in the clinical file, 9.3.

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT to be made aware and correct</td>
<td>Physical Restraint Audit</td>
<td>Yes</td>
<td></td>
<td>09/07/2019</td>
<td>Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for Code of Practice for all MDT staff</td>
<td>Training Records</td>
<td>yes</td>
<td></td>
<td>30/08/2019</td>
<td>Heads of Disciplines</td>
</tr>
</tbody>
</table>
The approved centre was non-compliant with this code of practice because not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1.

<table>
<thead>
<tr>
<th>Corrective Action</th>
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<th>Achievable/Realistic</th>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All relevant staff to sign Policy Log</td>
<td>Signature Logs</td>
<td>Yes</td>
<td>09/07/2019</td>
<td>Heads of Disciplines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Training Records</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual signature log on Policies to be maintained for each discipline</td>
<td></td>
<td>Yes</td>
<td>30/08/2019</td>
<td>Heads of Disciplines</td>
</tr>
</tbody>
</table>
### Rules Governing the Use of Seclusion

#### Reason ID : 10000188

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>All staff involved in seclusion to sign policy log to indicate they have read and understand policy.</td>
<td>Training Logs. Policy Signature List.</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Schedule of workshops on seclusion policy to be developed</td>
<td>Training records.</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
</tr>
</tbody>
</table>

#### Reason ID : 10000189

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Seclusion room cleaned and tidied immediately.</td>
<td>Hygiene Audit</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Revised cleaning programme for seclusion room set up with cleaning contractors. Seclusion room hygiene checklist in place.</td>
<td>Monthly Hygiene Audit. Seclusion room hygiene checklist in place.</td>
<td>Yes</td>
<td>Note: Commenced and on going</td>
</tr>
</tbody>
</table>

#### Reason ID : 10000190

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Bring to the attention of responsible consultant</td>
<td>Seclusion Audit</td>
<td>Yes  Note: Completed</td>
<td>09/07/2019</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Training for staff member on completing seclusion register</td>
<td>Seclusion audit post each episode of seclusion</td>
<td>Yes  Note: Commenced and on going</td>
<td>09/07/2019</td>
</tr>
</tbody>
</table>
Appendix 2: Background 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.