Department of Psychiatry, St Luke's Hospital

ID Number: AC0037

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, St Luke's Hospital
Freshford Road
Kilkenny

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

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, Acting Head of Services, CHO5 Mental Health Services

Inspection Team:
Sarah Moynihan, Lead Inspector
Marianne Griffiths
Siobhán Dinan
Karen McCrohan

Inspection Date:
2 – 5 July 2019

Inspection Type:
Unannounced Annual Inspection

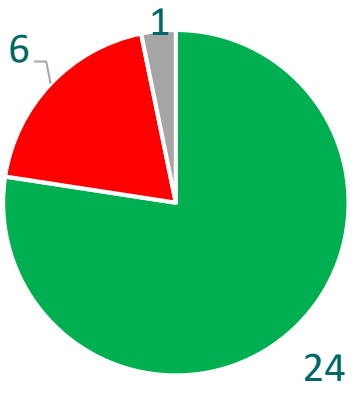
Previous Inspection Date:
6 – 9 November 2018
15 November 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

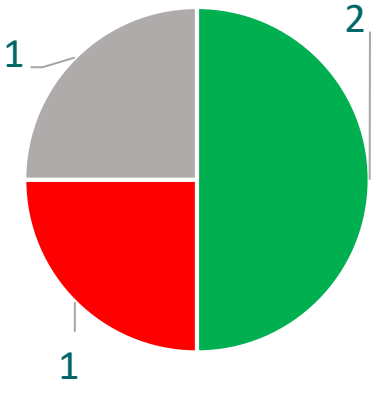
Date of Publication:
Monday 16 March 2020

2019 COMPLIANCE RATINGS

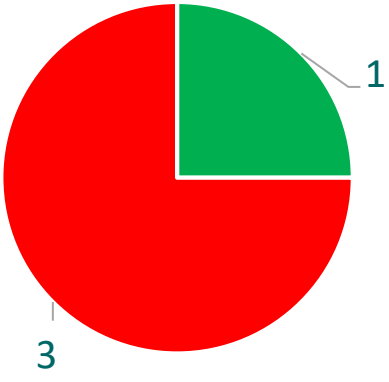
REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



CODES OF PRACTICE

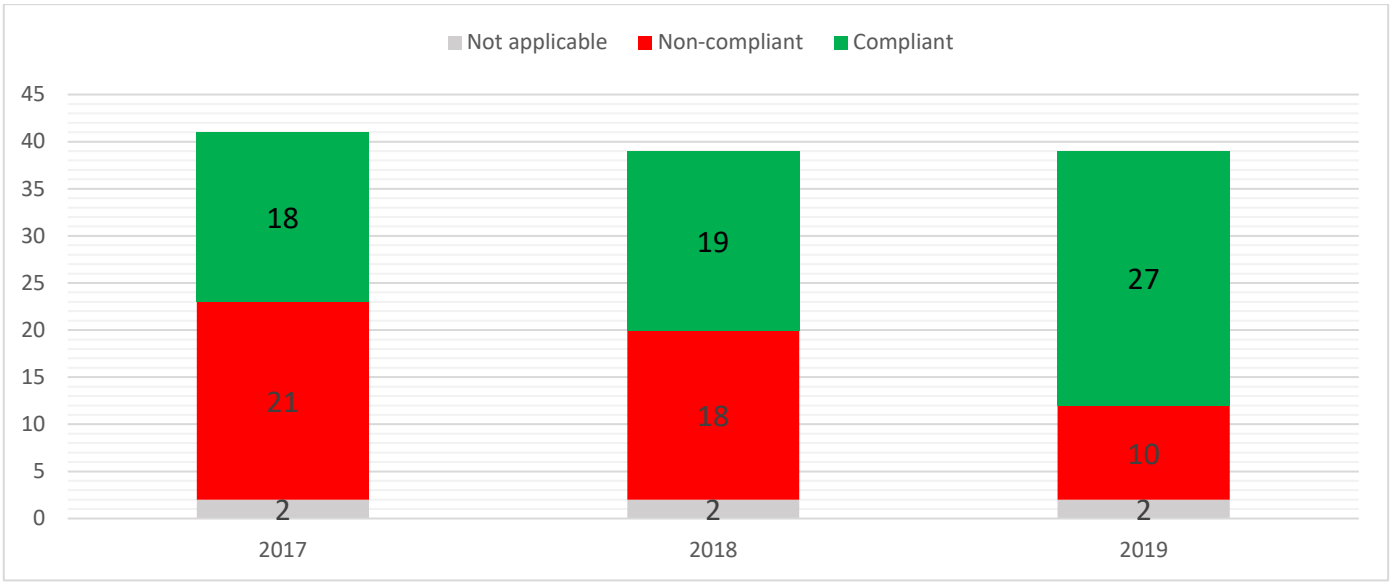


Compliant
Non-compliant
Not applicable

RATINGS SUMMARY 2017 – 2019

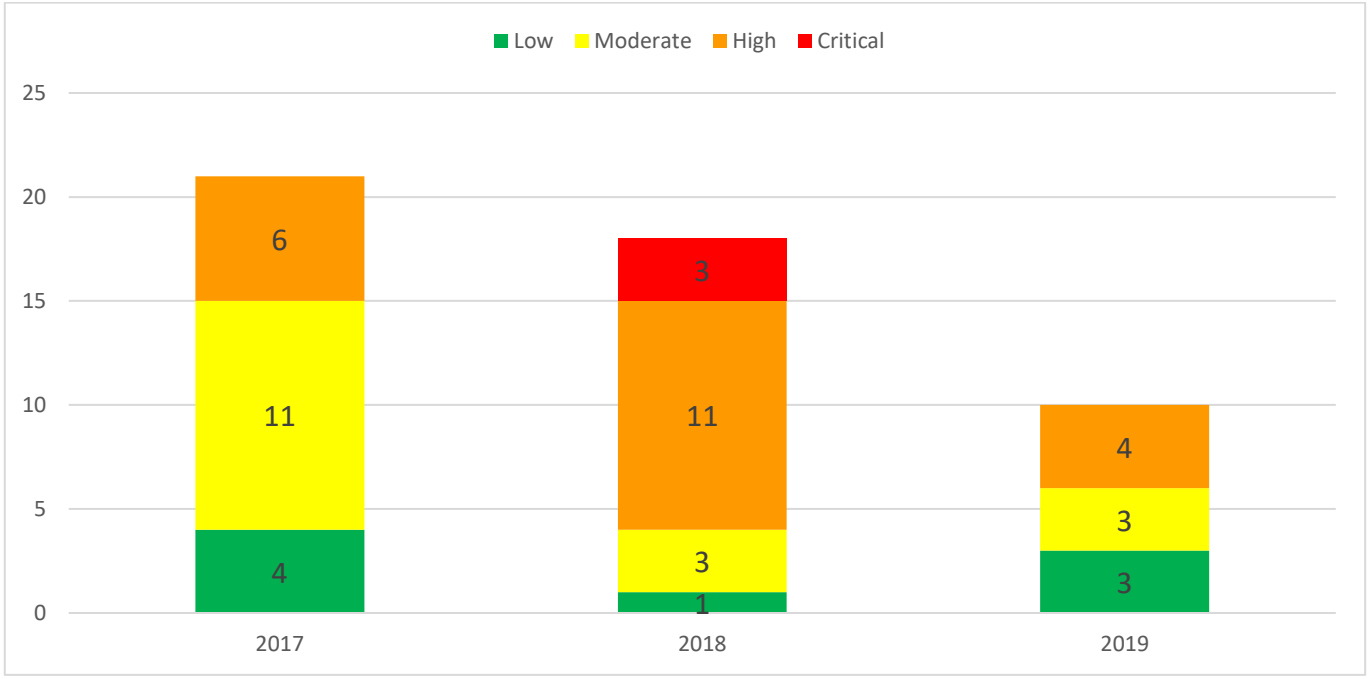
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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

Chart 2 – Comparison of overall risk ratings 2017 – 2019



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

The Department of Psychiatry, St Luke's Hospital was located on the grounds of St. Luke's General Hospital in Kilkenny City. The approved centre served the catchment area of Carlow, Kilkenny and South Tipperary. Thirteen consultant-led multi-disciplinary teams provided care for residents admitted to the approved centre.

The approved centre comprised two units, Sycamore and Oak, which had 25 and 19 beds respectively. There was a sectioned area within the Oak Unit that contained a seclusion room and two single bedrooms.
A substantial amount of work on the premises of the approved centre had been completed since last year's (2018) inspection.

There had been a significant improvement in compliance with regulations, rules and codes of practice from 46% in 2017, 51% in 2018 to 73% in 2019. This reflects considerable efforts by staff to improve the quality of services delivered. There were 13 compliances with regulations rated as excellent.

Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection.

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

Finding on this inspection: The approved centre was not in breach of Condition 1 but was non-compliant with Regulation 15: Individual care plans at the time of inspection.

Condition 2: *To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: On this inspection, the approved centre was not in breach of Condition 2 but was non-compliant with Regulation 21: Privacy and Regulation 22: Premises at the time of inspection.

Safety in the approved centre

- The '8 Step Safety Plan', developed in November 2018, comprised a plan of support and crisis care for service users to aid in the prevention of acting on suicidal thoughts and/or thoughts of self-harm when they occur. This initiative has subsequently been shortlisted for the Irish Healthcare Centre Awards 2019.
- Ligature points had been minimised.
- The ordering, prescribing, storage and administration of medication was managed in a safe manner.
- There was adherence to Food Safety requirements.

However:

- Not all health care staff were trained in fire safety, Basic Life Support, management of violence and aggression and the Mental Health Act 2001.
- In two episodes of physical restraint reviewed, a medical examination of the resident had not been completed within three hours after the start of an episode of physical restraint.

Appropriate care and treatment of residents

- An individual care plan (ICP) was developed for all residents within seven days of admission. All ICPs inspected indicated that the resident was offered a copy of their ICP. Residents had access to their ICPs and were kept informed of any changes.
- All therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. Two psychologists attended the approved centre each week to facilitate two groups; 'Emotional Regulation Skills' and 'Tolerating Distress'. Two full time occupational therapists were based in the approved centre to facilitate group work.
- Files inspected evidenced that each of the four residents who had been in the approved centre for more than 6 months had received a physical examination. Residents on antipsychotic medication, had received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels.
- The "Referral Pathway for Patients of the Department of Psychiatry to St. Luke's General Hospital" document was developed in January 2019. These guidelines assist staff in improving the care of the residents within the approved centre with acute medical conditions who require the general acute services.
- Records were secure, up-to-date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements.

However:

- One of the ICPs inspected had not been developed by the full MDT. One of the ten ICPs inspected did not contain appropriately defined goals for the resident. One ICP did not adequately document resources required to meet the resident's individual care needs.
- The six-monthly general health assessments records showed a number of omissions.

- Three children had been admitted to the approved centre since the previous inspection in 2018. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided and the children did not have access to age-appropriate advocacy services.

Respect for residents' privacy, dignity and autonomy

- The approved centre was kept in a good state of repair inside and outside. The approved centre had a cleaning schedule implemented, and it was clean, hygienic, and free from offensive odours throughout.
- A new medication storage and dispensing room, on Oak unit, facilitated a quiet and private space for medication administration.
- Residents were appropriately dressed, had access to phones and internet and could receive visitors in private.
- The resident's consent was sought and documented, prior to any search taking place. The search was implemented with due regard to the resident's dignity, privacy and gender, and at least one of the staff members who conducted the search was the same gender as the resident being searched.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

However:

- The window in one shared bedroom dormitory did not have blinds or curtains on the first day of the inspection. This was rectified during inspection.
- The approved centre had operated at overcapacity on several occasions. As a result, residents were accommodated on a sofa, in the sitting room, which infringed their privacy and dignity.
- The inside of the seclusion room was visible to residents and members of the public from the bedroom located opposite the seclusion room and from the main corridor.
- Provision of sufficient furnishings to support resident independence and comfort was inadequate. While the approved centre was registered for 44 beds, the dining room had 8 tables, with 4 chairs per table, meaning it could only seat 32 residents at the time of the inspection. Residents reported that they could be waiting for a seat to eat their meals.
- There were no clear signs in prominent positions to indicate where CCTV cameras were located. At the time of the inspection two CCTV cameras were recording images of residents in the Sycamore garden and smoking area. Residents were not aware of this. The CCTV recording function was deactivated during inspection.

Responsiveness to residents' needs

- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays. Among the week day activities on offer were board games, indoor exercise equipment, newspapers, television and outdoor exercise, including gardening and outdoor exercise equipment. Weekend activities were mainly up to the residents' self-initiative and included TV and

exercise equipment access, while yoga was offered once a week on Thursdays and occasionally on Saturdays. Residents communicated that there was not a lot to do at weekends.

- There was a choice of food at mealtimes and meals, including special diets, were attractively presented.
- Written information was available about the approved centre and residents' diagnosis and medication.
- There was a robust complaints procedure in place.

Governance of the approved centre

- The Department of Psychiatry, St Luke's Hospital was part of the Carlow, Kilkenny, South Tipperary Mental Health Services. Carlow, Kilkenny, South Tipperary Mental Health Services were part of the South East Community Healthcare. The approved centre's Quality and Patient Safety Committee reported to the Carlow, Kilkenny, South Tipperary Mental Health Services Executive Management Team. The Quality and Patient Safety Committee met fortnightly and was multi-disciplinary. A number of sub-committees and groups fed into the Quality and Patient Safety Committee.
- A Support Services Manager for Carlow, Kilkenny and South Tipperary Mental Health Services had been recently appointed in order to improve premises, hygiene and catering processes and monitoring.
- A Mental Health Commission Compliance Officer had been newly appointed on a pilot basis for the Carlow, Kilkenny, and South Tipperary Mental Health Services.
- Clinical supervision was in place for all disciplines. Annual staff training plans were completed to identify required training. Multiple non-mandatory training courses were available to staff.
- The Policy, Procedure, Protocol and Guideline Group provided a multi-disciplinary approach to policy development, review, approval and dissemination.
- There was a culture of implementing quality improvement audit tools to monitor and evaluate standards of care. The Best Practice Guidance for Mental Health Services audits tools were used for the majority of audits. There was no definitive audit schedule and consequently the benefits of re-auditing was at risk of being lost.
- The approved centre's registered proprietor held overall responsibility for the risk management process. The Quality and Patient Safety Committee monitored and maintained the approved centre's risk register. Incidents and trends were discussed at quarterly meetings. The risk register fed into the wider South East Community Healthcare risk register when deemed appropriate.
- The Area Lead for Mental Health Engagement was a member of the Carlow, Kilkenny, South Tipperary Mental Health Services Executive Management Team, as well as other Committees. The voice of the service user was also sought by the Area Lead for Mental Health Engagement and the approved centre through opportunities, such as the Kilkenny Mental Health Engagement and Recovery Forum, Emergency Department Volunteers Forum, Service User Community Meetings, Patient Hygiene Questionnaires and Comment, Compliment or Complaint Forms.

However:

- Not all disciplines had formal structures and processes in place for measuring and encouraging staff's performance planning and personal development.
- Records indicated that not all health professionals had up-to-date mandatory training due to staff shortages and the prioritisation of clinical care over training attendance.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The Seclusion Reduction Working Group, established in March 2019, which remained in its infancy had already undertaken several elements of work. Work included; seclusion and physical restraint training, sensory regulation training, service user's involvement in the management of violence and aggression training and a literature review into assessments for ascertaining previous trauma.

2. Quarterly Nurse Management and Consultation Group meetings commenced February 2019.

3. The '8 Step Safety Plan', developed in November 2018, comprised a plan of support and crisis care for service users to aid in the prevention of acting on suicidal thoughts and/or thoughts of self-harm when they occur. This initiative has subsequently been shortlisted for the Irish Healthcare Centre Awards 2019.

4. The "Mental Health Engagement Forum" developed recovery orientated posters and information leaflets for service users of the approved centre. This initiative commenced June 2019 and endeavoured to support dialogue with service users around promoting safe in-patient stay.

5. National Early Warning Score (NEWS) training completed and implemented, January 2019.

6. A new medication storage and dispensing room, on Oak unit, facilitated a quiet and private space for medication administration.

7. A pharmacist and a pharmacy technician attended the approved centre weekly, at a minimum, since January 2019.

8. The "Referral Pathway for Patients of the Department of Psychiatry to St. Luke's General Hospital" document was developed in January 2019. These guidelines assist staff in improving the care of the residents within the approved centre with acute medical conditions who require the general acute services.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry, St Luke's Hospital was located on the grounds of St. Luke's General Hospital in Kilkenny city. The Department of Psychiatry was independent of the general hospital however it had a working relationship in an effort to provide holistic services to its residents. The approved centre served the catchment area of Carlow, Kilkenny and South Tipperary. 13 consultant-led multidisciplinary teams cared for residents admitted to the approved centre.

The approved centre comprised two units, Sycamore and Oak, which had 25 and 19 beds respectively. There was a sectioned area within the Oak Unit that contained a seclusion room and two single bedrooms. Both units were of mixed gender. Each unit had access to separate garden areas. There was one large dining room shared by both units. The approved centre contained a reception area, ECT suite, TV areas, art room, occupational therapy room, quiet room, occupational therapy kitchen, assessment room, training room and offices.

The approved centre was found to be clean and bright and resident areas appeared pleasant and comfortable. A substantial amount of work on the premises of the approved centre had been completed since last year's (2018) inspection. Some of the work included: brightly coloured walls and ceilings, inspirational quotes and art work decorating the walls, new flooring in resident areas, re-tiling of bathroom areas and the installation of new window blinds, resident wardrobes, chairs, and artificial lights which improved lighting. A programme of anti-ligature work had taken place. New Velux windows were due to be installed in the coming weeks in order to increase ventilation and new bedside shelving was due to be installed in the coming months for the comfort of residents.

The inspection team were informed that the approved centre had operated at overcapacity on numerous occasions within the previous months, which led to residents using sitting rooms as bedrooms and sleeping on sofas.

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

Resident Profile	
Number of registered beds	***44***
Total number of residents	**40**
Number of detained patients	5
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	4
Number of patients on Section 26 leave for more than 2 weeks	1

3.2 Governance

The Department of Psychiatry, St Luke's Hospital was part of the Carlow, Kilkenny, South Tipperary Mental Health Services. Carlow, Kilkenny, South Tipperary Mental Health Services were a segment of the South East Community Healthcare. The approved centre was governed by the Quality and Patient Safety Committee which reported to the Carlow, Kilkenny, South Tipperary Mental Health Services Executive Management Team. The Quality and Patient Safety Committee met fortnightly and was multi-layered and multi-disciplinary. Numerous sub-committees and groups fed into the Quality and Patient Safety Committee, some of which included: the Drugs and Therapeutic Committee, Seclusion Reduction Working Group, Consultant Group Meetings, Delayed Discharge Group, Bed Management Group, Garda Liaison Committee, Emergency Department, Acute Medical Assessment Unit and Department of Psychiatry Liaison Group, Nurse Manager Group, and Pharmacy Group. The Health and Safety Committee and Operating Policy and Procedures Committee was held at South East Community Healthcare level. The various committees' purposes, structures, responsibilities and reporting relationships were well defined. The remit and authority of line managers for the various disciplines was clear. A Support Services Manager for Carlow, Kilkenny and South Tipperary Mental Health Services had been recently appointed in order to improve premises, hygiene and catering processes and monitoring. A Mental Health Commission Compliance Officer had been newly appointed on a pilot basis for the Carlow, Kilkenny, and South Tipperary Mental Health Services. His involvement in the approved centres governance structures had not been formalised at the time of inspection.

There was an induction programme for new staff and this process was formally documented. Not all disciplines had formal structures and processes in place for measuring and encouraging staff's performance planning and personal development. Clinical supervision was in place for all disciplines. A steering group was established for the co-ordination, promotion and implementation of clinical supervision. Annual staff training plans were completed to identify required training; however, records indicated that not all health professionals had up-to-date mandatory training. According to management the main barrier for staff not achieving the required mandatory training was staff shortages and the prioritisation of clinical care over training attendance. Multiple non-mandatory training courses were available to staff. Management facilitated and supported higher education programmes. In recent months, the approved centre had strategically mandatory training and staff training in Recovery Principles, Individual Care Plan and Seclusion and Restraint.

The Policy, Procedure, Protocol and Guideline Group provided a multidisciplinary approach to policy development, review, approval and dissemination. The approved centre was due to introduce a Policy Portal database in the coming months in order to facilitate policy access and dissemination. There was a culture of implementing quality improvement audit tools to monitor and evaluate standards of care. The Best Practice Guidance for Mental Health Services audits tools were used for the majority of audits. The audits completed provided rich data for improving patient care and outcomes. There was no definitive audit schedule and consequently the benefits of re-auditing was at risk of being lost. Clinical audits were undertaken by the multi-disciplinary team and the results reported to the appropriate governance committees.

The approved centre's registered proprietor held overall responsibility for the risk management process. The Quality and Patient Safety Committee monitored and maintained the approved centre's risk register. Incidents and trends were discussed at quarterly meetings. The risk register fed into the wider South East

Community Healthcare risk register when deemed appropriate. The main risks identified by the service were staff shortages and overcapacity. Staff shortages were highlighted across all disciplines and, where appropriate, registered on the South East Community Healthcare risk register. Overcapacity remained problematic and was also itemized on the South East Community Healthcare risk register. Numerous committees, either directly or indirectly, addressed overcapacity issues, including the 'Bed Management group', 'Delayed Discharge Group', 'Garda Liaison Committee' and the 'Emergency Department, Acute Medical Assessment Unit and Department of Psychiatry Liaison Group'. A senior management teleconference was initiated when the approved centre reached overcapacity with the aim of managing the implications and focusing on solutions.

The Area Lead for Mental Health Engagement was a member of the Carlow, Kilkenny, South Tipperary Mental Health Services Executive Management Team, as well as the Quality and Safety Executive Committee, the approved centre's Quality and Patient Safety Committee and Emergency Department, Acute Medical Assessment Unit and the Department of Psychiatry Liaison Group. Service users' representatives were also members of the approved centre's Quality and Patient Safety Committee, "Emergency Department, Acute Medical Assessment Unit and the Department of Psychiatry Liaison Group", "Garda Liaison Committee" and "Seclusion Reduction Working Group". The voice of the service user was also sought by the Area Lead for Mental Health Engagement and the approved centre through opportunities such as the Kilkenny Mental Health Engagement and Recovery Forum, Emergency Department Volunteers Forum, Service User Community Meetings, Patient Hygiene Questionnaires and Comment, Compliment or Complaint Forms.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 15: Individual Care Plan	✗	Moderate	✗	Moderate	✗	Low
Regulation 19: General Health	✗	Moderate	✗	High	✗	High
Regulation 21: Privacy	✗	High	✗	Critical	✗	High
Regulation 22: Premises	✗	High	✗	Critical	✗	Low
Regulation 25: Use of Closed Circuit Television	✓		✓		✗	Low
Regulation 26: Staffing	✗	High	✗	High	✗	High
Rules Governing the Use of Seclusion	✗	High	✗	Critical	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Moderate	✗	High	✗	Moderate
Code of Practice on the Admission of Children	✗	Moderate	✗	High	✗	High
Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre	✗	High	✗	High	✗	Moderate

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

4.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 13: Searches
Regulation 14: Care of the Dying
Regulation 16: Therapeutic Services and Programmes
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre had not admitted any children requiring educational service since the last inspection, this regulation was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

5.0 Service-user Experience

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

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

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

Twelve residents spoke with the inspection team over the course of the inspection. They were complimentary about the approved centre's environment, its garden areas and its cleanliness. Residents were complimentary about the taste of the food, although would like more healthy options; specifically, more vegetarian options. The dining room experience was noted to be overwhelming due to the volume of people. Residents stated they thoroughly enjoyed the fitness and psychology groups; however, in general, they would like more one-to-one and group therapeutic engagement. It was reportedly felt by some residents that nursing staff, in particular, were discourteous at times and not readily accessible.

Several residents reported to the IAN representative that they thought the exercise group was positive and they were complimentary about the approved centre's premises. Residents voiced that staff were often busy and they felt discounted. Some residents commented on how helpful and caring nursing staff were; however, a considerable amount of residents commented on feeling unheard, dismissed and disrespected by nursing staff. Residents reported they would like more activities, therapeutic groups and therapeutic engagement with staff. Several residents noted they had to sleep on a sofa, as no bed was available.

One resident questionnaire was returned to the inspectors. The completed questionnaire identified that the resident knew who their key-worker and multidisciplinary team were; however, the resident did not understand their individual care plan or feel involved in setting goals. The resident felt there was enough activities to do during the day and could communicate freely with their family, friends, or advocate. The resident felt they were not happy with how staff spoke to them and did not feel their privacy and dignity was respected. They sometimes felt safe and able to give feedback to staff or to make a complaint. On a scale of 1 to 10, with 1 being poor and 10 being excellent, the residents gave a rating of 10 for overall experience of care and treatment.

6.0 Feedback Meeting

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

- Area Director of Nursing
- Registered Proprietor Nominee
- Clinical Director
- Chief Officer
- Senior Occupational Therapist
- OT Manager
- Assistant Director of Nursing
- Executive Clinical Director
- Consultant Psychiatrist x3
- Mental Health Act Administrator
- Ward Clerk
- Clinical Risk Manager
- Clinical Psychologist
- Clinical Nurse Manager III
- Area Lead for Mental Health Engagement
- Clinical Nurse Manager II x2
- Support Staff Manager
- Quality and Patient Safety Lead

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.

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

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

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

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were offered a variety of wholesome and nutritious food, including portions from different food groups in the Food Pyramid. Hot meals were provided on a daily basis. Food, including modified consistency diets, was presented in an appealing manner in terms of texture, flavour, and appearance. Residents were offered hot and cold drinks regularly, and fresh water was available from dispensers on each ward and in the dining room.

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The approved centre used an evidence-based nutrition assessment tool to evaluate residents with special dietary requirements. Their special nutritional requirements were regularly reviewed by a dietitian. While there was no designated dietitian in the approved centre, residents were referred to a dietitian when necessary. Intake and output charts were maintained for residents, where appropriate.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in March 2019. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

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

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: No resident required nightclothes during the day. The availability of an emergency supply of clothing for residents was monitored on an ongoing basis.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which was clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents had an adequate supply of individualised clothing. There were no laundry facilities available for resident's personal clothing within the approved centre. Resident's clothes were either washed by carers or residents paid for an external laundrette service. In exceptional circumstances there was a fund available to help residents pay the launderette fee.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' personal property and possessions, which was last reviewed in May 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

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

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

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

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

Monitoring: A record was not maintained of the occurrence of planned recreational activities, including a log of resident attendance. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays mainly. Among the week day activities on offer were board games, indoor exercise equipment, newspapers, television and outdoor exercise, including gardening and outdoor exercise equipment. Weekend activities were mainly up to the residents' self-initiative and included TV and gym access, while yoga was offered once a week on Thursdays and occasionally on Saturdays.

A timetable of activities was given to residents. Residents communicated that there was not a lot to do at weekends. Activities were developed, maintained, and implemented with resident involvement, and resident preferences were taken into account. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. A fitness instructor attends the unit four times weekly and provides fitness instruction to both individuals and groups. There were suitable indoor areas for recreation. Records of resident attendance at events were maintained in the clinical files.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2019. The policy included all the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. There were facilities available to support residents' religious practices. Residents had access to multi-faith chaplains, if required. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed in the approved centre. Clinical files documented the names of visitors the resident did not wish to see and those who posed a risk to the resident. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times, and this was communicated to all relevant individuals publicly. The visiting rooms available were suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in January 2018. The policy included all the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in their individual care plan. Two current residents had restrictions on their external communication at the time of the inspection. Residents could use mail, fax, and a ward telephone if they wished. Wi-Fi was available, but only through residents own personal mobile phones.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The approved centre did not undertake environmental searches. The clinical files of three residents who were searched were inspected. Risk had been assessed prior to the search of the resident and their property appropriate to the type of search being undertaken. The resident's consent was sought and documented, prior to the search taking place, in each case.

Each resident was informed by those implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident's dignity, privacy and gender, and at least one of the staff members who conducted the search was the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

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

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

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The care of the dying policy was last reviewed in July 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.

Monitoring: One sudden death occurred in the approved centre seven days before the inspection.

Evidence of Implementation: The sudden death of the resident was managed in accordance with legal requirements. The sudden death of the resident was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident's representatives, family, next of kin, and friends. The death was reported to the Mental Health Commission within the required 48-hour time frame.

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

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating Low

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 June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

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

Evidence of Implementation: The ICPs of ten residents were inspected. Each ICP was a composite set of documents stored in the clinical file. Each resident was assessed at admission and an initial care plan was completed by the admitting clinician to address the immediate needs of the resident. A key worker was identified in all ten ICPs inspected to ensure continuity in the implementation of residents' ICPs. ICPs were discussed, drawn up, and agreed with the participation of residents, and where appropriate their representatives. The ten ICPs inspected included an individual risk management plan.

In all ICPs reviewed, an ICP was developed within seven days of admission. However, one of the ICPs inspected had not been developed by the full MDT; there was no occupational therapist present at the development of the ICP. One of the ten ICPs inspected did not contain appropriately defined goals for the resident. One ICP did not adequately document resources required to meet the resident's individual care needs.

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

a) **One of the ten ICPs had not been developed by the MDT.**
b) **One of the ten ICPs inspected did not contain appropriately defined goals for the resident.**
c) **One of the ten ICPs inspected did not adequately document resources required to meet the resident's individual care needs.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: All therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents' individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents in the format of a weekly timetable.

All therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Adequate resources and facilities were available. Two psychologists attended the approved centre each week to facilitate two groups; 'Emotional Regulation Skills' and 'Tolerating Distress'. Two full time occupational therapists were based in the approved centre to facilitate group work.

Therapeutic services and programmes were provided in separate, dedicated rooms, and each ward had facilities to carry out group programmes or one-to-one sessions. Where a resident required a therapeutic service or programme that was not provided internally, such as dietician, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents' clinical files.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre mental health ward to the general ward of the hospital was examined. The resident was transferred to receive physical health treatment.

Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented. Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, and the resident's accompaniment requirements on transfer.

The resident's entire individual care plan was not sent. Instead, a summary of the admission assessment was detailed in the issued transfer form. This summary included the resident's needs and risks. The resident was risk assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident's needs. A documented justification as to why the resident's consent to being transferred was not received from the resident, and this was recorded. The resident lacked capacity to consent.

The following information was issued, with copies retained as part of the transfer documentation: a letter of referral, including a list of current medications, and the resident transfer form. A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the residents' clinical file.

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

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Residents' take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had not been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had not been completed to identify opportunities for improving general health processes.

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

Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. The four clinical files inspected showed that all four residents received appropriate general health care interventions in line with their individual care plans.

Resident's general health needs were monitored and assessed at least every six months. Four residents were in the approved centre for over six months, and their clinical files were inspected. While files inspected showed that these four residents had received a six-monthly general health assessment, the assessment itself was not adequately completed.

All four files inspected evidenced that each of the four residents had received a physical examination. The six-monthly general health assessment records had the following discrepancies:

- In one of the four clinical files inspected, the resident's family history, smoking status, nutritional status and medication review, were not recorded.
- In two of four of the clinical files examined the residents' weight was not recorded.
- In three of four of the clinical files examined the residents' Body Mass Index and waist circumference, were not recorded.

Full records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Three residents on antipsychotic medication, received an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and prolactin levels. Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre which included retina check (diabetics only), and bowel screening. Residents had access to smoking cessation supports.

The approved centre was non-compliant with this regulation because the six-monthly general health assessment records and associated tests were not fully complete for the following reasons:

a) **In one of the four clinical files inspected, the resident's family history, smoking status, nutritional status, and medication review were not recorded, 19 (1) (b).**
b) **In two of the four clinical files examined the residents' weight was not recorded, 19 (1) (b).**
c) **In three of the four clinical files examined the residents' Body Mass Index and waist circumference, were not recorded, 19 (1) (b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

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

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. At the time of the inspection, there were no restrictions on information regarding a resident's diagnosis applied to any resident.

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

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

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in July 2019. The policy addressed all of the requirements of the *Judgement Support Framework*.

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

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

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

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. Not all observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. The window in one shared bedroom dormitory, 'bedroom 11', did not have blinds or curtains on the first day of the inspection. This was addressed during the inspection. The seclusion room was visible to residents and members of the public from the bedroom located opposite the seclusion room and from the main corridor.

The approved centre had operated at overcapacity on several occasions. As a result, residents were accommodated on a sofa, in the sitting room, which infringed their privacy and dignity. Rooms were not overlooked by public areas, with the exception of one part of the garden in the Sycamore unit which was visible from a public roadway. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

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

a) **The window in one shared bedroom dormitory, 'bedroom 11', did not have blinds or curtains on the first day of the inspection.**
b) **The seclusion room was visible to residents and members of the public from the bedroom located opposite the seclusion room and from the main corridor.**
c) **The approved centre had operated at overcapacity on several occasions. As a result, residents were accommodated in the sitting room, which infringed their privacy and dignity.**

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: The approved centre had completed a hygiene audit. Ligature audits were completed. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately lit, heated and ventilated. The design of the physical environment of the approved centre provided residents with access to personal space, and appropriately sized communal rooms. The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities.

Ligature points had been minimised. The approved centre was kept in a good state of repair inside and outside. The approved centre had a cleaning schedule implemented, and it was clean, hygienic, and free from offensive odours throughout.

The heating system in the approved centre was underfloor heating and it was controlled centrally. It could not be safely controlled in the residents own room. The approved centre did not have a dedicated laundry room.

The approved centre did not provide suitable furnishings to support resident independence and comfort. While the approved centre was registered for 44 beds, the dining room had 8 tables, with 4 chairs per table, meaning it could only seat 32 residents at the time of the inspection. Residents from Sycamore unit

and Oak unit had their meals at the same times. Residents reported that residents could be waiting for a seat to eat their meals. Remote or isolated areas of the approved centre was monitored.

The approved centre was non-compliant with this regulation because it did not have adequate and suitable furnishing having regard to the number and mix of residents. While the approved centre was registered for 44 beds, the dining room could only seat 32 residents at the time of the inspection, 22(2).

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had 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 been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of appropriate medication management practices, including a record of two resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. The Medical Council Registration Number of every medical practitioner prescribing medication to the resident was present within each resident's MPAR. A record was kept when medication was refused by the resident.

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

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

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

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in March 2019. 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. 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 checked regularly to ensure that the equipment was operating appropriately. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were no clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. At the time of the inspection two CCTV cameras were recording images of residents in the Sycamore garden and smoking area. Residents were not aware of this. The CCTV recording function was deactivated during inspection. The CCTV monitors were located on a main corridor in a locked press and could only be viewed by health professionals responsible for the residents. The CCTV monitors were not used for monitoring purposes and management decommissioned their use during inspection. The usage of CCTV was disclosed to the Mental Health Commission.

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

a) **The use of CCTV was not clearly labelled and evident, 25 (1)(b).**
b) **The CCTV system was capable of recording a resident's image. At the time of the inspection two CCTV cameras were recording images of residents in the Sycamore Ward garden areas and in the smoking areas, 25 (1)(d).**

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The policy was last reviewed in March 2019. The policy included the requirements of the *Judgement Support Framework*, with the following exceptions:

- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.

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

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place, which illustrated 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 had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times. Opportunities were made available to staff by the approved centre for further education.

The number and skill mix of staffing were insufficient to meet residents' needs. There were significant staff deficits in psychology and social work. These deficits were documented on the risk register. There were six vacant social work and four vacant psychologist posts within the thirteen sector teams that fed into the approved centre. Social work and psychology provided cross cover between sector teams and prioritised residents in the approved centre. However, despite these efforts conflicting priorities led to residents needs not being meet within an appropriate timeframe.

A written staffing plan was not available within the approved centre. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

Not all health care staff were trained in the following:

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

All staff training was documented and staff training logs were maintained.

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (43)	43	100%	35	81%	23	53%	39	91%	42	98%
Consultant Psychiatrist (14)	10	71.5%	7	50%	7	50%	7	50%	12	86%
Medical (17)	13	76%	8	47%	7	41%	8	47%	15	88%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (7)	5	71%	4	57%	6	86%	5	71%	7	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%	2	100%

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

Ward or Unit	Staff Grade	Day	Night
Oak Ward	ADON	1 (shared)	0
	CNM III	1 (shared)	1 (shared)
	CNM2	1	0
	RPN	5	2 (1 shared)
	HCA	0	1 (1 shared)
	Occupational Therapist	2 (shared)	0
	Social Worker	Referral	0
	Psychologist	Referral	0

Ward or Unit	Staff Grade	Day	Night
	ADON	1 (shared)	0
	CNM III	1 (shared)	1 (shared)
	CNM2	1	0
	RPN	4	2
Sycamore Ward	HCA	0	0
	Occupational Therapist	2 (shared)	0
	Social Worker	Referral	0
	Psychologist	Referral	0

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

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, PMAV, 26(4).**
b) **Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).**
c) **The number and skill mix of staffing were insufficient to meet residents' needs, 26 (2).**

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Only authorised staff made entries in residents' records. Records were found to be legible, written in black indelible ink and were readable when photocopied. Entries in resident records were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Each entry denoted the time automatically when records were accessed. The inspection found where an error was made specifically on the seclusion register, it was not scored out with a single line and it was not corrected appropriately.

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

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

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in June 2017. It included all of the requirements of the *Judgement Support Framework.*

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

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

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

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

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

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in June 2018. The policy and procedures included all of the requirements of the *Judgement Support Framework.*

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

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

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

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available and based in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure, including how to contact the nominated person was publicly displayed, and it was detailed within the service-user's information booklet. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Complaints could be lodged verbally, in writing, electronically through e-mail, by telephone, and through complaint, feedback, or suggestion forms.

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

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

All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. The complainant's satisfaction or dissatisfaction with the investigation findings was not documented.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in July 2019. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. There was no documented audit of the risk register. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the

lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint, seclusion, electronic convulsive therapy, and at resident admission, transfer but not at resident 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 effectively mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. 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 reviewed incidents for any trends or patterns occurring in the service.

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

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

Regulation 33: Insurance

COMPLIANT

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

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 59: The Use of Electro-Convulsive Therapy

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy was last reviewed in June 2019. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a surgical theatre suite. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. A single named consultant anaesthetist had overall responsibility for anaesthesia.

At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse. The clinical file of one involuntary patient who received ECT since the last inspection was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed capable of consenting to receiving ECT.

Appropriate information on ECT was given by the consultant psychiatrist to enable the patient to make a decision on whether or not to agree to receive ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that the patient could understand. The patient was informed of their rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia.

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

The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre and post ECT assessments were detailed and recorded in the clinical file. Adverse events during or following ECT were addressed in full and were recorded. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical file.

The approved centre was compliant with this rule.

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, which was reviewed annually. It was last reviewed in June 2019. The policy addressed who may implement seclusion, the provision of information to the resident, and ways of reducing rates of seclusion use.

Training and Education: The approved centre did not maintain a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy.

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

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings, which did not endanger resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file.

Three seclusion episodes and associated documentation were inspected. In all episodes, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

In one seclusion episodes, the residents' next of kin or representative were not informed about the seclusion episode, and there was no explanation documented for this. In two seclusion episodes, there was no documented evidence of the resident being informed of the ending of an episode of seclusion. In two seclusion episodes, the reason for ending seclusion was not recorded in the clinical file. In one seclusion episode, the seclusion was not reviewed by members of the MDT and documented in the clinical file within two working days of the episode.

All episodes of seclusion were recorded in the resident's clinical file and all uses of seclusion were recorded in the seclusion register. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours, in all cases. A copy of the seclusion register was in place within the resident's clinical file and available to inspectors.

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

a) **The approved centre did not maintain a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy, 10.2 (b).**
b) **In one seclusion episodes, the residents next of kin or representative were not informed about the seclusion episode, and there was no explanation documented for this, 3.7 (a).**
c) **In two seclusion episodes, there was no documented evidence of the resident being informed of the ending of an episode of seclusion, 7.3.**
d) **In two seclusion episodes, the reason for ending seclusion was not recorded in the clinical file, 7.4.**
e) **In one seclusion episode, the seclusion was not reviewed by members of the MDT and documented in the clinical file within two working days of the episode, 10.3.**

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

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The inspection team examined the clinical file of one detained patient who was identified as being in continuous receipt of medication for a period in excess of three months. The patient had consented to treatment, and there was a written record to this effect. Details were provided of the medications prescribed and there was a record of the following:

- The patient's ability to understand the nature, purpose, and likely effects of the medication had been confirmed.
- That a discussion with the patient had taken place on the nature and purpose of the medication, the effects of the medication, and the supports provided to the patient in making the decision to consent.
- That the responsible consultant psychiatrist had undertaken a capacity assessment.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in June 2019. The policy addressed the following:

- The provision of information to the resident.
- Those who can initiate and implement physical restraint.
- Child protection processes where a child is physically restrained.

Training and Education: The approved centre did not maintain a documented written record indicating that all staff involved in the use of physical restraint had read and understood the policy.

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

Evidence of Implementation: Three physical restraint episodes in relation to two residents were inspected. Physical restraint was only used in rare and exceptional circumstances when residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each resident. Staff had first considered all other interventions to manage each resident's unsafe behaviour. In all cases, the restraint order lasted for a maximum of 10 minutes. Each episode of physical restraint was recorded in the clinical file.

In all of the episodes of physical restraint reviewed, the consultant psychiatrist had been informed of the physical restraint as soon as was practicable, and the clinical practice form was signed by a consultant psychiatrist. All episodes of physical restraint were reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days of each episode.

The following discrepancies were found on inspection:

- In two episodes of physical restraint reviewed, a medical examination of the resident had not been completed no later than three hours after the start of an episode of physical restraint.
- In one physical restraint episode, the resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reason for not informing them was not documented.
- In three episodes of physical restraint the resident's next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in two cases.

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

a) **The approved centre did not maintain a documented written record indicating that all staff involved in physical restraint had read and understood the policy, 9.2 (b).**
b) **In two episodes of physical restraint reviewed, a medical examination of the resident had not been completed no later than three hours after the start of an episode of physical restraint, 5.4.**

c) **In one physical restraint episode, the resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reason for not informing them was not documented, 5.8.**
d) **In three episodes of physical restraint the resident's next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in two cases, 5.9 (a).**

Admission of Children

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had policies and protocols in place in relation to the admission of a child. The approved centre had a policy requiring each child to be individually risk assessed. A policy and procedures were in place with regard to family liaison, parental consent, and confidentiality. Procedures were in place for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in the Children First guidelines.

Evidence of Implementation: The inspection team reviewed three clinical files in relation to three children who were admitted to the approved centre since the last inspection. As the children were admitted for a short period, ranging from a two night stay to a nine day stay, they did not require educational services. The approved centre was an adult facility, therefore age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. Provisions were in place to ensure the safety of the children and to respond to the children's particular needs. The children did not have access to age-appropriate advocacy services. In all cases, consent for treatment was obtained from at least one parent.

In relation to child protection issues, staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated and included segregation according to age and gender, sleeping arrangements, and bathroom areas. Staff were gender sensitive.

Each child was provided with an information booklet, and as such had their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical files did not record each child's understanding of the explanation given. Appropriate visiting times for families, including children, were available. The Mental Health Commission was notified of all children admitted to the approved centres for adults within 72 hours, using the appropriate notification form.

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

a) **Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).**
b) **The children did not have access to age-appropriate advocacy services, 2.5 (g).**
c) **Children's understanding of their rights was not recorded, 2.5 (h).**

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. It was last reviewed in June 2019. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

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

A single named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse. The clinical file of one voluntary patient who received ECT since the last inspection was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed capable of consenting to receiving ECT.

Appropriate information on ECT was given by the consultant psychiatrist to enable the patient to make a decision on consent. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that the patient could understand. The patient was informed of his/her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia. The consultant psychiatrist administered a capacity assessment on the patient.

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

The ECT record, which was completed after each treatment, was placed in the clinical file, and the signature of the registered medical practitioners administering ECT were detailed. All pre and post ECT assessments were detailed and recorded in the clinical file. Adverse events during or following ECT were addressed in full and were recorded. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in October 2018, the transfer policy was last reviewed in May 2018, and the discharge policy was last reviewed in May 2018. The policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was not co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan. The discharge plan documented the estimated date of discharge and all other aspects of the discharge process were recorded in the clinical file.

There was no documented evidence of a discharge meeting taking place with the resident and their key worker, relevant members of the multi-disciplinary team (MDT), and the resident's family. A pre-discharge assessment was completed which addressed the resident's psychiatric and psychological needs and a current mental state examination. The discharge assessment did not include a comprehensive risk assessment and risk management plan, social and housing needs, and informational needs.

A preliminary discharge summary was issued to primary care within three days. A comprehensive discharge summary was issued within 14 days to relevant personnel. The discharge summaries included details of diagnosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, and names and contact details of key people for follow-up. The discharge summaries did not include details of the resident's prognosis, and risk issues such as signs of relapse.

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

a) **There was no documented evidence of a discharge meeting taking place with the resident and their key worker, relevant members of the multi-disciplinary team (MDT), and the resident's family, 34.4.**
b) **A pre-discharge assessment was completed which addressed the resident's psychiatric and psychological needs and a current mental state examination. The discharge assessment did not include a comprehensive risk assessment and risk management plan, social and housing needs, and informational needs, 34.4.**
c) **The discharge was not co-ordinated by a key-worker, 37.1.**
d) **The discharge summaries did not include details of the resident's prognosis, and risk issues such as signs of relapse, 38.4.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10000788		**The use of CCTV was not clearly labelled and evident, 25 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The use of CCTV is now clearly displayed on the unit.	Walk through review	Achievable + Realistic	05/07/2019	ADON
Preventative Action	Appropriate signage clearly outling the use of CCTV is displayed on the unit.	Walk through review	Achievable + Realistic	05/07/2019	ADON
Reason ID : 10000789		**The CCTV system was capable of recording a resident's image. At the time of the inspection two CCTV cameras were recording images of residents in the Sycamore Ward garden areas and in the smoking areas, 25 (1)(d).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The CCTV system is incapable of recording a resident's image	Written cofirmation from the Technical Services Manager	Achievable + Realistic	29/11/2019	Technical Services Manager
Preventative Action	Technical Services have reassured unit management that the CCTV system is incapable of recording a resident's image.	Written confirmation	Achievable and Realistic	29/11/2019	Technical Services

Regulation 19 General Health

Reason ID : 10000798		In one of the four clinical files inspected, the resident's family history, smoking status, nutritional status, and medication review were not recorded, 19 (1) (b). In two of the four clinical files examined the residents' weight was not recorded, 19 (1) (b). In three of the four clinical files examined the residents' Body Mass Index and waist circumference, were not recorded, 19 (1) (b)			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A new general health proforma template incorporating all aspects of the Regulation is in place.	Quarterly audit	Achievable and Realistic	31/01/2020	Clinical Director.
Preventative Action	A new General Health template incorporating all aspects of the Regulation is in place. Quarterly General Health audits will take place.	Quarterly audits	Achievable and Realistic	31/01/2020	NCHD + Compliance Officer.

Regulation 22: Premises

Reason ID : 10000804		It did not have adequate and suitable furnishing having regard to the number and mix of residents. While the approved centre was registered for 44 beds, the dining room could only seat 32 residents at the time of the inspection, 22(2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An adequate number of chairs are available in the dining room to accomodate servives users at mealtimes.	Visual inspection.	Achievable/Realistic.	05/07/2020	ADON.
Preventative Action	An adequate number of chairs are available in the dining room to accomodate service users at mealtimes. Mealtimes in Oak and Sycamore Units are staggered to ensure an enhance service user experience.	Visual inspection.	Achievable/Realistic.	05/07/2020	ADON.

Regulation 26: Staffing

Reason ID : 10000805		Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, 26(4). Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff of the approved centre are prioritised for spring 2020 and autumn 2020 mandatory training in BLS, Fire Safety, PMAV and MHA 2001. Current mandatory training percentages are attached	Training records	Achievable/Realistic	31/03/2020	Heads of Discipline
Preventative Action	A rolling programme of mandatory training is in place	Training records	Achievable/Realistic	31/03/2020	Heads of Discipline
Reason ID : 10000807		**The number and skill mix of staffing were insufficient to meet residents' needs, 26 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Business cases are submitted to the Chief Officer for funded psychology and social work vacancies. These vacancies are recorded on the Risk Register. As an interim measure The Social Work Team are present on the unit from Monday - Thursday and in conjunction with the Recovery College provide support and educational groups to residents in the approved centre. The Psychology Team facilitates a skills group on the unit each Monday focusing on emotional regulation and distress tolerance skills. Each session is qualitatively evaluated by the residents.	Business case records	Achievable/Realistic	01/11/2019	Service Manager. Psychology Manager Social Work Team Leader
Preventative Action	Business cases are submitted to the Chief Officer for funded psychology and social work vacancies. These vacancies are recorded on the Risk	Business cases	Achievable/Realistic	01/11/2019	Service Manager. Psychology Manager Social Work Team Leader

	Register. As an interim measure The Social Work Team are present on the unit from Monday - Thursday and in conjunction with the Recovery College provide support and educational groups to residents in the approved centre. The Psychology Team facilitates a skills group on the unit each Monday focusing on emotional regulation and distress tolerance skills. Each session is qualitatively evaluated by the residents.				

Regulation 21: Privacy

Reason ID : 10000811		The window in one shared bedroom dormitory, 'bedroom 11', did not have blinds or curtains on the first day of the inspection.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All windows are fitted with blinds or curtains.	Visual inspection	Achievable/Realistic.	05/07/2019	Technical Services
Preventative Action	Areas that require maintenance attention are placed on the Arantico system immediately. A General Operative is appointed to the unit to ensure a timely response to maintenance requirements.	Visual inspection.	Achievable/realistic.	05/07/2019	Technical Services.
Reason ID : 10000812		**The seclusion room was visible to residents and members of the public from the bedroom located opposite the seclusion room and from the main corridor.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Bedroom 14 (adjacent to the seclusion room) is reserved for residents who are in seclusion to ensure their privacy is protected. Contact screening is applied to the door on the main corridor.	Visual inspection	Achievable/Realistic	30/08/2019	ADON/CNM3
Preventative Action	Bedroom 14 (adjacent to the seclusion room) is reserved for residents who are in seclusion to ensure their privacy is protected. Contact screening is applied to the door on the main corridor.	Visual inspection	Achievable/Realistic	30/08/2019	ADON/CNM3
Reason ID : 10000813		**The approved centre had operated at overcapacity on several occasions. As a result, residents were accommodated in the sitting room, which infringed their privacy and dignity.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Bed Management Guidelines and a Surge Capacity Management Plan are in place. All admissions are consultant approved. Senior medical decision	Review of daily occupancy levels	Achievable/Realistic	01/11/2019	EMT + MDT's

	makers are available daily to review all admissions. EMT and MDT's are notified daily of bed occupancy levels. Teleconferencing with stakeholders take place as required. Weekly MDTmeetings, weekly bed management meetings and monthly delayed transfer of care meetings take place.				
Preventative Action	Bed Management Guidelines and Surge Capacity Management Plan are in place. All admissions are consultant approved. Senior medical decision makers are available daily to review all admissions. EMT and MDT's are notified daily of bed occupancy levels. Weekly MDT meetings, weekly bed management meetings and monthly delayed transfer of care meetings take place.	Review of daily occupancy levels	Achievable/Realistic	01/11/2019	EMT + MDT's

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10000790		**There was no documented evidence of a discharge meeting taking place with the resident and their key worker, relevant members of the multi-disciplinary team (MDT), and the resident's family, 34.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Discharge planning is prioritized at each MDT meeting. Discharge meetings, where appropriate will be recorded in the healthcare record.	Documentation review	Discharge meetings with all families will pose a challenge to fully implement.	01/11/2019	MDT
Preventative Action	Discharge meetings, where appropriate will be recorded in the clinical file.	Documentation review	Discharge meetings with all families will pose a challenge to fully implement.	01/11/2019	MDT
Reason ID : 10000791		**A pre-discharge assessment was completed which addressed the resident's psychiatric and psychological needs and a current mental state examination. The discharge assessment did not include a comprehensive risk assessment and risk management plan, social and housing needs, and informational needs, 34.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Pre-discharge assessments will include a comprehensive risk assessment and risk management plan, social and housing needs and informational needs.	Audit	Achievable + Realistic	27/01/2020	MDT
Preventative Action	Pre-discharge assessments will include a comprehensive risk assessment and risk management plan, social and housing needs and informational needs.	Audit	Achievable + Realistic	27/01/2020	MDT
Reason ID : 10000792		**The discharge was not co-ordinated by a key-worker, 37.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Discharges will be co-ordinated by a key worker as decided by the MDT.	Documentation review	Achievable + Realistic	27/01/2020	MDT member
Preventative Action	Discharges will be co-ordinated by a key worker as decided by the MDT	Documentation review	Achievable + Realistic	27/01/2020	MDT member

Reason ID : 10000793		The discharge summaries did not include details of the resident's prognosis, and risk issues such as signs of relapse, 38.4.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Discharge summaries documentation will be reviewed to include details of the resident's prognosis and risk issues such as signs of relapse.	Documentation review.	Achievable + Realistic	28/02/2020	Clinical Director + ADON.
Preventative Action	Discharge summaries documentation will be reviewed to include details of the resident's prognoses and risk issues such as signs of relapse.	Documentation review	Achievable + Realistic	28/02/2020	Clinical Director + ADON

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10000794		**The approved centre did not maintain a documented written record indicating that all staff involved in physical restraint had read and understood the policy, 9.2 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A written record is maintained within the policy indicating that all staff involved in physical restraint have read and understood the policy.	Documentation review	Achievable and realistic	31/01/2020	CNM3
Preventative Action	All staff involved in physical restraint are reminded to sign the log indicating that they have read and understood the policy.	Documentation review	Achievable/Realistic	31/01/2020	CNM3
Reason ID : 10000795		**In two episodes of physical restraint reviewed, a medical examination of the resident had not been completed no later than three hours after the start of an episode of physical restraint, 5.4. In one physical restraint episode, the resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reason for not informing them was not documented, 5.8. In three episodes of physical restraint the resident's next of kin was not informed about the physical restraint and the reasons for not informing them was not documented in two cases, 5.9 (a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The policy is reviewed annually by the SECH Policy Group. Training for staff is provided on the Code of Practice on the Use of Physical Restraint. The Physical Restraint checklist was revised.	Audit	Achievable/Realistic	31/01/2020	CNM3/Compliance Officer
Preventative Action	Quarterly Physical Restraint audits will be completed. Weekly monitoring of compliance with the Code of Practice by the MHA Administrator will occur	Audit	Achievable/Realistic	31/01/2020	Compliance Officer/MHA Administrator

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10000801		**Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In the first instance should a child require admission to hospital a referral is sent to the national CAMHS inpatient service requesting an age appropriate inpatient facility for the child. If that child is admitted to the Department of Psychiatry while waiting for this age appropriate facility, he/she will be under the care of the local CAMHS Team who will source a programme of activities appropriate to age and ability of the child.	Documentation review.	Achievable/realistic.	06/01/2020	MDT.
Preventative Action	IIn the first instance should a child require admission to hospital a referral is sent to the national CAMHS inpatient service requesting an age appropriate inpatient facility for the child. If that child is admitted to the Department of Psychiatry while waiting for this age appropriate facility, he/she will be under the care of the local CAMHS Team who will source a programme of activities appropriate to age and ability of the child.	Documentation review.	Achievable/Realistic.	06/01/2020	MDT.
Reason ID : 10000802		**The children did not have access to age-appropriate advocacy services, 2.5 (g).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In the first instance should a child require admission to hospital a referral is sent to the national CAMHS inpatient service requesting an age appropriate	Documentation review.	Achievable/Realistic.	06/01/2020	MDT.

	inpatient facility for this child. If a child is admitted to the Department of Psychiatry while waiting for this age appropriate facility, he/she will be under the care of the local CAMHS Team who will source an age appropriate advocacy service for the child.				
Preventative Action	In the first instance should a child require admission to hospital a referral is sent to the national CAMHS inpatient service requesting an age appropriate inpatient facility for this child. If a child is admitted to the Department of Psychiatry while waiting for this age appropriate facility, he/she will be under the care of the local CAMHS Team who will source an age appropriate advocacy service for the child.	Documentation review.	Achievable + Realistic.	06/01/2020	MDT.
Reason ID : 10000803		**Children's understanding of their rights was not recorded, 2.5 (h).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A record of children understanding their rights will be maintained.	Documentation review.	Achievable + Realistic.	06/01/2020	MDT.
Preventative Action	In the first instance efforts will be made to source an age-appropriate facility for a child who requires admission.	Documentation review.	Achievable + Realistic.	06/01/2020	MDT.

Rules Governing the Use of Seclusion

Reason ID : 10000814		In two seclusion episodes, there was no documented evidence of the resident being informed of the ending of an episode of seclusion, 7.3. In two seclusion episodes, the reason for ending seclusion was not recorded in the clinical file, 7.4. In one seclusion episodes, the residents next of kin or representative were not informed about the seclusion episode, and there was no explanation documented for this, 3.7 (a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The seclusion policy is reviewed annually by the SECH policy group. The seclusion pack and checklist is revised. A seclusion reduction committee is established.Training is provided on the Rules Governing the Use of Seclusion.	Quarterly audit	Achievable/Realistic	01/11/2019	MDT
Preventative Action	Training is provided on the Rules Governing the Use of Seclusion. Quqrterly seclusion audits take place Daily monitoring of compliance is carried out by the MHA Administrator when the facility is in use.	Quarterly audit	Achievable/Realistic	01/11/2019	Compliance Officer MHA Administrator
Reason ID : 10000817		**The approved centre did not maintain a documented written record indicating that all staff involved in the use of seclusion had read and understood the policy, 10.2 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A record is maintained indicating that all staff involved in the use of seclusion have read and understood the policy.	Documentation review	Achievable/Realistic	01/11/2019	MDT's
Preventative Action	Training is provided on the Rules Governing the Use of Seclusion	Training records	Achievable/Realistic	01/11/2029	Compliance Officer
Reason ID : 10000818		**In one seclusion episode, the seclusion was not reviewed by members of the MDT and documented in the clinical file within two working days of the episode, 10.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The seclusion checklist is revised to ensure all aspect of the Rules	Quarterly audits	Achievable/Realistic	01/11/2019	CNM2's

	Governing the Use of Seclusion are fulfilled.				
Preventative Action	Training is provided on the Rules Governing the Use of seclusion. Quarterly seclusion audits take place	Quarterly audit	Achievable/Realistic	01/11/2019	Compliance Officer

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.

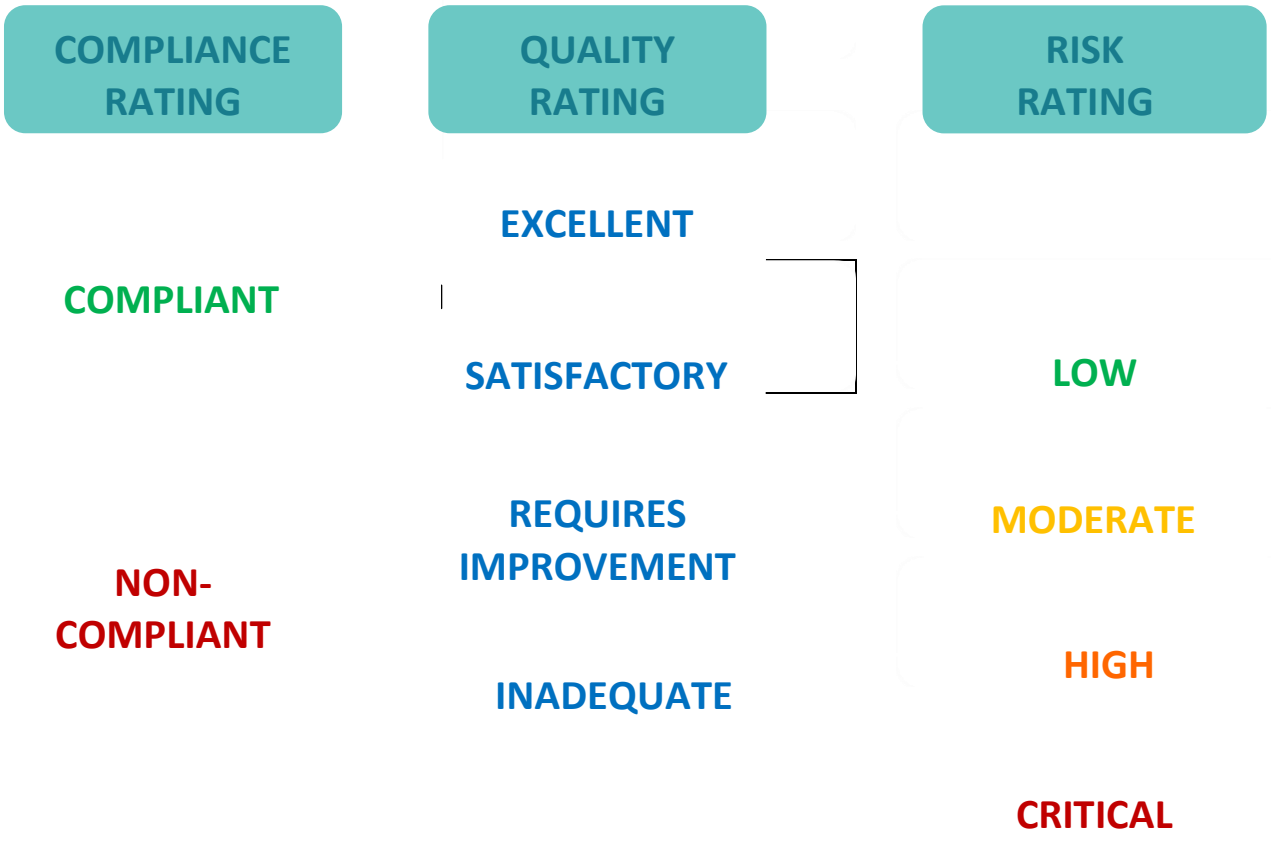
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly,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

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.



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.