Sligo/Leitrim Mental Health In-patient Unit

ID Number: AC0014

2019 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
- Acute Adult Mental Health Care
- Psychiatry of Later Life
- Mental Health Rehabilitation
- Mental Health Care for People with Intellectual Disability

Most Recent Registration Date: 1 March 2017

Registered Proprietor: HSE

Registered Proprietor Nominee:
Ms Teresa Dykes, General Manager, Mental Health CHO1

Inspection Team:
- Sarah Moynihan, Lead Inspector
- Marianne Griffiths
- Noeleen Byrne
- Dr Enda Dooley, MCRN004155

Inspection Date: 2 – 5 April 2019

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 9 – 12 October 2018

Date of Publication: Tuesday 17 December 2019

2019 COMPLIANCE RATINGS

REGULATIONS
- Compliant: 21
- Non-compliant: 9
- Not applicable: 1

RULES AND PART 4 OF THE MENTAL HEALTH
- Compliant: 1
- Non-compliant: 2
- Not applicable: 1

CODES OF PRACTICE
- Compliant: 1
- Non-compliant: 2
- Not applicable: 1

Conditions Attached: Yes

Sligo/Leitrim Mental Health Services
Clarion Road
Ballytivnan
Sligo

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The approved centre was a 32-bed acute adult mental health admission unit, located in Ballytivnan, on the outskirts of Sligo. The building dated from the 1930s and was unsuitable for providing a modern mental health service. Building has commenced for the development of a new approved centre on the campus of Sligo University Hospital.

The approved centre was registered for 32 beds and was divided into a 14-bedded female, 14-bedded male and a 4-bedded high-dependency ward. At the time of inspection, there were 17 residents in the 14-bedded female admission ward. Two interview rooms and a multi-purpose (team meeting/activities) room had been used as bedrooms to accommodate the extra female residents. The seclusion room was used as a bedroom at the time of inspection. Although registered to provide mental health services for people with intellectual disability, the approved centre was not suitable for this function.

Compliance with regulations, rules and codes of practice decreased significantly from 79% in 2018 to 66% in 2019. As compliance was 63% in 2017, there has been no overall improvement in three years. Five areas had been non-compliant for three consecutive years, all risk-rated as high. There were two conditions attached to the registration of the approved centre. Seven compliances with regulations were rated excellent.

Conditions to registration

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

**Condition 1:** To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Finding on this inspection:** The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

**Condition 2:** To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date with mandatory training.
areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 2 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Safety in the approved centre

- A programme to minimise ligatures to the lowest possible level was ongoing.
- Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations.

However:

- At the time of the inspection, the occupational therapy kitchen was dirty.
- There were errors in the medication prescription and administration records (MPARs).
- Not all health care staff were trained in fire safety, Basic Life Support, management of violence and aggression, The Mental Health Act 2001, and Children First.
- Clinical files were poorly maintained, so much so that it posed a risk to patient safety:
  - Five out of seven clinical files inspected had loose pages.
  - One entry in the residents’ records within clinical notes was illegible which meant it was not possible to tell if the clinical notes were accurate.
  - Records were not in a logical order.
  - Resident records were not reflective of the residents’ status at the time of inspection and the care and treatment being provided.
  - Not all resident records were maintained using an identifier, which was unique to the resident.
  - Not all residents’ records included the date and time for each entry.
- Risks were not assessed, rated, recorded, and reported within the approved centre and were not subject to on-going monitoring, as per the service’s Incident Management Reporting Policy.
- The approved centre did not have an evacuation plan in place as per the services Incident Management Reporting Policy.

Appropriate care and treatment of residents

- Each resident had an individual care plan (ICP). All ICPs had allocated spaces for goals, treatment, care, and resources required. The resident’s multi-disciplinary team (MDT) regularly reviewed and updated ICPs in consultation with each resident. Residents had access to their ICPs, and were kept informed of any changes.
- Therapeutic services and programmes provided by the approved centre were extensive, evidence-based, reflective of good practice guidelines, and met the assessed needs of the residents. Occupational therapy staff had the main responsibility for the therapeutic timetable. Social work and
psychology staff from the community were available to meet with residents of the approved centre on a one to one basis as required but they did not run groups.

- Therapeutic services and programmes were provided in separate dedicated rooms, and each ward had facilities to carry out group programmes or one to one sessions.

However:

- All clinical files inspected showed that these residents had received a six-monthly general health assessment but the assessment itself was not adequately completed. The six-monthly general health assessment records evidenced the following discrepancies on inspection:
  - Residents’ Body Mass Index, weight, and waist circumference was not checked and recorded.
  - Smoking status was not documented in three cases.
  - Nutritional status, including diet and physical activity, was not documented.
  - Dental health assessments were not documented.
  - Medication review, as per prescriber guidelines, was not documented.

- Although residents on antipsychotic medication received an annual electrocardiogram (ECG), residents’ glucose regulation, blood lipids, and prolactin levels were not consistently documented despite the requirement for these checks to take place annually.

Respect for residents’ privacy, dignity and autonomy

- Where a resident had been searched, consent was sought and documented. The resident was informed of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted, with at least one being the same gender as the resident being searched. A written record of every search of a resident was maintained.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- The approved centre was adequately heated and ventilated. There was a cleaning schedule implemented and the approved centre was clean, hygienic, and free from offensive odours.
- There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe a resident were incapable of recording or storing a resident’s image and were used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident.

However:

- The seclusion room was being used as a bedroom at the time of inspection.
- The light fittings in single bedrooms and in one dormitory were positioned on the outside of the door and there was no bedside lighting. The wardrobes did not have doors, which was not conducive to resident privacy and dignity.
- The interview rooms on the female ward had observation panels without a screen or curtain. These two interview rooms had regularly been used as bedrooms.
- Female residents were inappropriately accompanied to the high dependency ward and seclusion room through the male admission ward.
• Residents did not have access to adequate personal space. The six-bedded dormitory on the male ward was cramped and there was not enough personal space to move about freely.
• Appropriate signage and sensory aids were not provided to support resident orientation needs.
• The approved centre was not kept in a good state of repair inside and outside. The premises were not maintained in good structural condition.
• The approved centre did not have a dedicated therapy and examination room. On the first day of the inspection, interview rooms where assessments were undertaken and where medical staff had resident meetings, were used as bedrooms.

Responsiveness to residents’ needs

• The approved centre’s menus were approved monthly by a dietitian to ensure nutritional adequacy in accordance with the residents’ needs. Residents were provided with a variety of wholesome and nutritious food. Residents had at least two choices for meals.
• Healthcare professionals facilitated activities on weekdays and during every second weekend. Daily activities, which ran Monday to Friday, included board games, table tennis, relaxation, and discussion groups.
• Written information was provided about the approved centre, and residents’ diagnoses and medication.
• There was a robust complaints procedure in place.

However:
• Opportunities were not provided to residents for indoor and outdoor exercise and physical activity. The exercise bike and rowing machine on the male ward were broken at the time of the inspection. There was no exercise equipment on the female ward.
• There was no enclosed outdoor space. Accompanied walks were staff dependent, and rarely took place.

Governance of the approved centre

• Sligo/Leitrim Mental Health In-patient Unit was part of the Donegal, Sligo, Leitrim, Cavan, Monaghan Community Healthcare Organisation and was governed by the Sligo/Leitrim Mental Health Services (SLMHS) Area Mental Health Management Team (AMHMT). Numerous sub-committees fed into the SLMHS Area Mental Health Management Team.
• A multi-disciplinary approach was fostered within governance structures and clinical care. The various committees’ purpose, structures, responsibilities and reporting relationships were well defined. The remit and authority of line managers for the various disciplines was clear.
• Multiple non-mandatory training courses were also available to staff and management supported and facilitated higher education programmes.
• The Policy, Procedure, Protocol and Guideline Group provided a multi-disciplinary approach to policy development, review, approval and dissemination.
• Relevant internal and external audit findings were formally discussed at the SLMHS Quality and Patient Safety Risk Committee meeting.

• The approved centre’s registered proprietor held overall responsibility for the risk management procedures. The SLMHS Quality, Safety and Risk Committee monitored and maintained the Sligo/Leitrim service wide risk register. Service wide adverse incidents and trends were discussed at the Quality, Safety and Risk Committee meeting, which were held quarterly. The Sligo / Leitrim service wide risk register fed into the wider Donegal, Sligo, Leitrim, Cavan, Monaghan Community Healthcare Organisation risk register.

• The Area Lead for Mental Health Engagement was a member of the Donegal, Sligo, Leitrim, Cavan, Monaghan Community Healthcare Organisation management team. Service user representatives sat on the SLMHS Area Mental Health Management Team. Service user views was sought through a website forum “Care Opinion”, “Comment, Compliment or Compliant” forms and community meetings situated in the approved centre and the Sligo/Leitrim local service user forum.

However:

• Although there was an induction programme for new staff, not all disciplines documented the induction process formally.

• Not all disciplines had formal structures and processes in place for measuring and encouraging staff’s performance planning and personal development. The availability of clinical supervision varied across disciplines.

• Annual staff training plans were completed to identify required training; however, records indicated not all healthcare professionals had up-to-date mandatory training.

• Not all audits captured enough information to improve patient care and outcomes. There was no definitive audit schedule and therefore the benefits of re-auditing was at risk of being lost. Clinical audits had been primarily undertaken by nursing management, and there was limited evidence that other healthcare professionals had completed audits.

• The monitoring, maintenance, and governance process for the approved centre risk registers was unclear. Risks identified in the approved centre risk registers did not always identify risk owners, risk coordinators or risks ratings.
2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had recently started This is my Care Plan Group. This group informed residents of the care plan process and encouraged them to take ownership of their care plan.

2. ReSTRAIN Yourself Group promoted alternative tools, staff training, consumer involvement, data analysis and post event debriefing in an effort to reduce the use of seclusion and physical restraint. As part of this group, seclusion and physical restraint training commenced in March 2019.

3. Sligo Service User Forum held workshops on services user and carers’ experiences of the approved centre. Relevant information from these workshops fed into Senior Management meetings.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the Clarion Road, Ballytivnan, on the outskirts of Sligo town. The building dated from the 1930s and was situated on its own grounds, next to the former psychiatric hospital. Building has commenced for the development of a new approved centre on the campus of Sligo University Hospital.

The approved centre was a two-story building. Residents were accommodated on the ground floor and a training room, therapy rooms, and offices, were on the first floor. The approved centre was divided into a 14-bedded female, 14-bedded male and a 4-bedded high-dependency ward. The high-dependency ward was off the male ward and had the flexibility of transforming into a two-bedded ward. The surplus two beds from the high-dependency ward could be distributed into the 14-bedded male admission ward, increasing its bed capacity to 16. Bedrooms and corridors on the ground floor had high ceilings, heavy doors and minimal décor and furnishings, which made the approved centre, appear stark and void of comfort.

At the time of inspection, there were 17 residents in the 14-bedded female admission ward. Two interview rooms and a multi-purpose (team meeting/activities) room had been used as bedrooms to accommodate the surplus female residents. There were 12 residents in the 14-bedded male admission ward and 1 male in the 4-bedded high dependency ward.

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>32</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>29</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>6</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>1</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>5</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

Sligo / Leitrim Mental Health In-patient Unit was part of the Sligo / Leitrim Mental Health Services (SLMHS) and the wider Donegal, Sligo, Leitrim, Cavan, Monaghan Community Healthcare Services (Area 1). The approved centre was governed by the Sligo / Leitrim Mental Health Services (SLMHS) Area Mental Health Management Team (AMHMT) which reported to the Head of Service. Numerous sub-committees fed into the SLMHS Area Mental Health Management Team and included: the Ligature Reduction Committee; Policy, Procedure, Protocol and Guideline Group; Nurse Manger Group; Restrain Yourself Group; Drug and Therapeutics Committee; Quality, Safety and Risk Committee; SLMHS Occupational Health and Safety Group;
Finance Committee; and the Consultant Group. A multi-disciplinary approach was fostered within governance structures and clinical care. The various committees’ purpose, structures, responsibilities and reporting relationships were well defined. The remit and authority of line managers for the various disciplines was apparent; however, the service voiced the interconnecting governance structures between disciplines was not always clear.

There was an induction programme for new staff; however, not all disciplines documented the induction process formally. Not all disciplines had formal structures and processes in place for measuring and encouraging staff’s performance planning and personal development. The availability of clinical supervision varied across disciplines. Annual staff training plans were completed to identify required training; however, records indicated not all healthcare professionals had up-to-date mandatory training. Reportedly, the main barrier for healthcare professionals not achieving the required mandatory training was the prioritisation of clinical demand over training attendance. Multiple non-mandatory training courses were also available to staff, and management supported and facilitated higher education programmes.

The Policy, Procedure, Protocol and Guideline Group provided a multi-disciplinary approach to policy development, review, approval and dissemination. The service used a Policy Portal database to facilitate policy access and dissemination. There was a developing trend of implementing quality improvement audit tools to monitor and evaluate standards of care. The legitimacy of the audit tools and frequency of audit cycles varied. Not all audits captured enough information to improve patient care and outcomes. There was an audit schedule and, therefore, the benefit of re-auditing was captured. Clinical audits were primarily undertaken by nursing although there was evidence of other healthcare professionals input. Relevant internal and external audit findings were formally discussed at the SLMHS Quality and Patient Safety Risk Committee.

The approved centre’s registered proprietor held overall responsibility for the risk management procedures. The SLMHS Quality, Safety and Risk Committee monitored and maintained the Sligo/Leitrim service wide risk register. Service wide adverse incidents were noted at the Quality, Safety and Risk Committee meetings, which were held quarterly. The Sligo/Leitrim service wide risk register fed into the wider Donegal, Sligo, Leitrim, Cavan, Monaghan Community Healthcare Organisation risk register when deemed appropriate. There was no approved centre risk register however there were a suite of risk assessments on each unit.

Risks identified on the approved centre risk assessments did not always identify risk owners, risk coordinators or risks ratings. The monitoring, maintenance, escalation and governance process for the approved centre suite of risk assessments on each unit was unclear. Approved centre risks were not always appropriately reported, assessed, treated, monitored and documented on the risk register. There were plans for the development of a multi-disciplinary Business Management Group. It is purposed this group would develop an approved centre risk register and would monitor, maintain and govern the risk register. The approved centre risk register would feed into the Sligo/Leitrim service wide risk register, when appropriate. The estimated timeframe for formulating the Business Management Group and the initiation of one approved centre risk register was scheduled for quarter two of 2019.

The Area Lead for Mental Health Engagement was a member of the Donegal, Sligo, Leitrim, Cavan, Monaghan Community Healthcare Organisation management team. Service user representatives sat on the SLMHS Area Mental Health Management Team. The voice of the service user was sought by the SLMHS Area.
Mental Health Management Team and the Area Lead for Mental Health Engagement Officer through numerous forums, such as: Care Opinion, a website forum; Comment, Compliment or Compliant forms; community meetings situated in the approved centre; and the Sligo/Leitrim local service user forum, held in the community where discussions included the Sligo/Leitrim Mental Health In-patient Unit.

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 6: Food Safety</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>✓</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing &amp; Administration of Medicines</td>
<td>X Moderate</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X Moderate</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>X High</td>
<td>X Critical</td>
<td>X High</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X High</td>
<td>✓</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Code of Practice on the use of Physical Restraint in Approved Centres</td>
<td>X Moderate</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer, and Discharge to and from an Approved Centre</td>
<td>X Moderate</td>
<td>✓</td>
<td>X Low</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
</tr>
</tbody>
</table>
### 4.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As no involuntary patient had received ECT since the last inspection, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice 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>
</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.

Three residents spoke with the inspection team over the course of the inspection. Overall, they were complimentary about the staff, were satisfied with the quality of care provided, and felt comfortable approaching staff with queries or concerns. Residents reported that smoking within ward communal areas was a persistent issue despite the fact that both the male and female admission wards had a smoking pod / hub off their retrospective main corridors. It was noted by residents that breakfast time was particularly busy and their preference would be for medication to be administered after breakfast in private instead of during breakfast. Two residents commented on the high level of clinical activity on the wards at the time of inspection which they felt meant nursing staff were less readily available. An activity room was at times used as a bedroom and one resident noted this was confusing, as the space within the ward was not well defined.

Residents had reported to the IAN representative that they were frustrated with the lack of physical indoor and outdoor activity. Voluntary residents enjoyed going for a walk outside however complained that they were not always allowed to go for walks. Residents said they would like more opportunities to attend activities, especially at the weekends. Residents noted that because of bed shortages some residents had to sleep on temporary beds. Residents reportedly valued having access to a computer.

Four completed resident questionnaires were also returned to the inspectors. Three indicated that the residents understood their care plan and knew their multi-disciplinary team. All four indicated they knew who their key worker was and that when they arrived to the approved centre a member of staff had explained what was happening in a way that was understood. All four indicated that they had space for privacy but one felt their privacy and dignity was not always respected. Three of four felt that there was not enough activities during the day. Three residents indicated that they ‘sometimes’ felt safe in the approved
centre with one omitting this question. On a scale of 1-10, with 1 being poor and 10 being excellent, two residents rated 8 out of 10 for overall experience of care and treatment, one resident rated 6, and one resident rated 4.
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:

- Executive Clinical Director.
- Senior Occupational Therapist.
- Senior Clinical Psychologist.
- Area Director of Nursing.
- Registered Proprietor Representative.
- CNM I – Male Admissions.
- CNM II – Female Admissions.
- Business Manager.
- Area Lead Mental Health Engagement Officer.
- Social Worker Team Leader.
- ADON / Policies, Procedures, Protocols and Guidelines Lead.

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

The service commented on the time period between receiving the approved centres 2018 inspection report and the approved centres 2019 annual inspection. The service reported the short turn around period meant they had limited time to address issues highlighted in last year’s report (2018).
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 November 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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

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

The approved centre was compliant with this regulation. The quality assessment was 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 5: Food and Nutrition

| COMPLIANT |
| Quality Rating | Satisfactory |

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

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

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<th>INSPECTION FINDINGS</th>
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**Processes:** The approved centre had a written policy in relation to food and nutrition, which was last reviewed in February 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

**Monitoring:** A systematic review of menu plans 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 monthly 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 Irish Food Pyramid. Residents had at least two choices for meals. Food, including modified consistency diets, was presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance. Hot and cold drinks were offered to residents regularly.

For residents with special dietary requirements, their nutritional and dietary needs were assessed, where necessary, and addressed in residents’ individual care plans. An evidence-based nutrition assessment tool was used. Their special dietary needs were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillars.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in February 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff 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: 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.

At the time of the inspection, the occupational therapy kitchen was dirty and catering areas and associated catering and food safety equipment were not appropriately cleaned. This meant that hygiene was not maintained to support food safety requirements. The kitchen was appropriately cleaned prior to completion of inspection.

The approved centre was non-compliant with this regulation because a high standard of hygiene was not maintained in relation to the storage, preparation, and disposal of food. The occupational therapy kitchen was dirty, 6(1)(c).
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 September 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents were supported to keep and use personal clothing, which were clean and appropriate to their needs. Residents were provided with emergency personal clothing that was appropriate and took into account their preferences, dignity, bodily integrity, and religious and cultural practices. Residents had an adequate supply of individualised clothing.

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

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

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

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

Secure facilities were provided for the safekeeping of the residents’ monies, valuables, personal property, and possessions. 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 nursing staff and 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 September 2018. The policy included the requirements of the Judgement Support Framework with the exception of the facilities available for recreational activities, including the identification of suitable locations for recreational activities within and external to the approved centre.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. Healthcare professionals facilitated activities on weekdays and during every second weekend. The activities timetable displayed to residents, detailed accessible and user-friendly information on recreational activities, including the type and frequency of recreational activities. Daily activities, which ran Monday to Friday inclusive, included board games, table tennis relaxation, and discussion groups. There were two televisions on each of the male and female wards, and the television on the male ward had a gaming functionality. Weekend activities included general knowledge quizzes on the male ward, while the female residents played bingo.

The recreational activities provided by the approved centre were appropriately resourced. Opportunities were not provided to all residents for indoor and outdoor exercise and physical activity. The exercise bike and rowing machine on the male ward were broken at the time of the inspection. There was no exercise equipment on the female ward. There was no enclosed outdoor space. Accompanied walks were staff dependent, and rarely took place.

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 non-compliant with this regulation because residents did not have access to adequate and appropriate recreational activities.
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 November 2016. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre, and there were facilities available to support residents’ religious practices. Residents had access to multi-faith chaplains, if required. They were facilitated to observe or abstain from religious practice in accordance with their wishes. The care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed outside the male and female wards of the approved centre. No visitor was considered a safety risk to residents at the time of the inspection. While a designated visiting room was not available, it was possible for visits to take place in the interview room at reception.

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 12: Communication

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The service user access to communication facilities policy was last reviewed in December 2017. The policy included the requirements of the Judgement Support Framework with the exception of the assessment of resident communication needs.

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 could use mail, and their personal mobile phone including the internet, if they wished. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. No resident had their communication monitored by senior staff at the time of inspection. The Clinical Director or a senior staff member designated by the Clinical Director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
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 a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in October 2018. The policy addressed the requirements of the Judgement Support Framework, with the exception of the processes for communicating the approved centre’s search policies and procedures to residents and staff.

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

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

Evidence Of Implementation: No environmental searches had been conducted since the last inspection. The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file for one resident who was searched was inspected. Risk had been assessed prior to the search of the resident, or their property appropriate to the type of search being undertaken. The resident’s consent was sought and documented.

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

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

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes 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 in relation to care of the dying, which was last reviewed in May 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

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

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan: “... a documented set of goals developed, regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation”.]

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in January 2018. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Each resident had an ICP, ten of which were inspected. A key worker was identified to ensure continuity in the implementation of a resident’s ICP. All ICPs inspected were a composite set of documentation with allocated spaces for goals, treatment, care, and resources required. All ICPs were stored in the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. All ICPs were regularly reviewed and updated by the resident’s MDT in consultation with each resident. Residents had access to their ICPs, and were kept informed of any changes. All residents were offered a copy of their ICP, including any reviews.

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 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in April 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Therapeutic services and programmes provided by the approved centre were extensive, evidence-based and reflective of good practice guidelines. They were appropriate and met the assessed needs of the residents, as documented in the residents’ individual care plans. A list of therapeutic services and programmes provided within the approved centre was available to residents. All therapeutic programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Occupational therapy staff had the main responsibility for the therapeutic timetable. Social work and psychology staff from the community were available to meet with residents of the approved centre on one to one basis as required, but they did not run groups.

Adequate resources and facilities were available. Therapeutic services and programmes were provided in separate dedicated rooms, and each ward had facilities to carry out group programmes or one to one sessions. All therapeutic services and programmes needed were provided internally. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes, within residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

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

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

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 been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre for emergency treatment was examined. Communication records with the receiving facility were documented, and followed up with a written referral. Communication records included the reasons for transfer, the resident’s care and treatment plan, including needs and risks, and the resident’s accompaniment requirements on transfer. Transfer documentation was issued with copies retained. This included a letter of referral, which was not dated, and a list of current medications.

The resident was risk assessed prior to the transfer, and this included an individual risk assessment relating to the transfer and the resident’s needs. Consent requirements were met. A checklist was undertaken by the approved centre to ensure comprehensive records were transferred to the receiving facility, but the checklist was not dated. Copies of all records relevant to the transfer process were retained in the residents’ clinical file.

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

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

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

INSPECTION FINDINGS

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

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

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

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

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

Records were available demonstrating residents’ general health checks and associated results, including records of any clinical testing. Resident’s general health needs were monitored and assessed at least every six months. All clinical files inspected showed that these residents had received a six-monthly general health assessment, but the assessment itself was not adequately completed. All files inspected evidenced that each resident had received a physical examination. The six-monthly general health assessment records evidenced the following discrepancies on inspection:

- Residents’ Body Mass Index, weight, and waist circumference was not checked and recorded.
- Smoking status was not documented in three cases.
- Nutritional status: diet and physical activity, including sedentary lifestyle, was not documented.
- Dental health assessments were not documented.
- Medication review, as per prescriber guidelines, was not documented.
For residents on antipsychotic medication, they received an annual assessment of their heart function through an electrocardiogram. This was documented. Resident’s glucose regulation, blood lipids, and prolactin levels were not consistently documented despite the requirement for these checks to take place annually.

Residents had access to national screening programmes appropriate to age and gender. Information was not provided to any resident regarding the national screening programmes available through the approved centre. Residents had access to a nurse-led smoking cessation programme, and smoking supports in the approved centre.

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

a) The six-monthly general health assessment records and associated tests were not fully complete. The assessment did not comprehensively assess each resident’s general health needs. The assessment did not include Body Mass Index, waist circumference, smoking and nutritional status, dental review and medication review, in all cases, 19(1)(b).

b) For residents on antipsychotic medication, residents’ glucose regulation, blood lipids, and prolactin levels were not consistently documented despite the requirement for these checks to take place annually, 19(1)(b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

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

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

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

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

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition.

The information documents provided by or within the approved centre were evidence-based, and were appropriately reviewed and approved prior to use. Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education 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 May 2018. The policy addressed the requirements of the Judgement Support Framework with the following exceptions:

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

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

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

Evidence of Implementation: Residents were facilitated to make and receive private phone calls. The general demeanour of staff and the way in which staff interacted with residents was respectful. Residents wore clothes, which respected their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door. All of these locks had an override function.

The light fittings in single bedrooms and in one dormitory were positioned on the outside of the door and there was no bedside lighting. The wardrobes did not have doors, which was not conducive to resident privacy and dignity. The interview rooms on the female ward had observation panels without a screen or curtain. These two interview rooms had been used as bedrooms regularly and were used on the first day of the inspection.

Where clinically indicated, female residents were inappropriately accompanied to the high dependency ward and seclusion room through the male admission ward. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information.

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

a) The light fittings in single bedrooms and in one dormitory were positioned on the outside of the door, and there was no bedside lighting.

b) Residents’ wardrobes had no doors, which was not conducive to resident privacy or dignity.

c) Two interview rooms in the female ward had been used as bedrooms regularly and were used on the first day of the inspection.

d) Residents’ privacy was compromised as observation panels in the interview rooms did not have privacy screens or curtains when being used as bedrooms.
e) Where clinically indicated, female residents were inappropriately accompanied to the high dependency ward and seclusion room through the male admission ward.
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 October 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: The approved centre had completed separate hygiene and ligature audits. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre was adequately heated and ventilated. There was a cleaning schedule implemented and the approved centre was clean, hygienic, and free from offensive odours. There was a programme of general maintenance, decorative maintenance, and repair of assistive equipment. Records were maintained.

There was a sufficient number of toilets and showers for residents in the approved centre. Residents did not have access to adequate personal space. Bedrooms were not appropriately sized to address resident needs. The six-bedded dormitory on the male ward was cramped and there was not enough personal space to move about freely in. While there was a garden to the side of the approved centre for residents to engage in horticulture activities, there was no enclosed garden. Residents had access to smoking shelters. Appropriate signage and sensory aids were not provided to support resident orientation needs.

The approved centre was not kept in a good state of repair inside and outside. The premises were not maintained in good structural condition. The approved centre did not provide suitable furnishings to support resident independence and comfort. There were no doors on residents' wardrobes. A programme to minimise ligatures to the lowest possible level was ongoing.
The approved centre did not have a dedicated therapy and examination room. On the first day of the inspection, the interview rooms where assessments were undertaken and where medical staff had resident meetings were used as bedrooms. The female side of the approved centre had 17 residents in a 14-bedded ward. The two interview rooms and a multi-purpose (team meeting/activities) room were turned into bedrooms to facilitate the number of residents.

Where substantial changes were required to the approved centre premises, this was appropriately assessed prior to the implementation for possible impact on current residents and staff. The Mental Health Commission was informed prior to the commencement of works. Remote or isolated areas of the approved centre were monitored. Back-up power was available in the approved centre.

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

a) The premises was not adequately lit, 22(1)(b).

b) The registered proprietor did not ensure that the environment was maintained with due regard to the specific needs of residents as sufficient personal space was not provided nor did residents have access to outdoor space, 22(3).

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

d) The six-bedded dormitories were cramped and did not offer residents enough access to personal space, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

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

Training and Education: Not all pharmacy or medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing, medical, and pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

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

Evidence of Implementation: Each resident had an MPAR, ten of which were inspected. Each MPAR evidenced a record of medication management practices, including a record of two resident identifiers, details of dosage, and frequency of medication.

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

One MPAR did not record the discontinuation date for each medication. In two MPARs, a record of all medications administered to the resident had not been maintained, as omissions were evident. The Medical Council Record Number was omitted on one MPAR. Not all entries in one MPAR were legible.

All medication supplies were maintained in a locked press, trolley, or fridge. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Refrigerators used for medication were used only for this purpose and a log was maintained of the refrigeration storage unit temperatures. An inventory of medications was conducted on a monthly basis by pharmacy staff, checking the name and dose of medication, quantity of medication, and expiry date. Food and drink was not stored in areas used for the storage of medication.
Medications that were no longer required, which were past their expiry date, or had been dispensed to a resident but were no longer required, were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal. Pharmacy staff were responsible for this task.

The approved centre was non-compliant with this regulation because they did not have suitable practices relating to the prescription and administration of medications:

a) One MPAR did not record the stop date for each medication, 23(1).
b) In two MPARs, a record of all medications administered to the resident had not been maintained, as omissions were evident, 23(1).
c) The Medical Council Record Number was omitted on one MPAR, 23(1).
d) Not all entries in one MPAR were legible, 23(1).
Regulation 24: Health and Safety

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written operational policy and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in September 2018. The policy addressed the requirements of the *Judgement Support Framework* with the exception of the process for the allocation and documentation of safety representative roles, and details of vehicle controls in place.

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

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

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

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

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV, which was last reviewed in September 2017. The policy addressed all of the requirements of the regulation and the Judgement Support Framework. The policy articulated the function of CCTV in relation to the observation of a resident.

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

Monitoring: The CCTV equipment was checked regularly to ensure it was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence Of Implementation: There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe a resident were incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. The Mental Health Commission had been informed about the approved centre’s use of CCTV.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 26: Staffing

NON-COMPLIANT

Quality Rating  Requires Improvement
Risk Rating        HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

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

- Staff performance and evaluation requirements.
- The required qualifications of training personnel.

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

Monitoring: The implementation and effectiveness of the staff training plan were 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: Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. Staff within the approved centre had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

The number and skill mix of staffing were sufficient to meet resident needs. Staff were trained in manual handling, infection control and prevention, risk management and treatment, incident reporting, and recovery-centred approaches to mental health care and treatment. Staff were trained in the protection of children and vulnerable adults, and in Children First. Staff were not trained in risk management.

There was an organisational chart in place to identify the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Not all staff training was documented. Not all health care staff were trained in the following:
- fire safety
- Basic Life Support
- Management of Violence and Aggression
- The Mental Health Act 2001
- Children First

<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>
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</thead>
<tbody>
<tr>
<td>Nursing (46)</td>
<td>40</td>
<td>87%</td>
<td>31</td>
<td>67%</td>
<td>29</td>
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<tr>
<td>Consultant Psychiatrist (8.5)</td>
<td>6</td>
<td>71%</td>
<td>5</td>
<td>59%</td>
<td>5</td>
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<tr>
<td>Medical (14)</td>
<td>6</td>
<td>42%</td>
<td>3</td>
<td>21%</td>
<td>3</td>
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<tr>
<td>Occupational Therapist (2)</td>
<td>2</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>1</td>
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<tr>
<td>Social Worker (10)</td>
<td>9</td>
<td>90%</td>
<td>9</td>
<td>90%</td>
<td>9</td>
</tr>
<tr>
<td>Psychologist (5)</td>
<td>5</td>
<td>100%</td>
<td>5</td>
<td>100%</td>
<td>4</td>
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The following is a table of clinical staff assigned to the approved centre.

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<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
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<tbody>
<tr>
<td>Unit A</td>
<td>CNM1 or CNM II</td>
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</tr>
<tr>
<td></td>
<td>CNM III</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit B</td>
<td>CNM1 or CNM II</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>CNM III</td>
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<td>RPN</td>
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<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
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<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0</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 mandatory training in Basic Life Support, fire safety, management of violence and aggression or Children First, 26(4).

b) Not all staff were trained 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 in relation to the maintenance of records, which was last reviewed in February 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

Evidence of Implementation: Residents’ records were appropriately secured throughout the approved centre from loss, destruction, tampering, or unauthorised access or use. Seven clinical files were inspected. Five out of seven clinical files inspected had loose pages. One entry in the residents’ records within clinical notes was illegible which meant it was not possible to tell if the clinical notes were accurate. Two hand-written records were written in blue ink instead of black indelible ink. Records were not in a logical order. Each separate discipline wrote in a separate part of the clinical file, and the information they wrote was filed separately. Therefore, files were not maintained in a logical sequence and files were not maintained in a manner to ensure completeness, accuracy, and ease of retrieval.

Resident records were not reflective of the residents’ status at the time of inspection and the care and treatment being provided. Occupational therapy notes and nursing notes were kept separately in clinical files and as a result, whether records were reflective of clinical care provided was unclear. One clinical file contained information from 2015.

Not all resident records were maintained using an identifier, which was unique to the resident. There was no identifier on one page within one resident’s file. For data protection reasons, resident names were not on the front of each chart; the resident’s initials were. In addition, there was no identifier on one page within one resident’s file. Only authorised staff made entries in residents’ records, or specific sections of
the records. Resident records were physically stored together. The date was not entered on one resident record. Not all residents’ records included the time for each entry. Not all residents’ records included the date, and time for each entry. Where an error was made, the resident identifier was not consistently scored out with a single line.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

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

a) Five out of seven clinical files inspected had loose pages, 27(1).

b) One entry in the residents’ records, within clinical notes was illegible, which meant it was not possible to tell if the clinical notes were accurate, 27(1).

c) Records were not in a logical order. Each discipline wrote in a separate part of the clinical file, which made it difficult to see a logical order in the notes. This meant records were not maintained in a manner to ensure completeness, accuracy, and ease of retrieval, 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 up-to-date, register of residents admitted. The register contained all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in September 2018. It included all of the requirements of the Judgement Support Framework.

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

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

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

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

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 30: Mental Health Tribunals

COMPLIANT
Quality Rating  Excellent

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.
(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

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

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

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

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

The approved centre was compliant with this regulation. The quality assessment was rated 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 place in relation to the management of complaints. The policy was last reviewed in November 2018. The policy and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

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

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

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

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

(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 two written policies in relation to risk management and incident management procedures, which was last reviewed in March 2019. The policies combined included all of the requirements of the Judgement Support Framework.

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had not been completed to identify opportunities for improving risk management processes.

Evidence Of Implementation: The person with responsibility for risk was identified and known by all staff. Responsibilities were not allocated at management level and throughout the approved centre to ensure their effective implementation. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Individual risk assessments were completed prior to episodes of physical restraint and seclusion, at resident admission and transfer, and in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, remained and works to mitigate risks effectively were ongoing at the time of the inspection.
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, and were recorded on the national incident management system.

Responsibilities allocated at management level and throughout the approved centre to ensure the effect implementation of the risk management policy were unclear. The SLMHS Quality, Safety and Risk Committee monitored and maintained the Sligo/Leitrim service wide risk register. There was no approved centre risk register however there were a suite of risk assessments on each unit, one on the female admission ward and one on the male admission ward. The monitoring, maintenance, escalation and governance process for the approved centre suite of risk assessments on each unit was unclear. Not all identified risks were assessed, rated, recorded, reported and documented appropriately as per the approved centres risk management policy. The approved centre did not have an evacuation plan in place. Risk management procedures did not actively reduce identified risks to the lowest level of risk, as was reasonably practicable.

A six-monthly summary of incidents was provided to the Mental Health Commission by the Mental Health Act administrator. The information provided was anonymous at resident level. There was no emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. There was no emergency plan in place which incorporated evacuation procedures. The emergency plan was in draft format and a copy of the draft was not made available to inspectors.

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

a) Risks documented on risk assessment forms within the approved centre were not subject to on-going monitoring as per the service’s Incident Management Reporting Policy 31(1).

b) Risks were not assessed, rated, recorded, reported and documented within the approved centre as per the service’s Incident Management Reporting Policy 31(1).

c) The approved centre did not have an evacuation plan in place as per the service’s Incident Management Reporting Policy 31(1).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with two attached conditions. The certificate and attached conditions were displayed prominently at the entrance of the hospital.

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of seclusion, and the policy was reviewed annually. It was last reviewed in June 2018. The policy addressed who may implement seclusion, the provision of information to the resident, and ways of reducing rates of seclusion use.

Training and Education: The approved centre maintained a documented written record indicating that not all staff involved in the use of seclusion had signed to indicate that they had read and understood the policy.

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

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

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

One resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The reasons why the other two residents were not informed was documented in clinical files. Each resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident was informed of the ending of seclusion on all occasions.

All episodes of seclusion were recorded in the resident’s clinical file and all uses of seclusion were recorded in the seclusion register, but in one episode of seclusion, the seclusion register was not signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the resident’s clinical file and available to inspectors.
The approved centre was non-compliant with this regulation for the following reasons:

a) The seclusion room was used as a bedroom, 8.4.
b) Not all staff involved in the use of seclusion had signed to indicate that they had read and understood the policy, 10.2(b).
9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
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**

One clinical file was inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. This patient was assessed as being capable of providing consent to receiving treatment. The patient provided their consent to treatment, and their clinical file evidenced the following:

- The responsible consultant psychiatrist had undertaken a capacity assessment, which was documented.
- There was a record of the patient’s consent that contained:
  - A written record of the name of specific medications prescribed.
  - Confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s).
- Details were provided of discussion with the patient, including:
  - The nature and purpose of the medication.
  - The effects of medication, including risks and benefits and views expressed by the patient.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
All forms were completed within the appropriate timeframe.

The approved centre was compliant with Part 4 of the Mental Health Act 2001.
10.0 Inspection Findings – Codes of Practice

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2018. It addressed the following:

- The provision of information to residents regarding physical restraint.
- The individual authorised to initiate and conduct physical restraint.

**Training and Education:** There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

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

**Evidence of Implementation:** Three episodes of physical restraint were inspected. Physical restraint was used in rare and exceptional circumstances and in the best interests of the resident. Episodes of physical restraint were initiated after staff had first considered all other interventions and following a risk assessment. In one of the episodes of physical restraint reviewed, it was not clear if a medical examination of the resident had been completed no later than three hours after the start of an episode of physical restraint, as the medical examination did not document a time.

In one physical restraint episode, the resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing the resident were not documented. In all three episodes, the clinical restraint form for physical restraint was completed by the person initiating and ordering the use of physical restraint no later than three hours after the episode and the clinical practice form was signed by the consultant psychiatrist within the required 24-hour timeframe.

Two episodes of restraint were not reviewed by members of the multi-disciplinary team (MDT), and documented in the clinical file no later than two working days after each episode. Residents were afforded the opportunity to discuss the episode of restraint with members of their MDT as soon as was practicable. All episodes of physical restraint were recorded in the clinical practice forms and detailed and recorded within the clinical file.

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

- a) In one of the episodes of physical restraint reviewed, it was not clear if a medical examination of the resident had been completed no later than three hours after the start of an episode of physical restraint, as the medical examination did not document a time, 5.4.
- b) In one physical restraint episode, the resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing the resident were not documented, 5.8.
c) Two episodes of physical restraint were not documented as having been reviewed by the multi-disciplinary team within two working days, 9.3.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

Processes: An operational policy and procedures were in place in the approved centre on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was last reviewed in September 2018, and it was reviewed annually. All elements of the policy complied with the code of practice. The protocols in place included:

- How and where Dantrolene was stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hypothermia.
- Obtaining consent for the maintenance and continuation of ECT.

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

Evidence of Implementation: One resident was receiving ECT at the time of inspection. Their clinical file was examined. The resident was given an easy to read and understand ECT booklet, and an oral explanation by the consultant psychiatrist prior to consent. They were provided with all the required information. An interpreter was available if necessary to explain ECT. Information was provided on the likely adverse effects of ECT, including risk of cognitive impairment and amnesia. The resident’s consent was documented in relation to each episode of ECT treatment.

ECT suite was off site therefore ECT facilities not inspected. There was a named consultant psychiatrist responsible for ECT management, a named consultant anaesthetist with overall responsibility for ECT, and one designated ECT nurse.

Post-ECT assessments (clinical status and progress) were recorded in the resident’s clinical file after each treatment. The reasons for continuing or discontinuing ECT were recorded.

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 separate written policies in relation to admission, transfer, and discharge. All three policies were reviewed in March 2019. The policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident’s family were involved in the admission process. The resident received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and work situation, education, and dietary requirements. The resident received a full physical examination. All assessments and examinations were documented within the clinical file.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was coordinated by a key-worker. A discharge plan was in place as part of the individual care plan. The discharge plan documented the estimated date of discharge and all other 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 (MDT) and the resident’s family. A pre-discharge assessment was completed which addressed the resident’s psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. A family member was involved in the discharge process.

There was appropriate MDT input into discharge planning. A preliminary discharge summary was issued to primary care within three days. A comprehensive discharge summary was due to be issued within 14 days to relevant personnel, at the time of the inspection 14 days had not yet passed. A timely follow up appointment was scheduled to take place.

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

a) Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1.
b) Audits had not been completed on the implementation of and adherence to the admission and discharge policies, 4.19.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 9: Recreational Activities

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Residents did not have access to adequate and appropriate recreational activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Corrective Action</td>
</tr>
<tr>
<td>Specific</td>
<td>6 monthly regulation 9 audit</td>
</tr>
<tr>
<td>Measurable</td>
<td>achievable and realistic</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td></td>
</tr>
<tr>
<td>Time-bound</td>
<td>30/11/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>OT Nurse Managers</td>
</tr>
</tbody>
</table>
Weekly check from ward manager that exercise equipment is working and has regular servicing
**Regulation 19: General Health**

**Reason ID : 10000404**

The six-monthly general health assessment records and associated tests were not fully complete. The assessment did not comprehensively assess each resident's general health needs. The assessment did not include Body Mass Index, waist circumference, smoking and nutritional status, dental review and medication review, in all cases, 19(1)(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>June 2019 HM/CM21 General Health Care Policy Updated June 2019 Physical Health Assessment Approved Centre and Community updated and implemented October 2019 Metabolic Monitoring Form updated Policy/procedure to be updated in General Health Care Policy. October 2019 Metabolic Monitoring Form updated inclusive of BMI, Height, weight, waist circumference November 2019 Lifestyle Assessment to be trialled in 2 CMHTs and reviewed in January 2020 for service wide implementation. Memo from ECD to all Medical Staff re the importance of fully completing medical assessment forms</td>
<td>6 monthly auditing of regulation 19</td>
<td>Achievable and realistic</td>
<td>02/12/2019</td>
</tr>
</tbody>
</table>

**Preventative Action**

6 monthly auditing of Regulation 19 with presentation of findings at Approved Centre Business Meetings and Medical Staff training mornings

Compliance with completing audits will be monitored by CQPS office via audit schedule

Achievable and realistic

02/12/2019

Medical Staff

**Reason ID : 10000405**

For residents on antipsychotic medication, residents' glucose regulation, blood lipids, and prolactin levels were not consistently documented despite the requirement for these checks to take place annually, 19(1)(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>June 2019 HM/CM21 General Health Care Policy Updated June 2019 Physical</td>
<td>6 monthly auditing of Regulation 19</td>
<td>Achievable and realistic</td>
<td>02/12/2019</td>
</tr>
</tbody>
</table>

AC0014 Sligo/Leitrim Mental Health In-patient Unit  Approved Centre Inspection Report 2019  Page 75 of 94
Preventative Action | 6 monthly auditing of regulation 19 | CQPS will monitor compliance with completing regulation 19 audits via the audit schedule for the Approved Centre | Achievable and Realistic | 02/12/2019 | Medical staff |
### Regulation 6: Food Safety

**Reason ID**: 10000406

A high standard of hygiene was not maintained in relation to the storage, preparation and disposal of food. The occupational therapy kitchen was dirty, 6(1)(c).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Following the Occupational Therapy groups, the therapist and service users</td>
<td>will clean kitchen as part of the therapeutic activity. Where this cannot</td>
<td>Weekly checks Signing sheets to show cleaning complete Hygiene audits 3 monthly</td>
<td>Achievable and realistic</td>
<td>29/11/2019</td>
<td>OT All staff using kitchen Domestic Staff</td>
</tr>
<tr>
<td>• Occupational Therapists will ensure dirty dishes are placed in dishwasher after every group. The therapists will set dishwasher when needed and will put away any clean items from dishwasher after cycle is complete.</td>
<td>• Occupational Therapists will check fridge once a week for expired products and during this will ensure that fridge is clean.</td>
<td>• Occupational Therapists will label opened products with open date to ensure all products consumed are within expiry dates (e.g. some products may say use within X days after opening - e.g. milk says use within 2 days after opening). • OT will develop a check list where the staff that completes the weekly fridge check will sign the sheet. • Household staff to clean OT kitchen 2x week • Household staff to complete a deep clean fortnightly (e.g. tiles and walls may need a more thorough cleaning)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Occupational Therapists will check fridge once a week for expired products and during this will ensure that fridge is clean.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
clean...). • Household staff to sign in a sheet to prove clean was complete.

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Cleaning schedule Weekly checks documented Hygiene audits</th>
<th>Weekly checks and cleaning schedule. Any issues will be raised at Business meetings for Approved Centre</th>
<th>Achievable and realistic</th>
<th>29/11/2019</th>
<th>OT Domestic staff All staff using OT kitchen</th>
</tr>
</thead>
</table>
### Regulation 32: Risk Management Procedures

<table>
<thead>
<tr>
<th>Reason ID: 10000407</th>
<th>Risks documented on risk assessment forms within the approved centre were not subject to on-going monitoring as per the service’s Incident Management Reporting Policy 31(1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
</tr>
<tr>
<td>Specific</td>
<td>Local Escalated Risk Register for Approved Centre to be implemented and reviewed quarterly. All new risks to be reviewed at Business meetings on an ongoing basis. Risk assessments to be reviewed annually in conjunction with Safety Statement or sooner if required.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Audit of Regulation 32 to include review of risk management processes</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>Time-bound</td>
<td>30/10/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>Members of Business Meetings Group Ward Managers All staff who identify a risk</td>
</tr>
</tbody>
</table>

| **Preventative Action** |  
| Specific | Business group will ensure risks on risk register are reviewed quarterly. All non escalated risks will be reviewed at a minimum of yearly. |
| Measurable | yearly Health and Safety Audits will review risks and risk management processes |
| Achievable/Realistic | achievable and realistic |
| Time-bound | 30/10/2019 |
| Post-Holder(s) | All members of Business Group |

<table>
<thead>
<tr>
<th>Reason ID: 10000408</th>
<th>Risks were not assessed, rated, recorded, reported and documented within the approved centre as per the service’s Incident Management Reporting Policy 31(1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
</tr>
<tr>
<td>Specific</td>
<td>Information session with staff on the correct process for Risk Assessment. All managers to complete HSELand Managing Health and Safety in the Healthcare Setting. Risk Assessment and Management is standing agenda item at Approved Centre Business meetings.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Regulation 32 will be audited quarterly as per audit schedule. Approved Centre Business meeting will monitor compliance and understanding of Risk Processes and implement further actions as required</td>
</tr>
<tr>
<td>Achievable/Realistic</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td>Time-bound</td>
<td>29/11/2019</td>
</tr>
<tr>
<td>Post-Holder(s)</td>
<td>All Staff All Managers</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Regulation 32 will be audited quarterly as per audit schedule. Approved Centre Business meeting will monitor compliance and understanding of Risk Processes and implement further actions as required</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Yearly review of Evacuation Plan</td>
</tr>
</tbody>
</table>

**Reason ID: 10000409**

The approved centre did not have an evacuation plan in place as per the service's Incident Management Reporting Policy 31(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>Evacuation plan is now in place for the Approved Centre</td>
<td>Evacuation Plan will be reviewed yearly as part of Safety Statement Review</td>
<td>Achievable and Realistic</td>
<td>25/10/2019</td>
<td>Business Managers Meeting</td>
</tr>
<tr>
<td>Yearly review of Evacuation Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Regulation 27: Maintenance of Records**

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Five out of seven clinical files inspected had loose pages, 27(1). -One entry in the residents’ records within clinical notes was illegible, which meant it was not possible to tell if the clinical notes were accurate, 27(1). -Records were not in a logical order. Each discipline wrote in a separate part of the clinical file, which made it difficult to see a logical order in the notes. These meant records were not maintained in a manner to ensure completeness, accuracy, and ease of retrieval, 27(1).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly checks by Admin staff to ensure files are maintained to appropriate standard and any non compliances to be addressed immediately. Memo from Quality and Risk to all staff regarding legibility of writing and required standards. Quality and Risk to consider implementation of reconfiguration of the files so they follow a more logical sequence.</td>
<td>Weekly checks by admin staff 6 monthly regulation 27 auditing</td>
<td>Achievable and realistic</td>
<td>02/12/2019</td>
<td>PPG Quality and Risk Admin Staff</td>
<td></td>
</tr>
</tbody>
</table>

| Preventative Action | Weekly checks by admin staff 6 monthly regulation 27 auditing | Achievable and Realistic | 25/10/2019 | admin staff MDT |
Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID: 10000416</th>
<th>The six-bedded dormitories were cramped and did not offer residents enough access to personal space, 22(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>All beds will have curtain in place around bed All wardrobes have now been fitted with doors to improve privacy Lighting for above beds to be fitted Q4 2019 Move to new build to be complete Q1 2021 which provides all single rooms Communal areas to be arranged and maintained in such a way as to allow residents the optimum amount of personal space</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>weekly environmental checks by ward managers on bed curtains and ward environment to ensure optimum amount of personal space for residents AMHMT maintain oversight of move to new build for Q1 2021</td>
</tr>
</tbody>
</table>
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

**Reason ID : 10000417**

- One MPAR did not record the stop date for each medication, 23(1).
- In two MPARs, a record of all medications administered to the resident had not been maintained, as omissions were evident, 23(1).
- The Medical Council Record Number was omitted on one MPAR, 23(1).
- Not all entries in one MPAR were legible, 23(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memo from ECD to all Medical Staff regarding requirements of prescribing under Regulation 23 Compliance with regulation 23 is included at quarterly medical teaching sessions</td>
<td>Quarterly auditing of MPARS by Medical Staff with presentation of findings at Medical Staff teaching morning and oversight at Approved Centre Business Meetings Weekly checks from CQPS office with follow up as required</td>
<td>Achievable and Realistic</td>
<td>15/11/2019</td>
<td>ECD Medical Staff</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly auditing of MPARS by Medical Staff with presentation of findings at Medical Staff teaching morning and oversight at Approved Centre Business Meetings Weekly checks from CQPS office with follow up as required</td>
<td>CQPS will monitor compliance with completeness of quarterly audits</td>
<td>Achievable and Realistic</td>
<td>08/11/2019</td>
<td>Medical Staff CQPS</td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

<table>
<thead>
<tr>
<th>Reason ID : 0</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Monitor as condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Monitor as condition</td>
<td></td>
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</tr>
</tbody>
</table>
### Regulation 21: Privacy

#### Reason ID: 10000425

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No interview rooms will be used as bedrooms with immediate effect.</td>
<td>Ward managers will work with senior management regarding bed management and ensure no interview room will be used as a bedroom.</td>
<td>Achievable and realistic</td>
<td>13/11/2019</td>
<td>Ward Managers Business Managers meetings AMHMT</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward managers and senior management will actively manage bed allocation and ensure no interview room is used as a bedroom</td>
<td>Approved Centre Business meeting will maintain oversight of this CAPA and will ensure practice is in compliance with agreed actions</td>
<td>Achievable and realistic</td>
<td>13/11/2019</td>
<td>Ward managers</td>
<td></td>
</tr>
</tbody>
</table>

#### Reason ID: 10000427

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLMHS currently implements actions to mitigate any risk in a breach of a person's privacy and dignity posed by the location of the seclusion room and HOA, and the transfer of female residents to the seclusion room/HOA. Primarily SLMHS actively works to reduce seclusion and restraint.</td>
<td>Seclusion and Restraint Reduction Group will actively monitor the incidents of seclusion and restraint on the</td>
<td>Achievable and Realistic</td>
<td>25/10/2019</td>
<td>Ward Managers AMHMT</td>
<td></td>
</tr>
</tbody>
</table>
Incidents of seclusion and restraint via the Seclusion and Restraint Reduction Group. If seclusion/HOA is required for a female resident, the male staff ask all male patients to remain in rooms and off the corridor until the female resident has been accompanied through the ward. Move to new build Q1 2021.

<p>| Preventative Action | Seclusion and Restraint Reduction Group will actively monitor the incidents of seclusion on the units and any complaints in relation to privacy or dignity arising from same | Seclusion and Restraint Reduction Group will actively monitor the incidents of seclusion on the units and any complaints in relation to privacy or dignity arising from same | Achievable and Realistic | 08/11/2019 | Seclusion and Restraint Reduction Group |</p>
<table>
<thead>
<tr>
<th>Reason ID : 10000397</th>
<th></th>
<th>Code of Practice on Admission, Transfer and Discharge to and from an approved centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not all relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer and discharge policies, 9.1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Policy portal implemented in SLMHS in 2018 to ensure compliance with policy reading and electronic signatures for same. This will be monitored monthly through compliance reports run by CQPS who will liaise with managers to ensure compliance</td>
<td>Monthly monitoring of same with compliance reports and liaising with managers re same</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Monthly compliance reports and liaising with managers</td>
<td>Monthly reporting on compliance with reading policies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000398</th>
<th></th>
<th>Code of Practice on Admission, Transfer and Discharge to and from an approved centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audits had not been completed on the implementation of and adherence to the admission and discharge policies, 4.19.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Specific</td>
<td>Measurable</td>
</tr>
<tr>
<td>Implementation of and adherence to admission and discharge policies will be audited 6 monthly</td>
<td>This audit will be maintained as part of the audit schedule and reviewed to ensure completeness by the CQPS office</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Audit will be incorporated into the overall audit schedule and</td>
<td>Monthly review of audit schedule with cross referencing with</td>
</tr>
<tr>
<td>monitored for completeness by CQPS office</td>
<td>completed audits to ensure compliance</td>
<td></td>
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<tr>
<td>------------------------------------------</td>
<td>--------------------------------------</td>
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<td></td>
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</tbody>
</table>
## Code of Practice on the Use of Physical Restraint in Approved Centres

### Reason ID : 10000399

In one of the episodes of physical restraint reviewed, it was not clear if a medical examination of the resident had been completed no later than three hours after the start of an episode of physical restraint, as the medical examination did not document a time, 5.4.

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All medical staff to be reminded via memo from ECD of requirement to complete medical examination no later than 3 hours post episode of restraint and to time this examination</td>
<td>3 monthly auditing of physical restraint episodes</td>
<td>Achievable and realistic</td>
<td>08/11/2019</td>
<td>All medical staff</td>
</tr>
</tbody>
</table>

### Preventative Action

<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>3 monthly auditing of physical restraint episodes</td>
<td>3 monthly auditing of physical restraint episodes with presentation of findings at Business meetings, Medical staff teaching mornings and quality and risk committee.</td>
<td>Achievable and realistic</td>
<td>08/11/2019</td>
<td>CQPS and Medical staff</td>
</tr>
</tbody>
</table>

### Reason ID : 10000400

In one physical restraint episode, the resident was not informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. The reasons for not informing the resident were not documented, 5.8.

<table>
<thead>
<tr>
<th>Specific</th>
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<th>Achievable/Realistic</th>
<th>Time-bound</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memo to all nursing and medical staff re requirements for compliance with C.O.P on Physical Restraint</td>
<td>3 monthly auditing of physical restraint</td>
<td>Achievable and realistic</td>
<td>01/12/2019</td>
<td>Quality and Risk</td>
</tr>
</tbody>
</table>

CQPS and Medical staff
<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Preventative Action</th>
<th>Preventative Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 monthly auditing of physical restraint episodes Seclusion and restraint reduction group to actively monitor compliance rates and implement initiatives to reduce same where necessary</td>
<td>3 monthly auditing of episodes of Restraint episodes</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td>08/11/2019</td>
<td>Seclusion and Restraint Reduction Group Nursing and Medical Staff</td>
<td></td>
</tr>
</tbody>
</table>

**Reason ID : 10000401**

Two episodes of physical restraint were not documented as having been reviewed by the multi-disciplinary team within two working days, 9.3.

<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>Memo from Quality and Risk reminding all teams of the requirements in complying with C.O.P on Physical Restraint. Red Stamp to be used by teams to identify each review as an episode of physical restraint review</td>
<td>3 monthly auditing of physical restraint</td>
<td>achievable and realistic</td>
<td>02/12/2019</td>
<td>MDTs Quality and Risk</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Corrective Action</td>
<td>Preventative Action</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQPS will review audit schedule to ensure audits are completed on time</td>
<td>CQPS will review audit schedule to ensure audits are completed on time</td>
<td>CQPS will review audit schedule to ensure audits are completed on time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/11/2019</td>
<td>CQPS Medical staff Nursing staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason ID</td>
<td>The seclusion room was used as a bedroom, 8.4.</td>
<td>Specific</td>
<td>Measurable</td>
<td>Achievable/Realistic</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
<td>Client who was using room as a bedroom has since been transferred to another facility. SLMHS will no longer use seclusion room as a bedroom, same will be monitored by Nurse managers and CQPS office</td>
<td>Any incidents of using this room as a bedroom will be notified to senior management immediately and addressed</td>
<td>achievable and realistic</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
<td>3 monthly seclusion audits will include review of incidents for use of this room as a bedroom</td>
<td>3 monthly seclusion audits will review incidents of use of this room as a bedroom</td>
<td>Achievable and Realistic</td>
</tr>
</tbody>
</table>

*Reason ID : 10000403*  
Not all staff involved in the use of seclusion had signed to indicate that they had read and understood the policy, 10.2(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>SLMHS implemented the policy portal in 2018 to ensure compliance with staff signing to say they have read and understood policies. Compliance with signing for policies will be monitored</td>
<td>Monthly monitoring of same by CQPS</td>
<td>Achievable and Realistic</td>
<td>25/10/2019</td>
<td>All managers CQPS</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Monthly compliance reports from Policy Portal will be communicated to all managers who will work with staff to ensure compliance</td>
<td>Monthly compliance reports from Policy Portal will be communicated to all managers who will work with staff to ensure compliance</td>
<td>Achievable and realistic</td>
<td>25/10/2019</td>
</tr>
</tbody>
</table>
Appendix 2: Background to the inspection process

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

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

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

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

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

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

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

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

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

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

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