2019 Approved Centre Inspection Report (Mental Health Act 2001)

Central Mental Hospital

ID Number: AC0048

Approved Centre Type: Forensic Mental Health Care

Most Recent Registration Date: 1 March 2017

Registered Proprietor: HSE

Registered Proprietor Nominee: Ms Sarah Hennessy, General Manager, National Forensic Mental Health Services

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Inspection Date: 9 – 12 April 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 26 – 29 June 2018

Date of Publication: Thursday 26 September 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
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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The Central Mental Hospital, which was part of the National Forensic Mental Health Service, was situated in the urban location of Dundrum, Dublin. It comprised a number of buildings, mainly Victorian and dating back to 1852. None of the buildings were fit for purpose. Building of a long overdue new hospital, in Portrane, was underway and plans were in place for transition in early 2020.

Patients were admitted under the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006. The approved centre was comprised of nine separate units and each had a distinct function in the pathway that formed part of the therapeutic programme provided for the patients.

There was only one unit for the care and treatment of up to ten female patients. The level of security in the female unit included high, medium, and low needs, which was not in keeping with best practice or the model of care afforded to the male population. There were eight in-patient multi-disciplinary teams (MDTs) in the approved centre.

The approved centre has made little improvement in compliance with regulations, rules and codes of practice over the last three years: 70% compliance in 2017, 79% compliance in 2018, and 69% compliance in 2019. Only one compliance with regulations was 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: The approved centre shall submit a plan to the Mental Health Commission for the closure of the approved centre, including the transfer or discharge of all current residents. The approved centre shall provide updates on the closure plan in a form and frequency prescribed by the Commission. The updates shall include the ongoing programme of maintenance for the approved centre, up until all residents have been transferred or discharged.

Finding on this inspection: The approved centre was compliant with Condition 1.
Safety in the approved centre

- Food safety audits had been completed periodically. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in the main hospital kitchen in a manner which reduced the risk of contamination, spoilage, and infection. There was a cleaning schedule in the approved centre, and the catering manager had developed a hygiene inspection checklist. Catering areas and associated catering and food safety equipment were appropriately cleaned.
- Medication management processes were good.

However:

- Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard and rough surfaces were not minimised. A rotting wooden picnic table was observed in the garden area. Where wood had deteriorated, two nails were exposed protruding from the timber. Water was leaking from a washing machine and sink on Unit 3 leading to a slip hazard.
- Numerous ligature risks were observed and they were logged in the approved centre’s ligature audit.
- The seclusion rooms were designed with furniture and fittings which posed a potential risk to patient safety. There was no soft padding in the seclusion rooms.
- Despite the approved centre providing a forensic service, only 65% of staff were trained in the prevention and management of violence and aggression, posing a risk to both patients and staff. The numbers of staff trained in other mandatory areas (Basic Life Support, fire safety and the Mental Health Act, 2001) were also low.

Appropriate care and treatment of residents

- Each patient had an individual care plan (ICP) with assessed needs, goals, treatment, care, and resources and a risk management plan outlined. A key worker and a nurse were identified to ensure continuity in the implementation of a patient’s ICP. The ICP was discussed, agreed and drawn up with the participation of the patient and their representative. ICPs were reviewed by the MDT in consultation with patients on a weekly basis. Patients had access to their ICPs and were kept informed of any changes.
- A range of therapeutic programmes was available for patients. Each patient had an individual holistic, bio-psycho assessment of their history, needs, risk and strengths to inform an appropriate choice of therapeutic interventions and activities. These included Cognitive Remediation Therapy, Cognitive Skills Training, Dialectical Behaviour Therapy, Stress and Anger Management, Substance Misuse, Mental Health, Challenging Behaviour Interventions, and Offending Behaviour. There were vocational, self-help and peer support programmes available. Patients had access to occupational therapy, social work, clinical psychology, medical, dental and chiropody services.
- Registered medical practitioners assessed patients’ general health needs on admission and on an ongoing basis as part of the approved centre’s provision of care. The six-monthly general health assessments were completed satisfactorily. Adequate arrangements were in place for patients to access general health services and for their referral to other health services as required. Patients had
access to national screening programmes. The HSE policy on smoking cessation was used and implemented in the approved centre.

However:

- Adequate and appropriate resources and facilities were not available for therapeutic activities. Staff stated that there was a shortage of facilities and rooms to meet patients’ needs. The inspection team observed that residents used the kitchen to meet therapists on Unit 1. This was not an appropriate space but it was the only private space available.

Respect for residents’ privacy, dignity and autonomy

- To reduce the number of seclusion episodes, the service had opened a new high observation area in the male admission ward, which had reduced the number of days a patient had to stay in seclusion.
- Secure facilities were provided, on each unit, for the safekeeping of patients’ monies, valuables, personal property, and possessions. Patients were supported to manage their own property, unless this posed a danger to the patient or others, as indicated in their ICP and in accordance with the approved centre’s policy.
- Visiting times were appropriate and reasonable. A separate visitor room or visiting area was provided unless there was an identified risk to the patient or others, or a health and safety risk. There was an identified area for children visiting, which had to be pre-booked.
- A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the patient’s dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the patient being searched.
- Patients were accommodated in single bedrooms. All bedrooms had curtains fitted over the observation panels on the outside of the door.
- The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

However:

- On Unit B, the male admission unit, the emergency supply of clothing consisted of old clothes left behind by other patients. There was no underwear or supply of emergency clothing.
- There were blanket restrictions on mobile phones and monies. These restrictions were outlined in the Personal Property Policy of the approved centre.
- Due to the overcapacity in Unit 1, the inspection team were unable to access a private space to interview patients. An area of the dayroom was made available but it was not private.
- A log of searches was not maintained either on the unit or at hospital level. Patients’ consent was not documented prior to all searches. There was no documentary evidence that patients were informed by those implementing the search of what was happening during a search and why.
- At the time of the inspection, the female unit was overcapacity with 11 patients. One was sleeping in an interview room.
- The door to one of the offices was open with confidential information on the desks; there was no healthcare professional in the office. Noticeboards in two offices, that had patient names and other information, were viewable from outside the office through a transparent door window. One unit
had patients’ names and dates of birth printed on the spine of the files that were observable from outside the office.

- Bedrooms in Units 1, 2, 3, 5 and 7 were too small. Due to the inadequate storage space in the bedrooms, patients in Unit 7 were required to store their belongings in wardrobes located in corridors.

- The approved centre was not kept in a good state of repair externally and internally. Paint was peeling, plaster was chipped, floors were worn, there was discoloured ceiling tiles, there were rusting pipes and a broken curtain rail. Maintenance was undertaken on an as-needed basis. A malodour was detected in toilets on Unit 3 due to a blocked toilet. This was a recurring issue.

- The bathroom floor in Laurel Lodge was unhygienic due to the presence of deeply engrained dirt on the flooring.

- On Unit B, the images transmitted to a monitor were viewable by patients and non-healthcare professionals. This was remedied during the inspection.

- The approved centre was not compliant with the Code of Practice on Physical Restraint.

**Responsiveness to residents’ needs**

- Patients chose from menus provided and could request certain foods by filling in a dietary requisition form. Patients were provided with a variety of wholesome and nutritious food.

- There was a recreational activities department for patients use within all units. Activities were run from 8am - 9pm seven days per week and included indoor and outdoor games, walking, jogging groups, cricket, yoga classes, basketball, table tennis, guitar, saxophone and ukulele lessons, calypso music groups, table quizzes, and bingo nights. New activities recently added to the programme included Tai Chi, tag rugby, music theory and music appreciation. Throughout the year, there were discos, a summer garden party, and patients and staff participated in a Christmas show.

- Information was provided to patients with regard to the approved centre, their diagnoses and medications.

- There was a robust complaints procedure in place.

However:

- The recreation activities were not appropriately resourced due to a shortage of staff in the recreation activities department. This staffing shortage negatively impacted patients, and feedback from the patients’ confirmed that activities were cancelled on a regular basis.

- Menus in the approved centre were not approved by a dietitian to ensure nutritional adequacy in accordance with patients’ needs.

**Governance of the approved centre**

- The Area Management Team (AMT) reported directly to the Mental Health Division of the HSE.

- There was a new governance structure with the Executive Clinical Director, the Area Director of Nursing, General Manager, Occupational Therapy Manager, Principal Psychologist, and Principal Social Worker responsible for operational elements and overseeing the build and transition to Portrane.
- A new Operations Management Team (OMT) had been appointed and they were responsible for operational functions in Dundrum.
- Significant work had been done to develop an electronic system as part of the transition to the new hospital. A new Clinical Management System was in development and a Safety Management System was in place.
- An inaugural meeting of the new Quality and Safety Committee was scheduled. This committee had overall responsibility and was informed by sub groups that have responsibility for risk, health and safety, seclusion and restraint reduction, policy development, and patient leave.
- A new human resources manager had been appointed and there was a recruitment drive underway to fill vacant posts and to recruit for new posts through the National Recruitment Service.
- A new registered proprietor was in post for three weeks and was addressing the fact that not all staff had completed mandatory training.

However:

- The operating policies and procedures required to be reviewed within three years by the regulations were not all reviewed within that timeframe. A policy progress report was provided showing the plan to review all policies.
- Policies stated that the service monitor its performance as part of a quality improvement process. In practice, there was little evidence of audits and the audits presented lacked detail.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

EVOLVE Recovery College opened in November 2018. Since then programmes to help patients with their recovery have been running, supported by two peer educators. Programmes include Introduction to Recovery, Get Up, Stand Up, Exploring Schizophrenia, Exploring Anxiety and Be Well Stay Well. Sixteen people have been trained in co-production and basic facilitation skills. Six patients have co-facilitated a workshop.

1. Two new literacy programmes have been set up following hospital wide literacy screening and assessments as required. These programmes were delivered by specialist tutors.

2. An employment specialist had commenced working with patients to gain meaningful, mainstream, paid employment.

3. Service user forums were set up so that recovery-oriented initiatives and policies were discussed.

4. A policy development officer commenced in September 2018. Sixty policies that underpin how the service operates were due to be renewed prior to the transition to the new hospital. Patients were involved in the review of policies.

5. An induction checklist was created in line with the HSE induction checklist with additional items pertaining to the forensic mental health service. This checklist was approved by the Nursing and Midwifery Board of Ireland and nurses were awarded 35 Continuing Education Units on completion.

6. The carers group met monthly with management to discuss operational issues and to address concerns regarding the transition to the new hospital.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Central Mental Hospital, which was part of the National Forensic Mental Health Service, was situated in the urban location of Dundrum, Dublin. It extended over 34 acres of mature, well-tended, and manicured gardens. It comprised a number of buildings, mainly Victorian and dating back to 1852. While efforts had been made to refurbish and maintain the buildings, they were not fit for purpose and the Mental Health Commission had a condition attached to the approved centre’s registration for its closure.

Patients were admitted under the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006. The approved centre was comprised of nine separate units and each had a distinct function in the pathway that was provided for individual care and treatment. Known as ‘Pillars of Care’, there were seven identified pillars that formed part of the therapeutic programme provided for the patients. Typically, the male population progressed through a series of units which were sub divided into three clusters: acute, medium, and rehabilitation and recovery. One unit provided care and treatment for those patients with a dual diagnosis of mental illness with intellectual disability.

There was one unit for the care and treatment of up to ten female patients. At the time of the inspection, the female unit was overcapacity with 11 patients. One was sleeping in an interview room. The level of security in the female unit included high, medium, and low needs, which was not in keeping with best practice or the model of care afforded to the male population. There were eight in-patient teams in the approved centre.

Building of a new hospital, in Portrane, was nearing completion and plans were in place for transition in early 2020.

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

<table>
<thead>
<tr>
<th>Patient Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of registered beds</strong></td>
<td>103</td>
</tr>
<tr>
<td><strong>Total number of patients</strong></td>
<td>102</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>102</td>
</tr>
<tr>
<td><strong>Number of wards of court</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of patients in the approved centre for more than 6 months</strong></td>
<td>91</td>
</tr>
<tr>
<td><strong>Number of patients on Section 26 leave for more than 2 weeks</strong></td>
<td>0</td>
</tr>
</tbody>
</table>
3.2 Governance

Encompassing the approved centre and the wider National Forensic Mental Health Service, the Area Management Team (AMT) reported directly to the Mental Health Division of the HSE. There was significant additional demands on management work time with planning for the new hospital in Portrane and operational management in Dundrum. To this end, there was a new governance structure with the Executive Clinical Director, General Manager, Area Director of Nursing, Occupational Therapy Manager, Principal Psychologist, and Principal Social Worker responsible for operational elements and overseeing the build and transition to Portrane. A new Operations Management Team (OMT) had been appointed and they were responsible for operational functions in Dundrum. All positions were not backfilled and some of the management were sitting on both committees.

Significant work had been done to develop an electronic system as part of the transition to the new hospital. A new Clinical Management System was in development and a Safety Management System was in place. An inaugural meeting of the new Quality and Safety Committee was scheduled and the inspection team were presented with a new governance structure by the quality and risk advisor. This committee had overall responsibility and was informed by sub groups that have responsibility for risk, health and safety, seclusion and restraint reduction, policy development, and patient leave.

The service had a proven track record in the care and treatment of patients and a therapeutic programme deliver through seven pillars ensured patients rehabilitation. To reduce the number of seclusion episodes, the service had opened a new high observation area in the male admission ward. The availability of a high observation unit reduced the number of days a patient had to stay in seclusion. Patients could be transferred to a high observation area while being assessed.

A new human resources manager had been appointed and there was a recruitment drive underway to fill vacant posts and to recruit for new posts through the National Recruitment Service. A new registered proprietor was in post for three weeks and was addressing the fact that not all staff had completed mandatory training. A training needs analysis showed that additional training days were required to ensure 100% compliance. Fire safety would only achieve 83% compliance according to the training needs analysis. A commitment was made to look at additional training at induction and an increase in the number of additional training days.

The policy review group were aware that a number of policies were out of date and provided details of the review of over 60 policies. A policy progress report was provided showing the plan to review all policies. Service users and carers were involved in policy review. Policies stated that the service monitor its performance as part of a quality improvement process. In practice, there was little evidence of audits and the audits presented lacked detail. The inspection team were informed that arrangements were in place to introduce an audit programme.

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.
4.1 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>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>✓</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
<td>✓</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 25: CCTV</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X Moderate</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓ Moderate</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X Low</td>
<td>X Moderate</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical restraint</td>
<td>X Moderate</td>
<td>X Low</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge</td>
<td>X Low</td>
<td>X Low</td>
<td>X Moderate</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 area were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</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 the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice 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 met with the inspection team and shared feedback from patients.

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 twenty-four patients. Overall, patient feedback was very positive. Some patients praised the food and said the choice had improved. Unit 2 and Unit 3 shared a dining room and food was served in two sittings. Patients who ate at the second sitting said the food was often cold. There was a lengthy waiting list to get on some of the education programmes. Two patients said education was directed at junior and leaving cert standard, which they already had. Online and long-distance education was not possible as there was no internet. The Recovery College was praised by those who had attended and all thought the recovery programme was beneficial. One patient said he got a chance to try things he never thought he would be good at.

Several patients mentioned that there was a shortage of staff, which impacted them. Sessions to the gym were often cancelled and opportunities to go outside were reduced. Patients said not having enough to do resulted in sitting around on the corridor for long hours. Those that engaged in the Garden Project and the woodwork project, Wild Wood, were very complimentary of the staff and really enjoyed their time there.

Patients knew all the members of their multi-disciplinary team (MDT) and several said they were easy to talk to and they could ask questions about their care and treatment. Patients also were familiar with their Individual Care Plans (ICP) and were involved in setting goals for their recovery.

Twenty-two completed service user questionnaires were returned to the inspection team. Twenty patients indicated that they understood their care plan and knew who their key worker was. It was reported that patients knew their respective sector MDT and patients stated they met with team members two to three
times weekly. The patients stated that they were always involved with setting their goals for their individual care plan. Nine completed questionnaires indicated that the patient felt there was not enough activities.

Eleven patients said their privacy was respected. Patients indicated that they could communicate freely with family/friends or advocates. Most stated that they always felt able to give feedback to staff and to make a complaint, with two indicating ‘sometimes’ to this question. On a scale of 1-10 with 1 being poor and 10 being excellent, 2 patients rated between 1 and 2, 11 rated between 5 and 7 and 9 patients rated between 8 and 10 for their overall experience of care and treatment.

The Irish Advocacy Network provided a full time advocacy service to the patients in the approved centre with an advocate available Monday to Friday. The advocate also attended the Residence Forum Meetings that were held six-weekly. The inspection team was advised that the advocate visited each unit three or four times weekly. Feedback from patients to the advocate was extremely positive and any issues raised had been discussed or included in the questionnaires by the patients themselves.
A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Registered Proprietor
- Acting Clinical Director
- Consultant Forensic Psychiatrist x 3
- Area Director of Nursing
- Interim Director of Nursing
- Assistant Director of Nursing
- Head of Psychology
- Social Worker representing Interim Principal Social Worker
- Quality and Risk Advisor
- Nurse Practice Development Coordinator
- Clinical Nurse Manager 3
- Catering Officer
- Mental Health Act Administrator

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. Some documents had been updated and would be sent to the inspection team by Tuesday 16 April 2019.
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 patients, which was last reviewed in 2017. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to the identification of patients.
- The process for identifying patients with the same or similar name.

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

Monitoring: An annual audit had not been undertaken to ensure that there were appropriate patient identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the patient identification process.

Evidence of Implementation: Arrangements were in place in the approved centre to ensure that each patient was readily identifiable by staff. Two person-specific identifiers were used by the approved centre. Name, date of birth, and photograph were on all clinical files. An appropriate patient identifier was used prior to the administration of medication, the undertaking of medical investigations, and the provision of health care services. An appropriate identifier was used prior to the provision of therapeutic services and programmes. Appropriate identifiers and alerts were used for patients with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
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 February 2016. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A systematic review of menu plans had been undertaken to ensure that patients 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: Patients chose from menus provided and could request certain foods by filling in a dietary requisition form. Patients were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Hot and cold drinks were offered to patients regularly. A source of safe, fresh drinking water was available to patients at all times in easily accessible locations in the approved centre.

Menus in the approved centre were not approved by a dietitian to ensure nutritional adequacy in accordance with patients’ needs. An evidence based nutrition assessment tool was used for patients with special dietary requirements. Patients, their representatives, family, and next of kin were educated about patients’ diets, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 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 February 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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 was suitable and sufficient catering equipment in the approved centre. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Patients were provided with appropriate crockery and cutlery.

Food was prepared in the main hospital kitchen in a manner which reduced the risk of contamination, spoilage, and infection. There was a cleaning schedule in the approved centre, and the catering manager had developed a hygiene inspection checklist. Catering areas and associated catering and food safety equipment were appropriately cleaned.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 7: Clothing

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 the protocol for the use of night clothes during the day, which was last reviewed in February 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the responsibility of the approved centre to provide new clothing to patients, where necessary, with consideration of the patients’ preferences, dignity, bodily integrity, and religious and cultural practices.

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 patients’ clothing, as set out in the policy.

Monitoring: Clinical nurse managers confirmed that the supply of emergency clothing was checked weekly; however, this was not documented. No patient was wearing nightclothes during the day at the time of the inspection.

Evidence of Implementation: Patients were supported to keep and use their personal clothing as appropriate. Each unit had a laundry and patients were supported to undertake their own laundry as appropriate. Patients clothing was clean and appropriate to their needs.

On Unit B the male admission unit, the emergency supply of clothing consisted of old clothes left behind by other patients. There was no underwear or supply of emergency clothing. On Unit 1, the female unit, there was a comprehensive supply of female emergency clothing including underwear and shoes. A fund was available to purchase clothing if needed.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all patients had access to a supply of appropriate clothing at all times.
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 patients’ personal property and possessions, which was last reviewed in February 2016. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to patients’ personal property and possessions.

Evidence of Implementation: Secure facilities were provided, on each unit, for the safekeeping of patients’ monies, valuables, personal property, and possessions, as necessary. On admission, the approved centre compiled a detailed property checklist with patients of their personal property and possessions. The property checklist was kept separately to the patient’s Individual Care Plan (ICP) and was available to the patient. Patients were supported to manage their own property, unless this posed a danger to the patient or others, as indicated in their ICP and in accordance with the approved centre’s policy. There were blanket restrictions on mobile phones and monies. However, these restrictions were based on risk and were clearly outlined within the Personal Property Policy.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
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, which was last reviewed in October 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of patient uptake and attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities. An annual needs assessment analysis was completed and patient views were obtained through an organised patient community meeting or individual feedback.

Evidence of Implementation: There was a recreational activities department for patients use within all units. Activities were run from 8am-9pm seven days per week. There was a master hospital recreational activities programme; each unit had their own specific timetable which was derived from the master programme. Additionally, each patient had their own individual timetable which was risk based.

Patients in the approved centre had access to a wide range of appropriate recreational activities, which included indoor and outdoor games, walking, jogging groups, cricket, yoga classes, basketball, table tennis, guitar, saxophone and ukulele lessons, calypso music groups, table quizzes, and bingo nights. The approved centre also had a band called Rhythm, which staff and patients were involved in. Patients in each Unit had access to relaxation groups. New activities recently added to the programme included Tai Chi, tag rugby, music theory and music appreciation. The recreation activities were not appropriately resourced due to a shortage of staff in the recreation activities department. This staffing shortage negatively impacted patients, and feedback from the patients’ confirmed that activities were cancelled on a regular basis.

Activities were facilitated in the communal areas within each unit. Additionally, patients used the ball alley, sports arena, football pitch and concert hall. Throughout the year, there were discos, a summer garden party and patients and staff participated in a Christmas show.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 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 patients, which was last reviewed in January 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of respecting patients’ religious beliefs during the provision of services, care, and treatment.

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 patients in the practice of their religion, as set out in the policy.

Monitoring: The implementation of the policy to support patients’ religious practices was not reviewed to ensure that it reflected the identified needs of patients.

Evidence of Implementation: Patients’ rights to practice religion were facilitated within the approved centre insofar as was practicable. There was a church within the hospital grounds, which patients could attend if they had ground leave. The church could be used for mass and other multi-faith services. Care and services that were provided were respectful of the patients’ religious beliefs and values and any specific religious requirements were clearly documented. Patients were facilitated to observe or abstain from religious practices in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
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 and procedures in relation to visits. The policy was last reviewed in July 2017. 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 were able to articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on patients’ rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate and reasonable. A separate visitor room or visiting area was provided unless there was an identified risk to the patient or others, or a health and safety risk. Appropriate steps were taken to ensure the safety of patients and visitors during visits. Visiting children were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly. There was an identified area for children visiting which was always pre-booked.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
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 policy in relation to patient communication. The policy was last reviewed in February 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the roles and responsibilities of staff in relation to patient communication processes.

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: Patient communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Patients had access to mail and telephone unless otherwise risk assessed with due regard to the patients’ well-being, safety, and health. Risk assessments had been completed for patients, 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 only examined incoming and outgoing patient communication where there was reasonable cause to believe the communication may result in harm to the patient or others.

The approved centre was compliant with this regulation. The quality assessment was rated was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and monitoring pillars.
Regulation 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 and procedures in relation to the implementation of patient searches. The policy was last reviewed in February 2016. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

Monitoring: A log of searches was not maintained either on the unit or at hospital level. Each search record had not been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes.

Evidence of Implementation: On-going risk assessments were undertaken in all cases prior to a search of a patient, their property, or the environment. The clinical files of two patients who had been searched were inspected. Patients consent was not documented prior to all searches. General written consent was sought for routine environmental searches as part of the admission process. Both clinical files and interview with staff confirmed that the procedure was to accept and document verbal consent. Where consent was not received this was not documented however the process to search without consent was implemented.
There was no documentary evidence that patients were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the patient’s dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the patient being searched. A written record of every search of a patient and every property search was available, in the clinical file.

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

a) It was not clearly evidenced that the consent of the resident was sought in all cases 13(4).

b) Evidence that the patient was informed of what was happening and why, was not documented 13(8).
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 policy was last reviewed in February 2018. The policy included all of the requirements of the Judgement Support Framework.

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

As no patient had received end of life care or had died since the last inspection, the monitoring and evidence of implementation pillars were not applicable.

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

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

Monitoring: Patients’ ICPs were not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Each patient had an ICP, ten of which were inspected. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. A key worker and a nurse was identified to ensure continuity in the implementation of a patient’s ICP. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

Patients had been initially assessed pre admission and at admission by the admitting clinician. An initial ICP was completed by the admitting clinician to address the immediate needs of the patient. All patients received an evidenced-based comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the patient and their representative, and next of kin, as appropriate. Family were involved in patients’ ICPs with the patient’s consent.

The ICPs identified patients’ assessed needs, appropriate goals, the care and treatment required to meet the identified goals including the frequency and staff responsibilities for implementing the care and treatment. The ICP identified the resources required to provide the care and treatment identified. The ICP included a risk management plan. None of the ten ICPs inspected included a preliminary discharge plan, which was appropriate to the forensic context of the approved centre.

ICPs were reviewed by the MDT in consultation with patients on a weekly basis. Patients had access to their ICPs and were kept informed of any changes. All patients were offered a copy of their ICP, including any reviews.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
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 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: A range of therapeutic programmes was available to patients. The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the patients, as documented in patients’ individual care plans (ICPs). The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of patients.

Each patient had an individual holistic, bio-psycho assessment of their history, needs, risk and strengths to inform an appropriate choice of therapeutic interventions and activities. There was a Physical Exercise and Recreation Programme that addressed health and social skills. Groups included Couch to 5km run, Relapse Prevention, Wellness Group, healthy living skills and cooking groups. There were psycho-educational programmes which addressed mental state, psychological functioning, and the individual’s insight and awareness into their mental health.

There were cognitive and behavioural programmes which covered a wide range of individual and group behavioural and cognitive therapies provided by a range of disciplines and included Cognitive Remediation Therapy, Cognitive Skills Training, Dialectical Behaviour Therapy, Stress and Anger Management, Substance Misuse, Mental Health, Challenging Behaviour Interventions, and Offending Behaviour. There were vocational programmes which addressed the development of occupational skills and the process of recovery through meaningful activities including the garden project, occupational adaptation, and the library project.

A self-help and peer support programme was available, which promoted personal growth through a weekly GROW meeting. Alcoholics Anonymous meetings were held twice weekly within the approved centre. There was also a Friends and Families Information Day held twice yearly. Patients had access to occupational therapy, social work and clinical psychology on an individual basis. It was reported that there

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Quality Rating Satisfactory
has been a delay accessing psychology for some patients. Patients also had access to medical, dental, and chiropody services.

A list of all therapeutic services and programmes was available to residents on all units. Where a patient required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location or onsite. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within the patient’s progress notes and in formal reports.

Adequate and appropriate resources and facilities were not available. Staff stated that there was a shortage of facilities and rooms to meet patients’ needs. The inspection team observed that residents used the kitchen to meet therapists on Unit 1. This was not an appropriate space but it was the only private space available.

The approved centre was compliant with this regulation. The quality assessment was rated was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the evidence of implementation pillar.
Regulation 18: Transfer of Residents

(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 patients. The policy was last reviewed in February 2018. The policy addressed requirements of the Judgement Support Framework, with the exceptions of:

- The process for managing patient medications during the transfer from the approved centre.
- The process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.

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

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

Evidence of Implementation: Full and complete written information for each patient was transferred when he or she moved from the approved centre to another facility. Information was sent in advance and accompanied the patient upon transfer to a named individual, along with a photocopy of the Medication Prescription and Administration Record (MPAR). A letter of referral, including a list of current medications was issued, with copies retained, as part of the transfer documentation.

A patient transfer form or patient transfer checklist were not used as part of the transfer documentation.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, monitoring 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 written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in February 2018. The medical emergencies policy was last reviewed in January 2017. The policies and procedures combined addressed requirements of the Judgement Support Framework, with the following exceptions:

- The management, response, and documentation of a medical emergency, including cardiac arrest.
- The resource requirements for general health services, including equipment needs.
- The protection of patient privacy and dignity during general health assessments.
- The referral process for residents’ general health needs.

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

Monitoring: Patients’ 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 patients occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: There was evidence that the policies on the provision of general health services and responding to medical emergencies had been implemented throughout the approved centre. The approved centre had seven Automated External Defibrillators on-site. Each unit in the approved centre had access to emergency equipment and medication. Registered medical practitioners assessed patients’ general health needs on admission and on an ongoing basis as part of the approved centre’s provision of care.

Five clinical files were inspected in order to monitor and assess patients’ general health needs and specific needs not less than every six months. The six-monthly general health assessment documented the following: a physical examination; family and personal history; body mass index, weight, and waist circumference; blood pressure; smoking status; nutritional status (diet and physical activity, including sedentary lifestyle tendencies); a medication review, as per prescriber guidelines and dental health. Adequate arrangements were in place for patients to access general health services and for their referral to other health services as required. Patients had access to national screening programmes, available
based on age and gender, which included breast check, cervical screening, retina check (for diabetics only), and bowel screening.

The HSE policy on smoking cessation was used and implemented in the approved centre. Staff resources to aid smoking cessation included education programmes and nicotine replacement therapy. A number of patients had been supported to stop smoking.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
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 policy and procedures in relation to the provision of information to patients. 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: 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 patients, as set out in the policy.

Monitoring: The provision of information to patients was monitored on an ongoing basis to ensure it was appropriate and accurate. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to patients.

Evidence of Implementation: Required information was provided to patients and their representatives on admission, including the approved centre’s information folder that detailed care and services. The information booklet was available in the required formats to support patient needs and information was clearly and simply written. It contained details of the following: housekeeping arrangements, including procedures for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies; patients’ rights. Patients were provided with details of their multi-disciplinary team.

Patients were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, provision of such information might be prejudicial to the patient’s physical or mental health, well-being, or emotional condition. The justification for restricting information regarding a patient’s diagnosis was documented in the clinical file. Medication information sheets as well as verbal information were provided in a format appropriate to patient needs. The content of medication information sheets included information on indications for use of all medications to be administered to the patient, including any possible side effects.
The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.
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 patients’ privacy, which was last reviewed in January 2017. The policy did not address the following requirements of the Judgement Support Framework:

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring patient 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 patient privacy. Analysis had not been completed to identify opportunities for improving the processes relating to patients’ privacy and dignity.

Evidence of Implementation: Patients were called by their preferred name. The general demeanour of staff and the way in which staff addressed and communicated with patients was respectful. All bathrooms, showers, toilets, and single bedrooms had locks with an override facility. Staff were discreet when discussing the patient’s condition or treatment needs.

Patients were accommodated in single bedrooms. All bedrooms had curtains fitted over the observation panels on the outside of the door. Rooms were not overlooked by public areas. One Unit was overcapacity with one patient using the interview room as a bedroom. The door to one of the offices was open with confidential information on the desks; there was no healthcare professional in the office. Noticeboards in two offices, that had patient names and other information, were viewable from outside the office through a transparent door window. One unit had patients’ names and dates of birth printed on the spine of the file that were observable from outside the office.

Due to the overcapacity in Unit 1, the inspection team were unable to access a private space to interview patients. An area of the dayroom was made available but it was not private.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that patients’ privacy was appropriately respected at all times for the following reasons:

a) Office noticeboards displayed confidential information, that was viewable to patients, from outside the office.

b) Confidential patient information on patient files was viewable to other patients, from outside the office where they were stored.

NON-COMPLIANT

Quality Rating: Requires Improvement
Risk Rating: HIGH
c) There was no available space on Unit 1 for private conversations.
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 January 2017. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The approved centre’s utility controls and requirements.
- The identification of hazards and ligature points in the premises.

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

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

Evidence of Implementation: The approved centre had appropriately sized day rooms and communal spaces where patients could sit. Rooms were ventilated. The temperature was adequate throughout the approved centre, but heating could not be safely controlled in the patient’s own room. There was a sufficient number of showers for patients. There were enough non-assisted toilets for patients, but there was not an assisted toilet in each unit.

The approved centre did not have any lifts. Unit A did not have a dedicated therapy room. Not all bedrooms were appropriately sized to meet patients’ needs. Bedrooms in Units 1, 2, 3, 5 and 7 were too small. Due to the inadequate storage space in the bedrooms, patients in Unit 7 were required to store their belongings in wardrobes located in corridors.
Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard and rough surfaces were not minimised. A rotting wooden picnic table was observed in the garden area. Where wood had deteriorated, two nails were exposed protruding from the timber. Water was leaking from a washing machine and sink on Unit 3 leading to a slip hazard. Numerous ligature risks were observed and they were logged in the ligature audit. Mitigation was through observation levels and risk assessment.

The approved centre was not kept in a good state of repair externally and internally. Paint was peeling, plaster was chipped, floors were worn, there was discoloured ceiling tiles, there were rusting pipes and a broken curtain rail. The maintenance manager walked every unit every day and noted any maintenance issues. This formed the basis of a maintenance log. Maintenance was undertaken on an as needed basis. A malodour was detected in toilets on Unit 3 due to a blocked toilet. This was a recurring issue and had been reported.

There was a cleaning schedule on each unit and it was implemented daily, however, the bathroom floor in Laurel Lodge was unhygienic due to the presence of deeply engrained dirt on the flooring.

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

a) The premises were not clean and maintained in good structural and decorative condition, 22 (1)(a).

b) A programme of routine maintenance and renewal of the fabric and decoration of the premises was not developed and implemented, 22 (1)(b).

c) The condition of the physical structure and the overall approved centre environment was not maintained with due regard to the safety and well-being of patients, 22 (3).
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 series of written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication. The Rapid Titration Policy was last reviewed in July 2015. The policies combined included the requirements of the Judgement Support Framework with the following exceptions:

- The process for crushing medications.
- The processes for medication management at admission, transfer, and discharge.
- The process for medication reconciliation.

Training and Education: All nursing and medical staff had signed the signature log to indicate that they had read and understood the policies. All nursing and medical staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical 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 not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes. The inspection team were informed that the pharmacist from the Community Pharmacy that supplied medications had completed medication audits. Copies of these audits were not made available to the inspection team.

Evidence of Implementation: Each patient had an MPAR. Each MPAR evidenced a record of appropriate medication management practices, including a record of two patient identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. MPARs detailed the generic name of the medication and preparation. One MPAR used the abbreviated term for micrograms, MCG, instead of writing the name of it in full. Stop dates were included for all each medications.

The Medical Council Registration Number of every medical practitioner prescribing medication to the patient was present within each patient’s MPAR. The signature of the medical practitioner was present on each MPAR entry. MPARs did not contain dedicated space for once-off medications, instead once-off medications were prescribed and documented in the ‘as required’ (PRN) medications.

All entries in MPARs were 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 patient’s care or condition. This was documented in the clinical file. Medicinal products were administered in accordance with the
directions of the prescriber. The expiration date of the medication was checked prior to administration, and expired medications were not administered. All medicines were administered by a registered nurse or registered medical practitioner and any advice provided by the patient’s pharmacist regarding the appropriate use of the product was adhered to. Good hand-hygiene techniques were implemented during the dispensing of medications. When a patient’s medication was withheld, the justification was not always recorded in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. All medications were kept in a locked storage area within a secured locked room. Refrigerators used for medication were used only for this purpose. Not all fridges, within the clinical rooms, had a thermometer so temperatures were not logged daily. Medication storage areas were incorporated in the cleaning and housekeeping schedules.

A monthly system of stock rotation was implemented to avoid the accumulation of old stock. Food and drink was not stored in areas used for the storage of medication. Medications that were no longer required, which were past their expiry date, or had been dispensed to a patient but were no longer required, were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, monitoring and evidence of implementation pillars.
Regulation 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 two written operational policies, and one safety statement in relation to the health and safety of patients, staff, and visitors. The health and safety policy was last reviewed in March 2017 and the safety statement was last reviewed February 2019. The policy and safety statement combined included all of the requirements of the Judgement Support Framework.

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

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

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

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

(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 two written policies and protocols in relation to the use of CCTV. The policies were last reviewed in January 2016. The policies combined addressed the requirements of the Judgement Support Framework, including the purpose and function of using CCTV for observing patients in the approved centre.

The policy did not include the following:

- The maintenance of CCTV cameras by the approved centre.
- The process to cease monitoring a patient using CCTV in certain circumstances

Training and Education: All relevant staff had signed the signature log to indicate that they had read and understood the policy. All relevant 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 not checked regularly to ensure that the equipment was operating appropriately. 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 indicating where CCTV cameras were located in the approved centre. CCTV cameras used to observe a patient were incapable of recording or storing a patient’s image on a tape, disc, and hard drive. CCTV was used solely for the purposes of observing a patient by a health professional who was responsible for the welfare of that patient. CCTV was not used to monitor a patient if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre’s use of CCTV. On Unit B, the images transmitted to a monitor were viewable by patients and non-healthcare professionals.

This was remedied during the inspection.
The approved centre was non-compliant with this regulation because the Registered Proprietor did not ensure that the CCTV monitoring system on Unit B was viewed solely by a healthcare professional, 25 (1)(a).
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 in relation to its staffing requirements. The policy was last reviewed in June 2017. The policy addressed the requirements of the Judgement Support Framework, including the following:

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

The policy did not address the following:

- Staff performance and evaluation requirements
- The process for transferring responsibility from one staff member to another.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

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

Evidence of Implementation: There was an organisational chart in place, which identified the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s 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 was
maintained in the approved centre which showed that an appropriately qualified staff member was on duty and in charge at all times.

Opportunities were made available to staff by the approved centre for further education. These opportunities were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. The number and skill mix of staffing were sufficient to meet patient needs although there were some vacant posts. A recruitment drive was underway with a view to employing additional staff for the new hospital in Portrane.

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>Unit A</td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit B</td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit 1</td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit 2</td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
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</tbody>
</table>
A written staffing plan was available within the approved centre. Staff were trained in line with the assessed needs of the patient group profile and of individual patients. The staff training plan below

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
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<tbody>
<tr>
<td>Unit 3</td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Unit 4</td>
<td>CNM2</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Unit 5</td>
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</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Unit 7</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Laurel Lodge</td>
<td>CNM2 or CNM1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
confirms that not all staff were trained in Basic Life Support, fire safety, management of violence and aggression, the Mental Health Act 2001 and Children First.

Staff were also trained in manual handling, infection control and prevention, care for patients with an intellectual disability, risk management and treatment, incident reporting, and the protection of vulnerable adults.

<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 (227)</td>
<td>174</td>
<td>77%</td>
<td>145</td>
<td>66%</td>
<td>186</td>
</tr>
<tr>
<td>Consultant Psychiatrist (11)</td>
<td>3</td>
<td>27%</td>
<td>5</td>
<td>45%</td>
<td>8</td>
</tr>
<tr>
<td>Medical (15)</td>
<td>15</td>
<td>100%</td>
<td>15</td>
<td>100%</td>
<td>15</td>
</tr>
<tr>
<td>Occupational Therapist (9)</td>
<td>6</td>
<td>66%</td>
<td>7</td>
<td>77%</td>
<td>7</td>
</tr>
<tr>
<td>Social Worker (11)</td>
<td>4</td>
<td>36%</td>
<td>3</td>
<td>27%</td>
<td>4</td>
</tr>
<tr>
<td>Psychologist (5)</td>
<td>3</td>
<td>60%</td>
<td>1</td>
<td>20%</td>
<td>1</td>
</tr>
</tbody>
</table>

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, the management of violence and aggression and Children First, 26(4).

b) Not all staff had 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 January 2018. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

- The required patient record creation and content.
- Those authorised to access and make entries in patients’ records.
- Record retention periods.
- The destruction of records.

The policy and procedures did not address the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- General safety and security measures in relation to records.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

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

Monitoring: Patient records were not audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Patients’ records were not appropriately secured from loss, destruction, tampering, and unauthorised access or use. An office in a patient area, with confidential information was left unlocked and unattended. All patient records were reflective of the patients’ status and the care and treatment being provided. Clinical files inspected were in good order. Records were developed and maintained in a logical sequence.
Patient records were physically stored together. Patient records were maintained using an identifier, which was unique to the patient. Photographs, dates of birth, and names were used. Only authorised staff made entries in patients’ records, or specific sections therein. Hand-written records were legible and written in black indelible ink and were readable when photocopied. All patients’ records included the date, and time using the 24-hour clock. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was non-compliant with this regulation because all records were not kept in a safe and secure place 27 (1).
### Regulation 28: Register of Residents

| COMPLIANT |

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

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

### INSPECTION FINDINGS

The approved centre had a documented up-to-date, register of patients admitted. The register contained 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 reviewed in December 2018. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained 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 to be reviewed within three years by the regulations were not all reviewed within that time frame. Policies out of date included Patients’ Personal Property and Possessions, Communication, Searches, Provision of Information to Patients, CCTV and Complaints.

Policies incorporated relevant legislation, evidence-based best practice and clinical guidelines. At the time of the inspection, the process to update policies was underway and policies were communicated electronically to staff.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all written operational policies and procedures were reviewed every three years.
(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 February 2018. The policy and procedures included the requirements of the Judgement Support Framework, with the exception of the provision of information to the patient regarding the Mental Health Tribunals.

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

Monitoring: Analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

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

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes 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 in relation to the management of complaints. The policy was last reviewed in January 2016. The approved centre also used the HSE’s Your Service, Your Say complaints policy. The policy addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was analysed at the Operations Management Team meetings. Details of the analysis had been 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 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 through posters in the visitor areas and it was detailed within the service user’s information booklet. Patients, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally and in writing and through feedback forms. Senior management walked through the approved centre on a monthly basis to talk to patients and listen to their concerns.
All complaints were handled promptly, appropriately, and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a patient was not 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 to other complaints. Minor complaints from patients were sent directly to the complaints officer. If there was a pattern of minor complaints, the senior nurses in the unit were asked to address the issues at community meetings. The complaints officer responded in writing to all patients’ complaints.

Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the patient’s individual care plan. The complainant’s satisfaction or dissatisfaction with the investigation findings was documented.

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring 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 January 2018. The policy addressed requirements of the Judgement Support Framework, including the following:

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

The policy did not address the following:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The person responsible for the completion of six-monthly incident summary reports.
- The process for notifying the Mental Health Commission about incidents involving patients of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

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

**Monitoring:** The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

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

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of patient seclusion and physical restraint, and at patient admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

Structural risks, including ligature points, remained, but were mitigated by the fact that each patient was risk assessed and managed accordingly in relation to ligature risks. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. There was a separate visitor’s room for child visitors near the entrance.

Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service.

The Mental Health Act administrator, in line with the Code of Practice on the Notification of Deaths and Incident Reporting, provided a six-monthly summary of incidents to the Mental Health Commission. Information provided was anonymous at patient level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the hall of the main building.</td>
</tr>
</tbody>
</table>

**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: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated February 2019. The policy addressed the following:

- Who may implement seclusion,
- The provision of information about seclusion to the patient,
- The ways of reducing rates of the use of seclusion.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: The clinical files of three patients who had been in seclusion were inspected. Patients in seclusion had access to adequate toilet and washing facilities. The seclusion rooms were not used as bedrooms. The design and quality of the seclusion rooms posed a potential risk to patient safety, as there was no soft padding.

In all cases, seclusion was initiated by a registered medical practitioner and/or a registered nurse. The consultant psychiatrist was notified of the use of seclusion as soon as was practicable, and this was recorded in clinical files. Where a registered nurse initiated seclusion, an assessment, including a risk assessment, was completed prior to seclusion taking place. The seclusion orders were recorded in the clinical files and seclusion register by the registered medical practitioner. The registered medical practitioner indicated the duration of the seclusion order, which was no longer than eight hours.

Seclusion was used only in rare and exceptional circumstances, in the best interests of the patient, and after all other interventions to manage patients’ unsafe behaviour had first been considered. Cultural awareness and gender sensitivity were demonstrated in each episode of seclusion. In all cases, the implementation and use of CCTV to monitor patients in seclusion was appropriate, and viewing of CCTV was restricted to designated personnel. Patients were informed of the reasons for, duration of, and circumstances leading to the discontinuation of seclusion.
In each episode of seclusion, a registered nurse directly observed the patients for the entire duration of seclusion. A record of the patients in seclusion was made by the nurse every 15 minutes, and the patient’s level of distress and behaviour were documented. Nursing reviews and medical reviews in relation to seclusion took place, and were completed within the stipulated timeframe by registered medical practitioners.

All uses of seclusion were clearly recorded in the clinical files and on the seclusion register. The seclusion register was signed by the responsible consultant psychiatrist within 24 hours. In all episodes of seclusion inspected, patients were informed of the ending of seclusion. Each episode of seclusion was reviewed by the multi-disciplinary team, and documented in the clinical file within two working days of the episode of seclusion.

The approved centre was non-compliant with this rule because seclusion rooms did not have padding and their design was not guaranteed to protect patient safety as required under the Rule, 8.3.
Section 69: The Use of Mechanical Restraint

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

The clinical file of one patient who had required mechanical restraint was inspected.

The mechanical restraint was used to address an immediate risk of harm to the patient or others and when less restrictive alternatives were unsuitable. The restraint was ordered by the treating consultant psychiatrist. The clinical file indicated the situation in which mechanical restraint was applied, the duration of the restraint order, and the review date of the mechanical restraint.

The approved centre was compliant with Part 4 of the Rules Governing the Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others.
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 ten patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were inspected. In all cases, there was documented evidence that the consultant psychiatrist had undertaken a capacity assessment, which measured the patients’ ability to consent to receiving treatment.

In relation to four patients who did consent to receiving treatment there was a written record of consent which detailed:

- The names of the medications prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of discussions with the patient, including
  – The nature and purpose of the medications.
  – The effects of the medications(s), including any risks and benefits.
Six patients were unable to give consent and the administration of medication was approved by the responsible consultant psychiatrist and another consultant psychiatrist. The relevant parts of Form 17 (Administration of Medicine for More than 3 Months to an Involuntary Patient (Adult) – Unable to Consent) was completed in full by both consultant psychiatrists.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
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: The approved centre had a written policy on the use of Physical Restraint. The policy had been reviewed annually and was dated February 2019. It addressed the following:

- The provision of information to patient
- Those who initiate and implement physical restraint

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

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

Evidence of Implementation: The clinical files of three patients were examined in relation to three episodes of physical restraint. Clinical files indicated that physical restraint was only used in exceptional circumstances when patients posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each patient. Staff had first considered all other interventions to manage patients’ unsafe behaviour. In all cases, the physical restraint order lasted less than 30 minutes. Physical restraint was not prolonged beyond the period strictly necessary to prevent immediate and serious harm to self or others. In all cases inspected, the registered medical practitioner completed a physical examination of each patient within three hours after the start of an episode of physical restraint.

In all three cases, the patient was not informed of the reasons for, likely duration of and circumstances leading to discontinuation of Physical Restraint. The reason for not informing the patient was not documented or it was not documented that the information might have been prejudicial to the patient’s mental health, well-being or emotional condition. In one case the designated staff member was not responsible for leading in the physical restraint of a patient.

In one case, as soon as was practicable, with the patients consent, or where the patient lacked capacity and could not consent, the patients next of kin or representative was not informed of the use of physical restraint and justification for not informing the next of kin or representative was not recorded in the clinical file.

All episodes of physical restraint were reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode. All patients were given the opportunity to discuss the physical restraint episode with members of the MDT involved in their care as soon as was practicable. In all cases, the clinical practice form was signed by the consultant psychiatrist within 24 hours.

The approved centre was non-compliant with this code of practice because for the following reasons:
a) In one case, the designated staff member was not responsible for leading in the physical restraint of a patient, 5.2.

b) In three cases, the patient was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint. The reason for not informing the patients were not documented in the clinical files, 5.8.

c) In one case, as soon as was practicable, with the patients consent, or where the patient lacked capacity and could not consent, the patients next of kin or representative was not informed of the use of physical restraint and justification for not informing the next of kin or representative was not recorded in the clinical file, 5.9(a).
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.

Admission: The admission policy, which was last reviewed in March 2018, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in January 2018, did not address the following policy-related criteria for this code of practice:

- The protocol for discharging homeless people

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

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

Evidence of Implementation:

Admission: The clinical file of one patient was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The patient was assigned a key worker. The patient was transferred from a prison and their family member was contacted following admission into the approved centre. The patient received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information such as work situation, education, and dietary requirements. The patient 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 patient who was discharged was inspected. The patient was discharged back to a prison facility. The discharge was co-ordinated by a key worker. A discharge plan was in place as part of the individual care plan. The discharge plan recorded the estimated date of discharge, documented communication with the relevant general practitioner, a follow-up plan, and a reference to early warning signs and risks. A discharge meeting was held and attended by the patient, their key worker, relevant members of the multi-disciplinary team and the patient’s family member. A pre-discharge assessment was completed; which addressed the patient’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.

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

a) The discharge policy did not include a protocol for the discharge of homeless people, 4.12.
b) There was no documentary evidence available that audits of adherence to admission, transfer and discharge policies had been undertaken, 4.19.
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 25: Use of Closed Circuit Television

<table>
<thead>
<tr>
<th>Reason ID: 10000289</th>
<th>The registered proprietor did not ensure that the CCTV monitoring system on Unit B was viewed solely by a health professional, 25 (1)(a).</th>
</tr>
</thead>
</table>

<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></td>
<td>CCTV screens have been moved so that they are not able to be viewed by non healthcare professionals. Staff were immediately reminded of the Regulation 25 (1)(a).</td>
<td>Daily Inspection by CNM and ADON</td>
<td>Ensuring all staff are aware of their responsibility for ensuring adherence to the regulation.</td>
<td>09/04/2019</td>
<td>CMNII ADON Registered Proprieter Director of Nursing</td>
</tr>
</tbody>
</table>

| Preventative Action | A notice has been placed on CCTV screens outlining regulation 25 1(a) adherence as a daily reminder and education piece for all staff. Daily Inspection by CNMII and ADON with a record kept of this. Monthly audit by Operational Management Team during quality and safety walkthrough. | Daily Inspection record Monthly Audit by Operational Management Team | Achievable | 31/12/2019 | CMNII ADON Director of Nursing Operational Management Team (OMT). |
| This will be recorded in the walkaround minutes. |   |   |   |
### Regulation 7 Clothing

**Reason ID: 10000298**

<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>A clothing order was placed immediately. There is now a comprehensive stock of emergency clothing available.</td>
<td>A monitoring record is available at unit level when clothing is used and new supplies are ordered to keep optimum stock levels.</td>
<td>Yes</td>
<td>16/04/2019</td>
<td>CNMII ADON Director of Nursing Registered Proprieter</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A system is in place to ensure the availability of emergency clothing for patients where orders are placed through central stores. The frequency and volume of these orders has increased. A formalised stock taking procedure has been implemented at unit level.</td>
<td>Records of clothing orders are available through central stores and updates sent to Registered Proprieter Stocktaking occurs at unit level and is monitored by CNM and ADON.</td>
<td>Yes</td>
<td>30/09/2019</td>
<td>CNMII ADON Director of Nursing Registered Proprieter</td>
</tr>
</tbody>
</table>
### Regulation 13: Searches

#### Reason ID: 10000299

It was not clearly evident that the consent of the resident was sought in all cases 13(4).

<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>The need to implement consent process and to clearly document same has been highlighted for each individual search that is carried out.</td>
<td>Evidence of a change in practice to be monitored by review of files in line with searches log at unit level.</td>
<td>Yes</td>
<td>30/09/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Unit Based Search Log to be implemented Hospital Based Search Log to be implemented This will allow for robust governance and audit of searches and continuous improvement.</td>
<td>This will allow for robust governance and audit of searches and continuous improvement.</td>
<td>Yes</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000300

Evidence that the patient was informed of what was happening and why was not documented 13(8).

<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>Highlight the need to inform and involve patients each time a search is conducted and to document same.</td>
<td>Immediate oversight of changes that have been implemented at unit level.</td>
<td>Yes</td>
<td>12/04/2019</td>
</tr>
</tbody>
</table>

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## Preventative Action

<table>
<thead>
<tr>
<th>A Practice Development Form has been created which includes a checklist of all that is required for a search including obtaining consent and documentation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to high volume of searches needed in a forensic setting this will have to be piloted and reviewed to ensure its efficacy.</td>
</tr>
<tr>
<td>Yes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>31/12/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNMII ADON Director of Nursing Clinical Director Executive Clinical Director Registered Proprieter</td>
</tr>
</tbody>
</table>
### Regulation 29: Operating Policies and Procedures

**Reason ID : 10000301**

The registered proprietor did not ensure that all written operational policies and procedures were reviewed every three years, in particular, patients’ personal property and possessions, communication, searches, provision of information to patients, CCTV and complaints.

<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>A list of the policies identified during the inspection process as not fully meeting all of the requirements of the Judgement Support Framework or that had not been reviewed within the three year time frame was sent to the PPPG committee for prioritisation.</td>
<td>Status update on all policies must be discussed at weekly Operational Management Team meeting and the PPPG Committee on a monthly basis.</td>
<td>Yes</td>
<td></td>
<td>30/09/2019</td>
<td>Chair of PPPG group Registered Proprieter Quality and Risk Advisor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Tender for Quality management system underway which will allow us to store all policies online, have an effective oversight of policy review within the 1 year and 3 year time frame as appropriate.</th>
<th>Audit process and reminders are built into this system.</th>
<th>Achievable and realistic subject to successful procurement process and</th>
<th>31/12/2019</th>
<th>Chair of PPPG group Registered Proprieter Clinical Director Director of Nursing Principal Social Worker Occupational Therapy Manager Head of Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
### Regulation 27: Maintenance of Records

**Reason ID: 10000302**

All records were not kept in a safe and secure place 27 (1).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>Staff were reminded about the policy regarding appropriate storage and ensuring security and confidentiality of patient records.</td>
<td>This will be monitored by Unit Manager and ADON on a daily basis. This will be monitored by Operational Management Team in monthly quality and patient safety walkarounds and a record of this kept in minutes.</td>
<td>All staff to be aware of roles and responsibilities in relation to storage of records.</td>
<td>29/08/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>HSE module on record management and retention to be recirculated as a reminder. GDPR training has been offered onsite in March 2019 and will be reissued.</td>
<td>Attendance numbers at GDPR training. Adherence to the regulation will be monitored at OMT Quality and patient safety walkarounds.</td>
<td>Challenges will be availability of staffing so that they can be released to attend training or complete online training.</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>
## Regulation 26: Staffing

### Reason ID: 10000306

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

<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>Protected time has been identified to facilitate online training for childrens first and mental health act training for unit based staff.</td>
<td>Active management of mandatory training with monthly reminders and prompting to individuals and Heads of Department. For all new staff they will have these completed by the end of their formal induction to the service.</td>
<td>Availability of unit based staff who can be released from front line duties is a major challenge, due to recruitment and retention challenges.</td>
<td>31/12/2019</td>
<td>Director of Nursing Nurse Practice Development Coordinator Executive Clinical Director Clinical Director Human Resources Manager Principal Social Worker Occupational Therapy Manager Head of Psychology</td>
<td></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>Increase in staffing with current recruitment drive</td>
<td>Monitor Training Template on a monthly basis at the</td>
<td>Availability of unit based staff who can be released from front line duties is a</td>
<td>31/12/2019</td>
<td>Director of Nursing</td>
<td></td>
</tr>
<tr>
<td>HR department to coordinate and centralise staff training and development needs</td>
<td>Operational Management Team to achieve 100% compliance for all mandatory training for staff.</td>
<td>major challenge, this should improve with ongoing recruitment drive.</td>
<td></td>
<td></td>
<td></td>
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<td>---</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Mangement System will allow us to review when training is due for renewal.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nurse Practice Development Coordinator  
Executive Clinical Director  
Clinical Director  
Human Resources Manager  
Principal Social Worker  
Occupational Therapy Manager  
Head of Psychology
### Regulation 21: Privacy

#### Reason ID: 10000308

**Office noticeboards displayed confidential information, that was viewable to patients, from outside the office.**

<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>Blinds have been ordered to cover notice boards that contain confidential information, so that they are not viewable to patients or other visitors from outside the office.</td>
<td>All notice boards to be fitted with blinds and completed list to be sent to the Registered Proprieter by the maintenance department.</td>
<td>Blinds ordered and staff to be reminded of their responsibilities in relation to confidential information.</td>
<td>30/09/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>CNMII to monitor the appropriate use of the blinds on a daily basis. Operational Management Team to monitor their use on the monthly quality and patient safety walkarounds on all units.</td>
<td>Daily checks by CNMII Monthly check by Operational Management Team to be recorded in the minutes of the quality and patient safety walkarounds on all units.</td>
<td>Process in place for recording adherence daily and monthly on the quality and patient safety walkarounds on all units.</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>

#### Reason ID: 10000309

**There was no available space on Unit 1 for private conversations.**

<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>Due to overcapacity on Unit 1, on the day of inspection a designated space</td>
<td>Weekly bed management meeting takes place to discuss all</td>
<td>Due to limited bed capacity and waiting lists to be admitted to the NFMHS, there is a possibility that</td>
<td>10/04/2019</td>
</tr>
</tbody>
</table>
was not available for private conversations. When the unit returned to its identified capacity (10 Beds) on the 10th April a designated space was available to use for private conversations. Referrals and admissions and discharges to the NFMHS. Daily bed management would occur at unit level with the Consultant and Nursing Management. Only in the most exceptional circumstances and to ensure patient safety and to meet our obligations under the Criminal Law Insanity Act would the unit operate over its intended bed capacity.

| Preventative Action | Active bed management to ensure that the service is not over capacity. Currently it is planned to move to a purpose built new hospital with increased bed capacity for patients and a significant | Active bed management to ensure that the service is not over capacity. | If someone decompensates in the community, for safety and security they will have to be admitted so that we are meeting our obligations under the Criminal Law Insanity Act. | 31/12/2019 | CNMII ADON Executive Clinical Director Registered Proprieter Clinical Director Principal Social Worker Occupational Therapy Manager Head of Psychology |
Increase in space and rooms.
<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>The discharge policy did not include a protocol for the discharge of homeless people, 4.12.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>This was brought to the immediate attention of the PPPG committee for prioritisation of the review of the policy. The updated policy which included a protocol for the discharge of homeless people was signed off and made available to guide staff practice.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Policy was reviewed and signed off by PPPG Committee and Area Management Team.</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td>Yes</td>
</tr>
<tr>
<td>Time-bound</td>
<td>26/04/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>Chair of PPPG committee Registered Proprieter OMT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>The service has begun the tendering process for an online solution to this issue. All policies will be stored online in a Quality Management Policy Folder.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>When the online solution is implemented it will be possible to have a reminder sent to the Management Team and the PPPG committee when a policy is due for review. This will assist us in prioritising and scheduling the reviews and to ensure that none of</td>
</tr>
<tr>
<td>Measurable</td>
<td>This solution will involve national procurement and tendering which can take a number of months.</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td></td>
</tr>
<tr>
<td>Time-bound</td>
<td>31/12/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>Chair of PPPG committee Registered Proprieter OMT, Clinical Director, Director of Nursing</td>
</tr>
</tbody>
</table>
Reason ID : 10000291

<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>
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</thead>
<tbody>
<tr>
<td></td>
<td>Lead person identified to complete this audit.</td>
<td>Audit to be completed and the learnings from same to be disseminated throughout the organisation with a focus on improving our practice in relation to admission, transfer, and discharge.</td>
<td>Training is required for additional staff to support them to complete audits.</td>
<td>31/10/2019</td>
<td>Registered Proprieter Clinical Director Director of Nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable and realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The service has identified audit as an area of improvement needed throughout the service. An audit committee will be re-established to identify what audits need to be completed and to identify a lead person responsibl for each.</td>
<td>Audit committee to meet monthly Minutes of the Audit Committee Meeting to be made available to all staff within the service.</td>
<td></td>
<td>31/12/2019</td>
<td>Registered Proprieter Clinical Director Director of Nursing Principal Social Worker Occupational Therapy Manager Head of Psychology</td>
<td></td>
</tr>
</tbody>
</table>
## Code of Practice on the Use of Physical Restraint in Approved Centres

**Reason ID : 10000292**

In one case, as soon as was practicable, with the patient's consent, or where the patient lacked capacity and could not consent, the patient's next of kin or representative was not informed of the use of physical restraint and justification for not informing the next of kin or representative was not recorded in the clinical file.

5.9(a)

<table>
<thead>
<tr>
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<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
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</tr>
</thead>
</table>
| **Corrective Action** | A memo has been sent to all staff to remind and clarify for them that if an episode of physical restraint is initiated the patient's next of kin or representative should be informed if consent is given. If the next of kin is not informed, justification for this must be recorded in the clinical file on every occasion. | Ensure that all relevant staff have received this memo and that Unit Managers have discussed it in detail with all staff. Evidence of this to be provided | Yes | 30/08/2019 | CNMII
Director of Nursing
Clinical Director
Registered Proprieter
Principal Social Worker
Occupational Therapy Manager
Head of Psychology |
| **Preventative Action** | A section on contacting next of kin has been included on the Physical Restraint Monitoring Form which is reviewed each month at the Seclusion Monitoring andAudit of restraint forms is also completed at monthly Seclusion Monitoring and Restraint Group (SMARG). | Yes. Monthly minutes will record this | 31/12/2019 | CNMII
Director of Nursing
Executive Clinical Director
Clinical Director
Registered Proprieter |
Reason ID: 10000293

In three cases, the patient was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint. The reason for not informing the patients were not documented in the clinical files, 5.8. Resident was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of PR unless the information might be prejudicial to the resident's mental health, well-being or emotional condition.

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Memo sent to all staff to remind and clarify for them that during an episode of physical restraint the patient should be informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, unless the information might be prejudicial to the resident's mental health, well-being or emotional condition. Unit Managers and</td>
<td>Evidence that all relevant staff have received this memo and that line managers have discussed this in detail with them. Evidence of this is to be provided to the Operational Management Team weekly meetings.</td>
<td>Yes</td>
<td>30/08/2019</td>
<td>Director of Nursing Executive Clinical Director Clinical Director Principal Social Worker Occupational Therapy Manager Head of Psychology</td>
</tr>
</tbody>
</table>
Heads of discipline were asked to discuss this with their staff and report back to the Operational Management Team.

| Preventative Action | TMAV trainers have been asked to include Rules governing Physical Restraint in their training and refresher training which happens on a weekly basis with clinical staff. | Evidence of these learning points to be added to the curriculum and monitored by the Operational Management Team. | Yes. | 31/12/2019 | Director of Nursing Executive Clinical Director Clinical Director CNM Principal Social Worker Occupational Therapy Manager Head of Psychology |

**Reason ID : 10000294**

In one case, the designated staff member was not responsible for leading in the physical restraint of a patient, 5.2.

| Corrective Action | Memo sent to all staff to remind and clarify on the Code of Practice for Physical Restraint and each persons role and responsibility within that. | Evidence of this discussion to be brought back to the Operational Management Team meeting. | Yes | 30/08/2019 | Director of Nursing Clinical Director Executive Clinical Director CNM Principal Social Worker Occupational Therapy Manager Head of Psychology Registered Proprieter |

| Preventative Action | Code of Practice for Physical Restraint needs to be covered | Code of practice needs to be included in TMAV | Yes. Training programme needs to be amended to include this. | 31/12/2019 | Director of Nursing Clinical Director |
In detail at TMVA staff training and refresher training which occurs on a weekly basis.

Monitoring and oversight of this needs to take place by the Operational Management Team.

| Executive Clinical Director |
| Practice Development Coordinator |
| Principal Social Worker |
| Occupational Therapy Manager |
| Head of Psychology |
| Registered proprietor |
### Rules Governing the Use of Seclusion

**Reason ID: 10000297**

<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>A number of samples of protective padding for hard edges in seclusion rooms have been tested by the service from a number of different suppliers but they all failed testing – each type could be torn from the walls and hard edges which would present another risk to patient safety. The service continues to explore other options to resolve this. Ongoing assessment of risk and continuous observation of patients is undertaken to ensure patient safety.</td>
<td>Continuous observation in seclusion is used as a means of ensuring patient safety so that they are not injured from hard edges.</td>
<td>If a suitable product is identified it will be implemented, but to date this has not been found.</td>
<td>31/12/2019</td>
<td>CNMII ADON Area Director of Nursing Registered Proprieter Clinical Director Executive Clinical Director</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>In the design of the new National Forensic Mental Health Service the seclusion rooms all have rounded wall edges to address this problem and minimise risk to patient safety.</td>
<td>There will be considerable testing and training of all materials in the new hospital including the seclusion rooms, which will be monitored.</td>
<td>Yes achievable</td>
<td>31/03/2020</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.