Highfield Hospital

ID Number: AC0088

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Highfield Hospital
Swords Road
Whitehall
Dublin 9

Approved Centre Type: Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Forensic Mental Health Care
Mental Health Care for People with Intellectual Disability

Most Recent Registration Date: 30 March 2018

Conditions Attached: None

Registered Proprietor: Mr Stephen Eustace
Registered Proprietor Nominee: N/A

Inspection Team:
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Inspection Date: 27 – 30 August 2019
Previous Inspection Date: 17 – 20 April 2018
Inspection Type: Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Monday 09 March 2020

2019 COMPLIANCE RATINGS

- REGULATIONS
  - Compliant: 24
  - Non-compliant: 5
  - Not applicable: 2

- RULES AND PART 4 OF THE MENTAL HEALTH
  - Compliant: 2
  - Non-compliant: 2
  - Not applicable: 2

- CODES OF PRACTICE
  - Compliant: 2
  - Non-compliant: 2
  - Not applicable: 2
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
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In brief

Highfield Healthcare was an independent care of the elderly and mental health healthcare provider. It provided care to adult and older persons living with mental health issues, Alzheimer’s disease, dementia and challenges of ageing. The approved centre was based in a hospital complex which was built in 2012 on grounds on the Swords Road in Dublin.

Highfield Healthcare approved centre had 112 beds in total. It comprised of Hampstead Clinic, an eleven bedded mixed acute psychiatric unit; Tuke Unit, a twelve bedded mixed Specialist Rehabilitation Unit; Farnham Unit, a 20 bedded high dependency older persons unit; Steele Unit, a 20 bedded female older persons unit; Domville Unit, 20 bedded female increasing dependency older persons unit; and Pinel Unit, a 29 bedded male mixed dependency older persons unit. It also had a day hospital on the campus.

The approved centre had a compliance rate with regulations, rules and codes of practice of 86% in 2017; 76% in 2018 and increasing again to 85% in 2019. Fourteen compliances with regulations were rated excellent.

Conditions to registration

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

Safety in the approved centre

- Regular food safety audits were carried out and kitchen areas were clean.
- Structural risks, including ligature points, were effectively mitigated in the admission unit and in other units through risk assessments of the residents.
- The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.
- There was excellent implementation of the processes for ordering, prescribing, storing and administration of medication.

However:
• Not all health care professionals were trained in Basic Life Support, Fire Safety, the Professional Management of Aggression and Violence, Children First, or the Mental Health Act, 2001.

Appropriate care and treatment of residents

• The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the needs of the residents. Therapeutic programmes included art therapy, music therapy, mindfulness, mental health education sessions, an interpersonal skill and relationship group, a medication information group, a discharge planning group, and an emotional regulation group, with individual sessions available.

However:

• Although each resident had an individual care plan (ICP), three care plans did not contain appropriate goals for the residents, two care plans did not contain applicable care and treatment for the resident and three care plans did not appropriately document the resources required.
• While each resident had a physical examination at least every six months, three of five six-monthly general health assessments were missing an annual assessment of the residents’ fasting glucose and prolactin levels, two of five six-monthly general health assessments were missing an annual assessment of the residents’ blood lipids, and one of five six-monthly general health assessments was missing an annual electrocardiogram.

Respect for residents’ privacy, dignity and autonomy

• All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Rooms were not overlooked by public areas and the windows had opaque glass if they were. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass to protect the privacy and dignity of residents.
• The approved centre was clean and well maintained. The layout decoration and furnishing met the needs of the resident group.
• All staff were noted to be respectful and friendly towards residents.
• There were ample spaces for residents to meet their visitors in private.

However:

• Three of the four-bedded rooms on Farnham Ward did not have privacy screens for the two beds nearest the window in each room. This issue was rectified and privacy screens were applied prior to the completion of inspection.
• Two noticeboards displayed resident names and identifiable information. Full names and photographs were displayed in a family tree within three wards. There were no consent forms for
most of the photographs. Bedrooms in older persons units' doors displayed the residents’ full name and photograph.

**Responsiveness to residents’ needs**

- Residents were provided with a clearly and simply written information brochure 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. Residents were provided with written and verbal information on diagnosis and medication.
- There were quarterly newsletters available for staff and a separate one for residents and their families.
- A baby room had been set up in order to enable a family friendly service and to cater for perinatal presentations. Perinatal psychiatric training was provided to relevant staff.
- There was a comprehensive and responsive complaints process in place.
- There was a wide range of recreational activities available to meet the needs of residents. They had access to TV, radio, newspapers, games, movie sessions, hairdressing and nail care sessions, a dog visitor, volunteer music sessions, and a gardening group. Many of the activities were supported and facilitated by volunteers who were managed by a volunteer coordinator.

**Governance of the approved centre**

- The approved centre was governed by the Highfield Healthcare Board and the Senior Management Team. The Senior Management Team includes the Chief Executive Officer, Head of HR, Head of IT, Head of Finance, Quality and Risk Manager, Director of Services, Clinical Director, Director of Nursing, Mental Health, Director of Nursing, Nursing Home Services and Director of Nursing, Alzheimer Care Centre. Numerous sub-committees and groups fed into the Senior Management Team.
- There were induction programmes for new staff which incorporated corporate and training induction. There were formal structures and processes in place for measuring and encouraging staff’s performance planning and personal development.
- Staff training analysis and plans were completed annually to identify and address training needs. Records indicated that not all health professionals had up-to-date mandatory training. Multiple non-mandatory training courses were available to staff.
- The Policy Development Committee provided a multi-disciplinary approach to policy development, review, approval and dissemination.
- There was a definitive audit schedule. Clinical audits were mostly undertaken by nursing staff. Audit data was analysed to produce monthly and yearly overviews.
- The approved centre’s Chief Executive Officer held overall responsibility for the risk management process. Each unit in the approved centre held a risk register. The Quality and Risk Management Committee monitored and maintained the approved centre’s risk registers quarterly.
- Highfield used a newly developed online Incident Management System (INY) to report, rate, manage and monitor incidents. All staff had access to the system. Managers were emailed notifications of any incidents that occurred in their area of responsibility for oversight and possible follow-up.
• There is no service user on governance committees within the approved centre at present. The service utilised an online feedback system to record and manage complaints, compliments and local issues.
• A patient satisfaction survey was ongoing. Service user’s satisfaction with therapeutic services and programmes were captured on therapy specific evaluation forms. The results were disseminated to staff and service users via staff and family newsletters, infographic leaflets and digital communication boards.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

Resident Focused Initiatives:

1. A new family and resident choir for the long term care units (Steele, Domville and Tuke) was established and lead by the Music Therapist in quarter one 2019.

2. The facilitation of a baby room had been set up in order to enable a family friendly service and to cater for perinatal presentations. Perinatal psychiatric training was provided to relevant staff.

3. A walking group had commenced for long term care units.

4. There was enhanced resident information provision in the format of new falls prevention leaflet, end of life care leaflet, rights under GDPR leaflet, outpatient leaflet and information on sharing your views.

5. A spirituality form was initiated in order to detail resident’s spiritual practices and preferences.

Patient Satisfaction:

6. Annual reports on the resident experience of Hampstead Clinic were produced and disseminated to staff and service users in January 2019. Infographs were developed which offered a user friendly snapshot of the findings.

Positive Mental Health Promotion and Community Links:

7. The service made links with “Life Skills” in order to enable the commencement of its programme within the approved centre, access for people in the community is free. The programme is aimed at young people to help improve wellbeing by making small and easy changes.

8. AWARE support and self-care meetings run every Wednesday within the approved centre. This meeting is open and free to attend.

Service Expansion and Redevelopment:

9. A new Specialist Rehabilitation Unit was opened in Oct 2018 in partnership with the HSE. The unit aims to foster a recovery approach to mental health care and support service user’s reintegration back into the community.

10. The acute unit expanded its beds from 10 to 11 in 2018.
11. Nurse Manager, doctors and allied health professionals staff has been increased throughout the approved centre over the past 12 months.

Education and Training:

12. A new programme of education and training sessions called “Tune in Tuesday” was set up. The programme facilitates different health and social care professional speakers and covers a wide variety of topics.

13. A nurse Leadership programme was introduced in October 2018.

14. HSE Best Practice Guidance for Mental Health Programme Training was initiated for staff.

15. The approved centre ran a Wellness Recovery Action Plan (WRAP) programme for staff.

16. The approved centre has enhanced its links with various universities and increased the volume of student nurses, student doctors and physician associates connected with the service.

17. Highfield has been approved by the Nursing and Midwifery Board Ireland (NMBI) as a placement site for candidates who need to undertake a period of clinical assessment and adaptation to enable registration in the Psychiatric Division of the Nursing Register.

Electronic System:

18. A new system of online incident reporting and management was introduced in the approved centre. The Information Technology (IT) reporting system was designed to encourage more timely and responsive actions to treat risk and improve patient safety.

19. The approved centre introduced online medication management with electronic Medication Prescription and Administration Records (MPARs) across the long stay and rehabilitation units (Steele, Domville and Tuke).

20. The British National Formulary (BNF) pharmaceutical reference book was made available online on all units to support good prescribing practices.

21. A new online feedback system was developed in order to capture local issues, complaints and compliments. It facilitates the capturing and recording of service user’s feedback and the local issues being raised.

22. Monthly reports on compliance with the Judgment Support Framework (Mental Health Commission, 2018) are in place and disseminated to teams.

3.0 Overview of the Approved Centre
3.1 Description of approved centre

Highfield Healthcare was an independent care of the elderly and mental health healthcare provider. It provided care to adult and older persons living with mental health issues, Alzheimer’s disease, dementia and challenges of ageing. The original hospital had been established in 1825 by Dr John Eustace, who was from a Quaker family in Cork. The hospital had remained in the Eustace family and was owned and managed by the sixth and seventh generations of the Eustace family. Facilities consisted of Alzheimer’s Care Centre, Elmhurst Nursing Home and the Mental Health Approved Centre. The approved centre was based in a hospital complex which was built in 2012 on grounds on the Swords Road in Dublin.

Highfield Healthcare approved centre was 112 bedded in total. It comprised of Hampstead Clinic, an eleven bedded mixed acute psychiatric unit, Tuke Unit, a twelve bedded mixed Specialist Rehabilitation Unit, Farnham Unit, a 20 bedded high dependency older persons unit, Steele Unit, a 20 bedded female older persons unit, Domville Unit, 20 bedded female increasing dependency older persons unit, and Pinel Unit, a 29 bedded male mixed dependency older persons unit.

The premises was well maintained and furnished with modern and elegant decor. Each unit had access to suitable activities, day rooms and well maintained grounds or rooftop gardens. A coffee shop and chapel were situated within the hospital complex.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>112</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>102</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>7</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>14</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>84</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

Highfield Healthcare was a privately owned independent healthcare service. The approved centre was governed by the Highfield Healthcare Board and the Senior Management Team. The approved centre was governed by the Highfield Healthcare Board and the Senior Management Team. The Senior Management Team includes the Chief Executive Officer, Head of HR, Head of IT, Head of Finance, Quality and Risk Manager, Director of Services, Clinical Director, Director of Nursing, Mental Health, Director of Nursing, Nursing Home Services and Director of Nursing, Alzheimer Care Centre. Numerous sub-committees and groups fed into the Senior Management Team, some of which included the Quality and Risk Committee, Drugs and Therapeutic Committee, Falls Committee, Policy Development Committee, Health and Safety Committee, Safeguarding Committee, Allied Health Professionals Therapeutic Services Group, HR Staffing,
Recruitment and Retention Group, Medical Advisory Committee, Academic and Training group and Bed Occupancy group. The approved centre had numerous clinical care, communication and business meetings which also fed into the above committees and the Senior Management Team. The approved centre’s nursing management structure had been additional resourced and reorganised since last year’s inspection in order to identify clean lines of authority and remit. The responsibility and authority of line managers for the various disciplines were clear. A 2019 – 2022 strategy plan was in place in order to communicate and focus the services goals and objectives.

There were induction programmes for new staff which incorporated corporate and training induction. This process was formally documented. There were formal structures and processes in place for measuring and encouraging staff's performance planning and personal development. At the time of inspection, these processes were under review for further expansion and improvement. The formal arrangements and availability of clinical supervision varied across disciplines and grades. Staff training analysis and plans were completed annually to identify and address training needs. Records indicated that not all health professionals had up-to-date mandatory training. Multiple non-mandatory training courses were available to staff. A leadership programme had been delivered in 2019 for all clinical nurse managers. Management facilitated and supported higher education programmes in specialist mental health to acquire proficient skills.

The Policy Development Committee 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. A computerised audit system was used to complete audits, actions plans and reports; however, not all regulations were found to be audited. The audits completed provided data for improving resident care and outcomes. Clinical audits were mostly undertaken by nursing staff and may benefit from a greater multi-disciplinary approach. There was a definitive audit schedule and consequently the benefits of re-auditing captured. Audit data was analysed to produce monthly and yearly overviews. The results and analysis were reported to the appropriate governance committees. Monthly reports on compliance with the Judgement Support Framework were also produced and disseminated to the relevant teams and governance meetings.

The approved centre’s Chief Executive Officer held overall responsibility for the risk management process. Each unit in the approved centre held a risk register. The Quality and Risk Management Committee monitored and maintained the approved centre’s risk register’s quarterly. Incidents and trends were also discussed at Quality and Risk Management Committee meetings on a monthly basis. The risk register fed into the wider Highfield Healthcare Corporate Risk Register when deemed appropriate. Some of the significant risks identified by the service included staffing levels and staff training.

Highfield used a newly developed online Incident Management System (INCY) to report, rate, manage and monitor incidents. All staff had access to the system and it had user friendly drop down boxes in order to facilitate a safety culture of incident reporting. Staff were provided with training on how to navigate the system by the Quality and Risk Manager. Managers were emailed notifications of any incidents that occurred in their area of responsibility for oversight and possible follow-up. Staff received email notifications when they had been assigned follow-up actions for completion in relation to any incidents. The system monitored opening to closing incident timelines and all incidents were automatically given 72 hours in order to encourage timely responses to manage and treat risk. The 72 hour timeline could be extended by the relevant manager if deemed appropriate.
There is no service user on governance committees within the approved centre at present. However, Highfield endeavours to access the voice of the service user through complaints and compliments. The service utilised an online feedback system to record and manage complaints, compliments and local issues. A patient satisfaction survey was rolled out on one unit of the approved centre, the Hampstead Inpatient Clinic. Service user’s satisfaction with therapeutic services and programmes were captured on therapy specific evaluation forms. The results were disseminated to staff and service users via staff and family newsletters, infographic leaflets and digital communication boards.

3.3 Reporting on the National Clinical Guidelines

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

4.1 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 14: Care of the Dying</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

Five residents met with the inspection team. The residents were very complimentary about the care, the food, the environment, the activities and the staff. One resident commented on how they found the involvement of peer support and recovery workers particularly helpful, as they added another recovery dimension to their care.

No residents, family members or carers completed the service user experience questionnaires.
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:

- Clinical Director
- Director of Nursing
- Therapeutic Services Co-ordinator
- Clinical Nurse Manager III x 3
- Quality and Risk Manager
- Chief Executive Officer
- Consultant Psychiatrist x 2
- Director of Services and Strategic Development
- Senior Social Worker
- Senior Clinical Psychologist
- Senior occupational Therapist

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

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 January 2019. The policy addressed requirements of the Judgement Support Framework, with the exception of the process for identifying residents with the same or similar name.

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

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

Evidence of Implementation: A minimum of two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. Resident identifiers, detailed in clinical files, were checked when staff undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to undertaking the provision of therapeutic services and programmes and two appropriate resident identifiers were used prior to administering medications. The identifiers used were person-specific, and appropriate to the residents’ communication abilities. Appropriate identifiers and alerts were not used for residents with the same or similar names.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 5: Food and Nutrition

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in February 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 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 provided with a variety of wholesome and nutritious food, including portions from different food groups as per the Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. Hot and cold drinks were offered to residents regularly.

In relation to residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in their individual care plans. Special dietary needs were regularly reviewed by a dietitian and an evidence-based nutrition tool was used. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate, specifically in relation to any contraindications with medication. Input and output charts were maintained for residents, where appropriate.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in 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 food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This 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. A food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services and hygiene was maintained to support food safety requirements. Appropriate protective equipment was used during the catering process and there was suitable and sufficient catering equipment. Catering areas and associated catering and food safety equipment were appropriately cleaned and food was prepared in a manner that reduces risk of contamination, spoilage, and infection. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. 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

The registered proprietor shall ensure that:
(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in January 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 interviewed were able to articulate the processes for residents’ clothing, as set out in the policy.

Monitoring: The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. This was documented. No residents were prescribed nightclothes in the approved centre at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Emergency personal clothing was available, appropriate and took into account residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours and residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents’ personal property and possessions, which was last reviewed in February 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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: Secure facilities were provided for the safe-keeping of residents’ monies, valuables, personal property, and possessions, as necessary. The residents were entitled to bring personal possessions with them, the extent of which is agreed at admission and the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. This property checklist was kept distinct from the resident’s individual care plan (ICP). The checklist was updated on an ongoing basis.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by two members of staff, and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of two staff issuing the money were retained. Where possible, this was countersigned by the resident or their representative.

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

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 January 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 interviewed were able to articulate the processes for recreational activities, as set out in the policy.

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and weekends. Residents had access to TV, radio, newspapers, games, movie sessions, hairdressing and nail care sessions, a dog visitor, volunteer music sessions, and a gardening group. Many of the activities were supported and facilitated by volunteers who were managed by a volunteer coordinator. Information was provided to residents in an accessible format, which was appropriate to their individual needs. Copies of activities information were posted on each unit and were available to residents and documented in their information booklets. The information included the types and frequency of appropriate recreational activities available within the approved centre.

Recreational activities programmes were developed, implemented, and maintained for residents, with resident and family involvement, where appropriate. The recreational activities provided by the approved centre were appropriately resourced and opportunities were provided for indoor and outdoor exercise and physical activity. Communal areas were provided that were suitable for recreational activities.

Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. Resident decisions on whether or not to participate in activities were respected and documented and documented records of attendance were retained for recreational activities in group records or within the resident’s clinical file, as 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 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in January 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 interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as is practicable and facilities were provided for residents’ religious practices. Residents had access to multi-faith chaplains and to local religious services for which they were supported to attend, if deemed appropriate following a risk assessment. There was a chaplain in the approved centre four days a week and mass was celebrated twice weekly.

The care and services provided were respectful of the residents’ religious beliefs and values, and any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. The resident was 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 January 2019. The policy and procedures included all of the requirements of the Judgement Support Framework.

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

Monitoring: There were no restrictions on resident’s rights to receive visitors at the time of inspection. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed in the approved centre and were appropriate and reasonable. There were no visiting restrictions in place at the time of inspection. Separate visitors’ rooms or visiting areas were provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting the approved centre were accompanied at all times to ensure their safety and this was communicated to all relevant individuals publicly. Visiting areas were suitable for 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

(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 and procedures in relation to resident communication. The policy was last reviewed in May 2017. The policy and procedures included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents had access to mail, fax, e-mail, Internet, and telephone, unless otherwise risk-assessed with due regard to the residents’ well-being, safety, and health. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and documented in their individual care plans. There were no restrictions on any resident’s communications at the time of inspection.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in May 2017. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

- The management and application of searches of a 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 searching processes, as set out in the policy.

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

Evidence of Implementation: The resident search policy and procedure was communicated to all residents. The file of one resident who had been searched was examined on inspection. A risk assessment had been carried out prior to the search and written consent was sought from the resident and documented. The resident was informed of reasons for the search and there were a minimum of two staff in attendance, with due regard paid to the resident’s dignity, privacy and gender. A written record of the search of the resident was available in their file, 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. A search form was used and countersigned, and the outcome of the search was documented.

There were no environmental searches in the approved centre since the last inspection. When applicable, policy requirements were implemented when illicit substances are found as a result of a search. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 14: Care of the Dying

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

(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

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

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

INSPECTION FINDINGS

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

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

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. There had been no sudden or unexpected deaths in the approved centre since the last inspection. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The death of one resident and the end of life care provided was examined on inspection. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of residents were protected as the approved centre had a dedicated end of life care facility with single rooms for residents. Representatives, family, next of kin, and friends of the resident were involved, supported, and accommodated during end of life care and support was given to other residents and staff following the resident’s death. The resident’s 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

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 August 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: In total, ten ICPs from across the approved centre’s units were reviewed on inspection. The ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, and were identifiable, uninterrupted, and not amalgamated with progress notes.

All ICPs were developed by an MDT following a comprehensive, evidence-based assessment, within seven days of admission. The comprehensive assessment included medical, psychiatric, and psychosocial history, as well as medication history, current medications, a detailed risk assessment, and social, interpersonal, and physical environment-related issues, including resilience and strengths. A current physical health assessment, communication abilities, and educational, occupational, and vocational history were also included in the comprehensive assessment.

Residents’ ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Three ICPs did not sufficiently identify the resident’s assessed needs or appropriate goals: the only assessed need entered in one resident’s ICP was to orientate the resident to a unit and support with the transfer; a second ICP only documented one need, which was to engage resident with psychology; while a third ICP had the need of the resident identified as simply that they had requested psychology.

Two ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Additionally, three individual care plans did not appropriately document the resources required to provide the care and treatment identified. The resources identified in these ICPs was a multi-disciplinary team, which by itself was insufficiently detailed.
A key worker was identified to ensure continuity in the implementation of a resident’s ICP, which included an individual risk management plan and a preliminary discharge plan, where appropriate. The ICPs were reviewed by the MDT in consultation with the resident, weekly in an acute setting and at least every six months for residents in a continuing care facility. The ICPs were updated following review, as indicated by the resident’s changing needs, condition, circumstances, and goals. Residents had access to their ICPs and were kept informed of any changes; however, it was not known for two residents whether they had been offered a copy of their ICPs or whether they had accepted or refused a copy, as this was not documented.

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

- a) Three care plans did not contain appropriate goals for the residents.
- b) Two care plans did not contain applicable care and treatment for the resident.
- c) Three care plans did not appropriately document the resources required, and instead listed, for example, MDT or all staff for person responsible.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to the provision of therapeutic services and programmes. These were: the Therapeutic Services and Programmes Highfield Private Hospital policy, which was last reviewed in November 2017, and; Therapeutic Services and Programmes Hampstead Clinic Services policy, last reviewed in July 2017. The policies included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. They were appropriate and met the needs of the residents. All the therapeutic programmes and services were provided by staff trained in accordance with their care delivery roles. The therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Therapeutic programmes specific to the Hampstead Unit, for example, comprised of art therapy, music therapy, mindfulness exercise, mental health education sessions, an interpersonal skill and relationship group, a medication information group, a discharge planning group, and an emotional regulation group, with individual sessions available.

A list of all therapeutic services and programmes provided in the approved centre was available to all residents. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. These included dietetics, speech and language therapy, and tissue viability nursing.

Therapeutic services and programmes were provided in a separate, dedicated room containing facilities and space for individual and group therapies. A record was maintained of participants, engagement, and outcomes achieved in therapeutic services or programmes within each resident’s clinical file.

COMPLIANT
Quality Rating  Excellent
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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in January 2018. The policy addressed requirements of the Judgement Support Framework, with the exception of the process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.

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

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

Evidence of Implementation: The file relating to the transfer of one resident was examined on inspection. Communication records with the receiving facility were documented, including agreement of resident receipt prior to transfer. Verbal communication and liaison took place between the approved centre and the receiving facility prior to the transfer taking place; this included a discussion of the reasons for transfer, the resident’s care and treatment plan, including needs and risk, and the resident’s accompaniment requirements on transfer.

The resident lacked capacity to consent to the transfer and this was documented and the resident’s next of kin was notified of the transfer. An assessment of the resident was completed prior to transfer, including an individual risk assessment relating to the transfer and the resident’s needs. This was documented and provided to the receiving facility. Full and complete written information for resident was transferred when they moved from approved centre to other facility and information was sent in advance to a named individual. A letter of referral, including a list of current medications, and a resident transfer form was issued as part of the transfer documentation. As an emergency transfer, communications between approved centre and receiving facility were documented and followed up with written referral. Copies of all records relevant to the resident transfer were retained in the resident’s clinical file.

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

(1) The registered proprietor shall ensure that:
(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
(b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
(c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies, which were last reviewed in February 2019. 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 policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

Monitoring: Residents’ take-up of national screening programmes was not 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 trolley and staff had access at all times to an AED, both of which were checked on a weekly basis. Records were available of a medical emergency within the approved centre and the care provided. Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as part of the approved centre’s provision of care and residents received appropriate general health care interventions in line with their individual care plans (ICPs). Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, but not less than every six months. The six-monthly general health assessments included a physical examination, family and personal history, blood pressure, nutritional status, medication review, and dental health, as well as Body Mass Index (BMI), weight, and waist circumference. Smoking status was included on the six-monthly general health assessment form, however this section was not always completed.

The files of five residents who were on anti-psychotic medication, and for whom an annual assessment was required, were examined on inspection. Three of the files examined did not include an annual assessment of the residents’ glucose regulation, while two of the five files were missing assessments of the residents’ blood lipids. Three files examined did not contain prolactin results and one of the five files was missing an electrocardiogram (ECG).

Adequate arrangement were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents’ completed general
health checks and associated results, including records of any clinical testing. Residents could access national screening programmes according to age and gender, including Breast Check, cervical screening, retina checks, and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre and residents had access to smoking-cessation programmes.

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

a) Three of five six-monthly general health assessments were missing an annual assessment of the residents’ fasting glucose and prolactin levels, 19(b).

b) Two of five six-monthly general health assessments were missing an annual assessment of the residents’ blood lipids, 19(b).

c) One of five six-monthly general health assessments was missing an annual electrocardiogram (ECG), 19(B).
Regulation 20: Provision of Information to Residents

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

   (a) details of the resident’s multi-disciplinary team;
   (b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
   (c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
   (d) details of relevant advocacy and voluntary agencies;
   (e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in May 2017. The policy and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to 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 not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with an information brochure 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 brochure 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).

Information was freely available regarding supportive agencies, and times of activities and groups, recreational activities and spiritual events. There were also quarterly newsletters available for staff and a separate one for residents and their families. 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.

Medication information sheets as well as verbal information were provided in a format appropriate to the residents’ needs. The content of medication information sheets included information on indications for
use of all medications to be administered to the residents, including any possible side-effects. Residents had access to interpretation and translation services when needed.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 21: Privacy

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. Not 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 names and the staff’s general demeanour, dress, and the manner in which they communicated with residents was respectful. Staff were discreet when discussing a resident’s condition or treatment needs and staff sought permission before entering a resident’s room. All 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. Rooms were not overlooked by public areas and the windows had opaque glass if they were. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass to protect the privacy and dignity of residents. Where residents shared rooms, bed screening was not sufficient as three of the four-bedded rooms on Farnham Ward did not have privacy screens for the two beds nearest the window in each room. This issue was rectified and privacy screens were applied prior to the completion of inspection. Two Noticeboards displayed resident names and identifiable information. Full names and photographs were displayed in a family tree within three wards. There were no consent forms for most of the photographs. Two consent forms were provided on the final day of inspection, however these did not contain the reason for the sharing of information. Bed screens in older persons units’ doors displayed the residents’ full name and photograph.

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

a) There were no privacy screens in three bedrooms on Farnham Ward.
b) Photographs and full names were on the walls of three wards in the form of a family tree.
c) Full names and photographs were on bedroom doors.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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


**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to its premises, which was last reviewed in April 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 interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

**Monitoring:** The approved centre had completed a hygiene audit. The approved centre had completed a ligature audit using a validated audit tool. Documented analysis had been completed to identify opportunities for improving the premises.

**Evidence of Implementation:** Accommodation for each resident assured their comfort. All bedrooms were appropriately sized to meet residents’ needs. There was a sufficient number of toilets and showers for residents. Communal rooms were of adequate size, and suitable furnishings were provided to support resident independence and comfort.

The approved centre was adequately lit, heated, and ventilated. Appropriate signage and sensory aids were provided to support resident orientation needs and dementia friendly signage was provided in several wards. Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised.

The approved centre was kept in a good state of repair externally and internally, and it was clean, hygienic, and free from offensive odours. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment in place. A record of this programme was maintained. Remote or isolated areas of the approved centre were monitored.
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 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in February 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: The approved centre operated an electronic patient record. Records of ten residents were inspected. An MPAR was maintained for each resident on the system, which detailed two appropriate resident identifiers, a record of any allergies or sensitivities to any medications, including if the resident had no allergies, and the generic name of the medication and preparation, where applicable. Names of medications and preparations were written in full and abbreviations were not used. There was dedicated space for routine, once-off, and “as required” (PRN) medications.

Residents’ MPARs detailed the frequency of administration, including the minimum dose interval for PRN medication, as well as the dose to be given, the administration route for the medication, a record of all medications administered to and refused by the resident, and a clear record of the date of initiation and discontinuation for each medication. Micrograms were written in full and the Medical Council Registration Number (MCRN) or Nursing and Midwifery Board of Ireland (NMBI) number of every medical practitioner prescribing medication to the resident was detailed in the MPARs. The signature of the medical practitioner or nurse prescriber for each entry was also contained in the residents’ MPARs.

All MPAR entries were entered electronically were therefore legible. Medication was reviewed and rewritten at least six-monthly, or more frequently where there is a significant change in the resident’s care or condition. A prescription was not altered where a change was required, and the electronic system documented changes appropriately. All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner.
Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the residents’ pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration and good hand-hygiene techniques were implemented during the dispensing of medications. When a resident’s medication was withheld or the resident refused medication, the justification and reasons were noted in the MPAR, documented in the clinical file and communicated to medical staff. Schedule 2 controlled drugs were checked by two staff members, one of which was a registered nurse, against the delivery form and details were entered on the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book and, following administration, the details were entered in the controlled drug book and signed by both staff members.

Direction to crush medication was only accepted from the residents’ medical practitioner, who provided a documented reason why the medication was to be crushed. The pharmacist was consulted about the type of preparation to be used and the medical practitioner documented in the MPAR that the medication was to be crushed. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist, and where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were clean and free from damp, mould, clean, litter, dust, pests, and spillage or breakage. Medication storage areas were incorporated in the cleaning and housekeeping schedules and food and drink was not stored in areas used for the storage of medication.

Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication trolley and medication administration cupboard remained locked at all times and secured in a locked room. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

A system of stock rotation was implemented, to avoid accumulation of old stock and an inventory of medications was conducted on a monthly basis, which checked the name and dose, quantity, and expiry date 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 returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 24: Health and Safety

(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 four written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. These were: the Safety Management System, dated April 2019; the Fire Safety Management policy, dated April 2019; the Manual of Infection Prevention and Control policy, dated February 2016, and; the Falls policy, dated September 2018. Together, the policies included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to its staffing requirements. The policy was last reviewed in August 2017. The policy/policies and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

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

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

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

Evidence of Implementation: The numbers and skill mix of staffing were sufficient to meet resident needs. There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff, as well as a planned and actual staff rota, showing the staff on duty at any one time during the day and night. All staff were recruited, selected and vetted in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment, and information from referees was sought and documented. Staff had the appropriate qualifications to do their job and an appropriately qualified staff member was documented to be on duty and in charge at all times.

There was a written staffing plan for the approved centre which addressed the skill mix, competencies, number and qualifications of staff. It also took into consideration the assessed needs of the resident group profile of the approved centre through the level of acuity of psychiatric illness, the physical care needs of residents, any challenging behaviour exhibited by residents, and the number of beds available. However,
it did not take the size and layout of the approved centre, or the age profile of residents, their length of stay and level of dependency or need for supervision, into consideration in the staffing plan. There were the required number of staff on duty at night to ensure safety of residents in the event of a fire or other emergency.

Where agency staff were used, there was a comprehensive contract between the approved centre and registered staffing agency used that set out the agency’s responsibilities in relation to the vetting of staff, professional indemnity, arrangements for responding to concerns, and the confirmation of identity, registration of status, and staff training.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training were also completed for staff. Not all health care professionals were trained in Basic Life Support, Fire Safety, the Professional Management of Aggression and Violence, Children First, or the Mental Health Act, 2001. Not all staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. Staff had been trained in manual handling, dementia care, end of life care, residents’ rights, incident reporting, risk management, and care for residents with intellectual disabilities. In addition, staff were trained in infection control and prevention, including sharps, and hand hygiene techniques, as well as recovery-centred approaches to mental health care and treatment, and protection of children and vulnerable adults. All staff training was documented and training logs were maintained.

Opportunities were made available to staff by the approved centre for further education, with these opportunities effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was completed by appropriately trained and competent individuals, and facilities and equipment were available for staff in-service education and training. 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.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (65)</td>
<td>51</td>
<td>78%</td>
<td>48</td>
<td>74%</td>
<td>54</td>
</tr>
<tr>
<td>Consultant Psychiatrist (5)</td>
<td>5</td>
<td>100%</td>
<td>3</td>
<td>60%</td>
<td>4</td>
</tr>
<tr>
<td>Medical (3)</td>
<td>2</td>
<td>67%</td>
<td>1</td>
<td>34%</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist (4)</td>
<td>4</td>
<td>100%</td>
<td>3</td>
<td>75%</td>
<td>3</td>
</tr>
<tr>
<td>Social Worker (2)</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist (3)</td>
<td>1</td>
<td>34%</td>
<td>2</td>
<td>67%</td>
<td>2</td>
</tr>
<tr>
<td>Health Care Assistants (55)</td>
<td>36</td>
<td>65%</td>
<td>39</td>
<td>71%</td>
<td>37</td>
</tr>
</tbody>
</table>
### Table of Clinical Staff Assigned to the Approved Centre

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hampstead Clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM III</td>
<td>1 (shared with Day Hospital)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM II</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Pinel Unit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM II</td>
<td>1 (shared with Farnham)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td><strong>Tuke Unit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM III</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM II</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Recovery Support Worker</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Peer Support Worker</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
The approved centre was non-compliant with this regulation for the following reasons:

a) Not all staff had up-to-date training in Basic Life Support, Fire Safety, the Professional Management of Aggression and Violence, or Children First, 26(4).

b) Not all staff had up-to-date training in the Mental Health Act, 2001, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in April 2017. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation and content.
- Those authorised to access and make entries in residents’ records.
- Record retention periods.
- The destruction of records.

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

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

Evidence of Implementation: While resident records were in good order and used in accordance with national guidelines and legislative requirements, not all were secure. A cupboard in the nurses’ station of Farnham Ward containing residents’ old drug Kardexes, medication check, and the ward’s incontinence folder, was found unlocked during the inspection; no nurses were present at the station and residents’ visitors were on the unit. A search log was located on a desk, outside of a secure cupboard on Pinel Ward.

A record was initiated for every resident assessed or provided with care services by the approved centre. Records were stored in both online and paper formats, which impeded ease of retrieval, specifically in terms of documentation relating to mechanical restraint and resident transfer. All resident records were reflective of the residents’ current status and the care and treatment being provided. Resident records were also maintained using an identifier that was unique to the resident and were in a logical sequence...
and in good order. The aforementioned issue regarding the secure storage of files meant that resident records were not only accessible by authorised staff and therefore resident’s access to their records was not managed in accordance with Data Protection Acts.

Only authorised staff could make entries in residents’ records, or specific sections therein. Records were maintained appropriately and were written legibly in black, indelible ink. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Each entry included the date, noted the time using a 24-hour clock and were followed by a signature. The approved centre also maintained a record of all signatures used in the resident record. All entries made by student nurses or clinical training staff were countersigned by a registered nurse or clinical supervisor. Two appropriate resident identifiers were recorded on all documentation and where a member of staff makes a referral to or consults with another member of the health care team, this person was clearly identified by their full name and title.

Where information or advice was given over the phone, this was documented as such by the member of staff who took the call and the person giving the information or advice was clearly identified. Records were not appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was and records were retained or destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

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

- a) Records were stored in both online and paper formats, which impeded ease of retrieval, 27(1).
- b) Potentially sensitive documentation relating to residents on Pinel and Farnham Wards was not stored in a secure location, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, dated July 2017. It addressed requirements of the Judgement Support Framework, with the exception of the process for making obsolete and retaining previous versions of operating policies and procedures.

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 time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. The operating policies and procedures required by the regulations were reviewed within the required three-year time frame. The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice and clinical guidelines. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff.

The format of policies was standardised and included the title, reference number and revision of the policy and procedure, the document owner, approvers, and reviewers. They also included the scope of the policy and procedures and the date which the policy was effective from. However, not all policies and procedures included a review date or list the total number of pages in the policy.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in May 2019. 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 attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in March 2019. 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 not been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make complaints verbally, in written form, by email or telephone, as well as through complaint, feedback, or suggestion forms. The registered proprietor ensured access, insofar as was practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process.

The approved centre’s management of the complaints process was well publicised and accessible to residents and their representatives. This included the provision of information about the complaints procedure to residents and their representatives at admission or soon thereafter. The complaints
procedure, including how to contact the nominated person, was publicly displayed and residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. A method for addressing minor complaints within the approved centre was provided and minor complaints were documented on an electronic system. At the time of inspection no minor complaints needed to be addressed by the complaints officer. The electronic system for complaints ensured that the complaints officer was made aware of any and all minor complaints. All complaints that were not minor were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s Individual Care Plan. 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.

Time frames were provided for responding to the complainant following its initial receipt, the investigation period for complaints and the required resolution of complaints. Where time frames were not achieved or further investigation time was required in relation to the complaint, this was communicated to the complainant. Complainants were informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them and documented, and complainants’ satisfaction, or dissatisfaction, with the investigation findings was documented. Where services, care, or treatment were provided on behalf of the approved centre by an external party, the nominated person was responsible for the full implementation of the approved centre’s complaints management process, including the investigation process and communication requirements with the complainant. All information obtained through the course of the management of the complaint and the associated investigation process is treated in a confidential manner and meets the requirements of the relevant data protection acts.

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

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

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

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

INSPECTION FINDINGS

Processes:
The approved centre had sixteen written policies in relation to risk management and incident management procedures. These were: the Organisational and Risk Management Strategy policy, last reviewed in March 2018; the Incident Reporting policy, dated April 2018; the Individual Safety Planning procedures, dated September 2019; the Major Emergency Plan, dated April 2017; the Unexplained Absence of a Resident (Missing Person) policy, dated April 2017; the policy on Preventing and Managing a Patient’s Absence Without Leave (Hampstead Clinic’s and Tuke Rehab Unit’s), dated October 2018; the Responding to Sudden Deaths policy, dated May 2018; the Sudden Death policy, dated September 2019; Pharmacological Prevention and Management of Aggression or Violent Behaviour policy, dated April 2019; the Locked Door policy, dated September 2019; Policy and Procedures for Safeguarding of Vulnerable Adults, dated July 2018; the Child Protection and Welfare policy, dated July 2018; the Responsive Behaviours policy, dated May 2019; the Challenging Behaviours policy, dated May 2019; the Conducting Critical Incident Reviews policy, dated December 2017 and EHS Safety Management System policy, dated April 2019.

The policies together 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 responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.
Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the risk management processes, as set out in the policies. All training was documented.

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

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

Clinical risks, corporate risks, and health and safety risks were identified, assessed, treated, monitored, and recorded in the risk register. Individual risk assessments were completed at admission, before and during episodes of physical and mechanical restraint, as well as at resident transfer, discharge, and in conjunction with medication requirements or administration, with the aim of identifying individual risk factors. Residents and/or their representatives were involved in individual risk management processes.

Structural risks, including ligature points, were effectively mitigated in the admission unit and in other units through risk assessments of the residents. 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. Clinical incidents were reviewed by the MDT at their regular meeting. A record was maintained of this review and recommended actions. There was an emergency plan that specified responses by the approved centre staff in relation to possible emergencies, and which incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.
Regulation 34: Certificate of Registration

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently at the entrance to each unit of the approved centre.

The approved centre was compliant with this regulation.
EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 69: The Use of Mechanical Restraint

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

INSPECTION FINDINGS

Evidence of Implementation: The clinical files of two residents who had been mechanically restrained were inspected. In both cases, mechanical restraint was only used when the residents posed an enduring risk of harm to themselves or to others or to address a clinical need, and it was only used when less restrictive alternatives were not suitable. Mechanical restraint was ordered by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the resident or the duty consultant psychiatrist acting on their behalf.

Each clinical file contained a contemporaneous record that specified that there was an enduring risk of harm to self or to others and that less restrictive alternatives were implemented without success. It also specified the type of mechanical restraint used, the situation where mechanical restraint was being applied, the duration of the restraint and order, and the review date.

The approved centre was compliant with this rule.
9.0 Inspection Findings – Mental Health Act 2001

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

56.- In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where –
   a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either–
   a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   b) where the patient is unable to give such consent –
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –
   a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

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

INSPECTION FINDINGS

The clinical files of seven patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In each case there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment.

In three cases, the patient was unable to consent to the continued receipt of medication and a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed in each of these cases. All of these forms contained the name of the medications being prescribed, the nature and purpose of the medication, any views expressed by the patient in regards to the medication and any supports provided to the patient in relation to these discussions. In all three cases, authorisation by a second consultant psychiatrist was documented as required.

In four cases, the patient had capacity to consent to medication. There was a written record of consent in each of these four cases, which included the name of the medications prescribed and a confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications. There was also documented details of a discussion with the resident that included the nature and purpose of the medications, the effects of medications, including risks and benefits and any views
expressed by the patient, and of any supports provided to the patient in relation to the discussion and their decision-making.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually; and it was last reviewed in January 2019. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restrain

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

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

Evidence of Implementation: Physical restraint was used in rare and exceptional circumstances within the approved centre and in these cases only after all alternative interventions to manage the residents' unsafe behaviour had been considered. Any use of physical restraint was based upon risk assessment and cultural awareness and gender sensitivity were demonstrated at all times.

Two cases of physical restraint were reviewed as part of the inspection process. In both cases, the physical restraint was initiated by a registered nurse or registered medical practitioner. A designated staff member was responsible for leading the physical restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and the registered medical practitioner completed a medical examination of the resident (physical examination) no later than three hours after the start of the episode of restraint. Each episode of physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A Clinical Practice Form was completed by the staff member initiating and ordering physical restraint within the required 3 hour timeframe; this form was signed by the consultant psychiatrist within 24 hours. A copy of the clinical practice form was placed in each of the files as required.

In all three episodes of physical restraint, the resident was informed of the reasons for, likely duration of and circumstances that would lead to the discontinuation of physical restraint. Both episodes of physical restraint were reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after each episode. All residents discussed the episode of restraint with members of their MDT as soon as was practicable.

The approved centre was compliant with this code of practice.
**Admission, Transfer and Discharge**

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a policy in relation to admission, transfer, and discharge.

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

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

**Discharge:** The discharge policy, which was last reviewed in January 2018, included all of the policy-related criteria for this code of practice.

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

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

**Evidence of Implementation:**

**Admission:** A key worker system was in place within the approved centre. The clinical file of two residents were inspected in relation to the admission process, with both admissions on the basis of a mental health illness or mental disorder. In each case an assessment was completed, which included the presenting problem, past psychiatric history, family and medical history, current and historic medication, current mental health state, and a risk assessment. The assessment also included social and housing circumstances, and a full physical examination, as well as any other relevant information. The residents’ family, carer or advocate were involved in the admission process, with the residents’ consent.

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

**Discharge:** The file of one resident who was discharged was inspected. The discharge was co-ordinated by a key worker. A discharge plan was in place as part of the individual care plan. All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team, and the resident’s family. A comprehensive pre-discharge assessment was completed, which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, and a comprehensive risk assessment and risk management plan.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to the general practitioner, primary care or community mental health team within three days. A comprehensive discharge summary was issued within 14 days, and the discharge summaries included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or
social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse. A timely follow up appointment with the resident following discharge was documented.

The approved centre was compliant with this code of practice.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 15: Individual Care Plan

| Reason ID : 10000835 | Three care plans did not contain appropriate goals for the residents, two care plans did not contain applicable care and treatment for the resident, and three care plans did not appropriately document the resources required and instead listed, for example, 'MDT' or 'all staff' for person responsible. |

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>All units have been audited since the last inspection. Corrective action plans have been put in place.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Online audit system captures all areas of non-compliance and monthly report issued to CNM's and MDT's which identifies areas for improvement.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Realistic. The importance of good documentation emphasised.</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Time-bound</td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Care planning refresher training sessions and tutorials have taken place at unit level and will be ongoing. Further training with CNM's to be arranged.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>Quarterly audits.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Yes, training will help staff understand the importance of documenting the person centred care delivered.</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Time-bound</td>
<td>Director of Nursing / CNM3</td>
</tr>
</tbody>
</table>
**Regulation 19: General Health**

**Reason ID : 10000830**

Three of five six-monthly general health assessments were missing an annual assessment of the residents' fasting glucose and prolactin levels, two of five six-monthly general health assessments were missing an annual assessment of the residents' blood lipids, and one of five six-monthly general health assessments was missing an annual electrocardiogram (ECG), 19(B).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>An audit of six monthly general health assessments will be completed to identify any items missing including annual assessments due.</td>
<td>Audit report</td>
<td>Realistic</td>
<td>29/02/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>The six monthly health assessments form is being moved onto the electronic patient record and this will be trialled. We are also aiming for ECG's and bloods to be carried out in advance of the six monthly assessment.</td>
<td>Review documentation, audit.</td>
<td>Realistic</td>
<td>01/04/2020</td>
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<tr>
<td>Regulation 21: Privacy</td>
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<td></td>
</tr>
<tr>
<td>Reason ID : 10000838</td>
<td>There was no privacy screens in three bedrooms on Farnham Ward</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><img src="https://via.placeholder.com/150" alt="Table" /></td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>The order for privacy screens was received while the inspection was still ongoing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation</td>
<td>Complete.</td>
<td>16/08/2019</td>
<td>Purchasing Manager</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Care staff to use the privacy screens in place for personal care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation</td>
<td>Achievable.</td>
<td>01/01/2020</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Reason ID : 10000839</td>
<td>Photographs and full names were on the walls of three wards in the form of a family tree, and full names and photographs were on bedroom doors.</td>
<td></td>
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<tr>
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<td><img src="https://via.placeholder.com/150" alt="Table" /></td>
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<tr>
<td><strong>Corrective Action</strong></td>
<td>The photos have been removed and full names replaced with first names only.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Observation and audit</td>
<td>Realistic.</td>
<td>31/08/2019</td>
<td>CNM3</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Staff reminded of the importance of maintaining resident privacy. Staff GDPR awareness session arranged for February.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation, training records.</td>
<td>Realistic.</td>
<td>29/02/2020</td>
<td>Director of Nursing.</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

Not all staff had up-to-date training in Basic Life Support, Fire Safety, the Professional Management of Aggression and Violence and Children's First, 26(4), and not all staff had up-to-date training in the Mental Health Act 2001, 26(5).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any staff members requiring training have been identified. Department managers have been contacted and relevant staff informed. The monthly mandatory training programme is ongoing and we are increasing the number of sessions for certain courses to accommodate those out of date. New staff asked to complete online training in advance of starting.</td>
<td>Monthly report</td>
<td>This is realistic but it may be difficult to provide enough training sessions to cover those outstanding and to release staff off rosters.</td>
<td>01/02/2020</td>
<td>Head of HR</td>
</tr>
<tr>
<td>A monthly report will be issued from HR to management for ongoing monitoring and review. Completion of mandatory training will comprise part of staff's performance appraisals. A training monitoring team will be set up to review attendance on a quarterly basis and identify additional actions required. Review timetable against rosters to ensure training is provided when the maximum number of staff are available to attend.</td>
<td>Monthly report</td>
<td>Due to staff turnover, ensuring full completion of mandatory training will remain an ongoing challenge for the service.</td>
<td>30/06/2020</td>
<td>Director of Nursing</td>
</tr>
</tbody>
</table>
### Regulation 27: Maintenance of Records

#### Reason ID: 10000841
Records were stored in both online and paper formats, which impeded ease of retrieval, 27(1).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong> Project plan being put in place to ensure every</td>
<td>Project plan with agreed timelines to be put in place.</td>
<td>Yes. Ongoing phased</td>
<td>30/06/2020</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>patient record is maintained in one place with a focus on completing a</td>
<td></td>
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<tr>
<td>first phase around scanning pre admission records.</td>
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<tr>
<td><strong>Preventative Action</strong> A phased approach to is being adopted to move</td>
<td>Project plan with clear tasks and timelines being agreed which will be</td>
<td>Training of new and</td>
<td>30/06/2020</td>
<td>Head of IT</td>
</tr>
<tr>
<td>patient records onto the online patient system with phase one focusing</td>
<td>measurable.</td>
<td>existing staff will</td>
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<tr>
<td>on the pre admission process of scanning documentation.</td>
<td></td>
<td>be important. Phase</td>
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<td></td>
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<td>one is due to be</td>
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<td>completed by mid</td>
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<td></td>
<td>year and phase two</td>
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<td></td>
<td></td>
<td>will likely be a</td>
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<td></td>
<td></td>
<td>longer project.</td>
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</tr>
</tbody>
</table>

#### Reason ID: 10000842 Potentially sensitive documentation relating to reisdents on Pinel and Farham wards was not stored in a secure place, 27 (1)

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong> Information is in locked presses and CNM2's have</td>
<td>Observation, spotcheck.</td>
<td>Realistic</td>
<td>31/08/2019</td>
<td>CNM2's</td>
</tr>
<tr>
<td>oversight of same.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Action</strong> CNM2’s to remind all staff to keep presses</td>
<td>Observation, spotcheck.</td>
<td>Realistic.</td>
<td>30/04/2020</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>locked. GDPR awareness session being held for staff in February.</td>
<td>Records audit.</td>
<td></td>
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</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

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

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

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

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

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

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