## 2019 Approved Centre Inspection Report (Mental Health Act 2001)

**Sycamore Unit, Connolly Hospital**

**ID Number:** AC0032

**2019 Approved Centre Inspection Report (Mental Health Act 2001)**

Sycamore Unit  
Connolly Hospital  
Blanchardstown  
Dublin 15

**Approved Centre Type:** Psychiatry of Later Life  
**Most Recent Registration Date:** 06 June 2016

**Conditions Attached:** None

**Registered Proprietor:** HSE

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

**Inspection Team:**  
Susan O’Neill, Lead Inspector  
Martin McMenamin  
Sarah Moynihan

**Inspection Date:** 26 – 28 February 2019  
**Previous Inspection Date:** 11 -15 June 2018

**Inspection Type:** Unannounced Annual Inspection  
**Date of Publication:** Thursday 11 July 2019

### 2019 COMPLIANCE RATINGS

**REGULATIONS**
- Compliant: 5
- Non-compliant: 3
- Not applicable: 23

**RULES AND PART 4 OF THE MENTAL HEALTH**
- Compliant: 2
  - Non-compliant: 2

**CODES OF PRACTICE**
- Compliant: 1
  - Non-compliant: 3
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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

Chart 2 – Comparison of overall risk ratings 2017 – 2019
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In brief
Sycamore Unit was located on the grounds of Connolly Hospital in Blanchardstown, Dublin. The approved centre was registered to provide a service for Psychiatry of Later Life with a bed capacity of 25. All admissions to the approved centre were from the catchment area of the North Dublin Old Age Psychiatry Service. Residents were admitted to an acute unit in St Vincent’s Hospital, Fairview for a period of symptom stabilisation prior to transfer to Sycamore Unit.

Compliance with regulations, rules and codes of practice has remained relatively stable over a three-year period: 85% in 2017, 87% in 2018 and 81% in 2019. Four compliances with regulation were rated as excellent.

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

Safety in the approved centre
- Staff received training in line with the assessed needs of the resident group profile. Training topics included manual handling, infection control, dementia care, incident reporting, protection of vulnerable adults and dignity.
- Individual risk assessments were completed upon resident admission, resident transfer, mechanical restraint, and in conjunction with medication requirements or administration.
- Structural risks were removed or effectively mitigated. Medication ordering, prescription, storage and administration was conducted in a safe manner.

However:

- Not all health care staff had up-to-date mandatory training in the following areas: Basic Life Support, fire safety, management of violence and aggression, and the Mental Health Act 2001.

Appropriate care and treatment of residents
- Each resident had an individual care plan (ICP) which identified goals, treatment, care, resources, and review. Due to the severity of illness, many residents were not provided with a copy of their ICPs; however, designated representatives were informed of any changes.
- Eight residents had died since the previous inspection. The end of life care provided was appropriate to the residents’ physical, emotional, social, psychological and spiritual needs, and religious and cultural practices were respected. Representatives, family, next of kin and friends were involved where appropriate, and fully supported by staff.
Residents’ general health needs were assessed upon admission to Sycamore Unit and on an on-going basis. All residents received a six-monthly general health assessment or were assessed as indicated by the residents’ specific needs.

However:

- While all general health assessments included a physical examination but not all general health assessments included a review of family or personal history, a record of Body Mass Index (BMI), weight, waist circumference, blood pressure, smoking status, nutritional status, medication, and dental health. Residents on antipsychotic medication received an annual assessment of blood lipids, glucose regulation and electrocardiogram.
- The clinical files inspected showed that not all residents received appropriate general health care interventions in line with ICPs. The numbers and skill mix of staffing were insufficient to meet the assessed needs of residents, as the approved centre did not provide access to services from a variety of health professionals including a physical health occupational therapist, a social worker and a psychologist. Access to a dietitian was provided for urgent referrals only and there were no routine assessments or review for any resident. This lack of provision of health services for this patient group is unacceptable.

**Respect for residents’ privacy, dignity and autonomy**

- Visiting times were appropriate and reasonable, and were publicly displayed within the approved centre. A large family room was available where residents could meet visitors in private.
- In consideration of the resident profile and associated risk, bathrooms and toilets did not have locks on the inside of the door.
- Where residents shared a bedroom, all bed areas had bedside curtains to ensure privacy was not compromised.
- Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information.
- A cleaning schedule was implemented and the approved centre was clean, hygienic, and free from offensive odours.

However:

- The approved centre was not kept in a good state of repair and the following issues were noted: holes in the walls where fixtures had been removed, scuff marks on the walls at many doorways, discoloured linoleum in one bathroom, unclean windows, and a broken curtain rail. A programme of general and decorative maintenance was not maintained.
- Communal rooms, including the sitting room and dining room, had minimal furnishings and décor. This imparted a stark appearance which was not conducive to the well-being and comfort of residents and not in line with good practice in specialist care of people with dementia. This has been highlighted in previous inspection reports.
Human Rights
The lack of access to essential health services for this patient group was a breach of human rights.

Responsiveness to residents’ needs

- The approved centre provided access to recreational activities appropriate to the resident group profile. Activities took place on both an individual and a group basis, and included playing cards, singing, music, reading, sensory sessions, doll therapy, reminiscence, and watching TV or films. Opportunities for indoor physical activity included playing snooker, and ball and exercise group. Gardening and walks were facilitated outdoors as appropriate.
- Information was provided for each resident in verbal and written form about the approved centre, diagnoses and medication. There was an adequate complaints procedure in place.

However:

- Recreational activities were scheduled from Monday to Thursday only. Activities occurred outside of this schedule; however, they were unplanned and dependant on staff availability.

Governance of the approved centre

- Sycamore Unit was part of the Dublin North City and County Community Healthcare and was governed by two systems of governance: North Dublin Mental Health Services (NDMHS) and Connolly Hospital Blanchardstown (CHB). NDMHS had oversight of all services and resources except for staffing of nursing personnel and estate management, which was managed by CHB.
- Resident and carer involvement in service improvement was principally achieved via feedback obtained by the process of lodging complaints (both minor and formal) and compliments.
- Processes for risk escalation from the local risk register to the Dublin North City Mental Health risk register and Connolly Hospital risk register were in place.

However:

- There was a lack of appropriate health professionals to support the needs of residents and the service. These included a pharmacist, an occupational therapist with physical health expertise, and a dietitian. Other staffing concerns included the absence of a social worker within the multi-disciplinary team. In addition, registered general nurses comprised the majority of the nursing staff complement compared to registered psychiatric nurses. This meant that, occasionally, a registered psychiatric nurse was not always on duty and in charge at all times. Not all health professionals had up-to-date mandatory training.
- Where actions to manage risks were identified, the risk register did not record timeframes for the completion of these actions and it was unclear how identified actions were progressing over time.
- A programme of audits was implemented in the approved centre; however, the documentation of the audits lacked relevant detail required to properly understand the audit context. This issue risked undermining the meaningful analysis of results and hence, the process of quality improvement. Clinical audits were undertaken chiefly by senior nursing management; however, the team acknowledged that the responsibility of undertaking the schedule of audit should rest with the multi-disciplinary team.
The following quality initiatives were identified on this inspection:

1. Provision of dementia related education and training sessions to clinical staff by the new Dementia Clinical Nurse Manager.

2. Implementation of short-term nursing staff rotations to general health environments to support physical health skill development.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

Sycamore Unit was located on the grounds of Connolly Hospital. The approved centre was registered to provide a service for Psychiatry of Later Life with a bed capacity of 25. All admissions to the approved centre were from the catchment area of the North Dublin Old Age Psychiatry Service. Residents were admitted to an acute unit in St Vincent’s hospital for a period of symptom stabilisation prior to transfer to Sycamore Unit.

The approved centre was a standalone, single story building. Bedroom areas were comprised of five dormitories and one single bedroom. A family room and multi-sensory room were also contained within the unit. There was a general lack of storage space and some areas were cluttered. Outside, there was a well-maintained landscaped sensory garden which was accessible to residents and visitors.

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>25</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>16</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>2</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>3</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>15</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

Sycamore Unit was part of the Dublin North City and County Community Healthcare and was governed by two systems of governance: North Dublin Mental Health Services (NDMHS) and Connolly Hospital Blanchardstown (CHB). NDMHS had oversight of all services and resources except for staffing of nursing personnel and estate management, which was managed by CHB. Sycamore Unit Management meetings occurred on a bimonthly basis and Executive Management Team meetings occurred monthly. The meeting minutes for Sycamore Unit were provided to the inspection team; however, in spite of repeated requests, the minutes of the Executive Management Team meetings were not provided.

Items reviewed at Sycamore Unit Management meetings related to staffing, training, safety, and quality and risk management. A key operational risk under active management related to staffing issues. The service was unable to fully access appropriate health professionals to support the needs of residents and the service. These included a pharmacist, an occupational therapist with physical health expertise, and a dietitian. Where actions to manage these risks were identified, the risk register did not record timeframes for the completion of these actions. In addition, on review of meeting minutes, it was unclear how identified actions were progressing over time. Processes for risk escalation from the local risk register to the Dublin North City
Mental Health risk register and Connolly Hospital risk register were in place; at the time of inspection, no risks had been escalated to either register.

Other staffing concerns included the absence of a social worker within the multi-disciplinary team. In addition, registered general nurses comprised the majority of the nursing staff complement compared to registered psychiatric nurses. This meant that, occasionally, a registered psychiatric nurse was not always on duty and in charge at all times. The process of recruitment of psychiatric nurses and a part time social worker was underway at the time of the inspection.

Annual staff training plans were completed to identify required training; however, records indicated that not all health professionals had up-to-date mandatory training. A variety of non-mandatory training courses were also available to staff, and management facilitated and encouraged staff members to engage in higher education programmes as relevant. New initiatives to support the skill development of nursing staff members were implemented since the previous inspection. These included delivery of education sessions from a newly appointed clinical nurse manager specialising in dementia care and the implementation of short term rotations of nurses to general health settings.

A programme of cyclical audit was implemented in the approved centre. The documentation of the audits lacked relevant detail required to properly understand the audit context. This issue risked undermining the meaningful analysis of results and hence, the process of quality improvement. Clinical audits were undertaken chiefly by senior nursing management; however, the team acknowledged that the responsibility of undertaking the schedule of audit should rest with the multi-disciplinary team.

Resident and carer involvement in service improvement was principally achieved via feedback obtained by the process of lodging complaints (both minor and formal) and compliments. Issues arising from minor complaints were resolved by staff in a timely and effective manner. Formal complaints and compliments were reviewed at the Sycamore Unit Management Meetings where the team identified underlying issues and took appropriate steps to manage them.

### 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>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>✔</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✔</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✔</td>
<td>✔</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>✔</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>Moderate</td>
<td>✔</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Low</td>
<td>X</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
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<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
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<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
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<tr>
<td>Regulation 14: Care of the Dying</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 13: Searches</td>
<td>As the approved centre did not conduct searches, as per local policy, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</td>
</tr>
</tbody>
</table>
5.0 Service-user Experience

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

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

Throughout the inspection process, none of the residents or their family members expressed an interest in discussing their experience of the service. No completed service user experience questionnaires were returned.
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:

- Head of Mental Health Services
- Clinical Nurse Manager 1
- Senior Occupational Therapist
- Clinical Director
- Assistant Director of Nursing
- General Manager

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. Specific clarifications or corrections were not received.
EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions
Regulation 4: Identification of Residents

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in January 2018. The policy included all 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 identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not 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, communication abilities and individual resident’s needs were used. Identifiers were person specific. Two appropriate resident identifiers were used prior to administration of medications, undertaking medical investigations and providing other healthcare services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Where residents of same or similar name are admitted, yellow sticker alerts are placed on clinical files.

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had not been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The approved centre menus were approved by a dietician in Connolly Hospital to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Hot meals are provided on a daily basis and residents had at least two choices of meals. Food, including modified consistency diets, was presented in an attractive and appealing manner. Hot and cold drinks are offered to residents at regular intervals throughout the day.

For residents with special dietary requirements, nutritional and dietary needs were not reviewed by a dietician where necessary. Where appropriate, residents, their representatives, family and next of kin were educated about resident’s diets, specifically in relation to any contraindication with any medication. Weight charts and intake and output charts were implemented and monitored for residents as appropriate. An evidence-based nutrition assessment tool was used.

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

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

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

Evidence of Implementation: Food was prepared in the main kitchen at Connolly Hospital and transported to the approved centre. Within the approved centre, there were proper facilities for the refrigeration, storage, preparation, cooking and serving of food. All catering areas were clean and contained appropriate hand-washing facilities and suitable catering equipment. Hygiene was maintained to support food safety requirements and personal protective equipment was used during the catering process. All food was handled in a manner that reduced the risk of contamination, spoilage, and infection. Residents were provided with suitable crockery and cutlery to address their specific needs.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. All residents were noted to wear clean clothing appropriate to their needs. Residents had an adequate supply of individualised clothing. If required, residents were provided with appropriate emergency personal clothing, taking into account their preferences, dignity, bodily integrity and religious and cultural practices.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Evidence of Implementation: Upon admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. A new checklist was completed as new possessions were acquired by the resident. The property checklist was kept separately to the resident’s ICP and was available to the resident. Secure facilities were provided within the approved centre for the safe keeping of residents’ monies, valuables, personal property and possessions as necessary. There was a locked safe within the approved centre to store small amounts of money and valuables. Larger amounts of money were transferred to secure facilities within Connolly Hospital.

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

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

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

Monitoring: A record was not maintained of the occurrence of planned recreational activities. Documented analysis had not 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. Activities took place on both an individual and a group basis, and included playing cards, singing, music, reading, sensory sessions, doll therapy, reminiscence, and watching TV or films. Opportunities for indoor physical activity included playing snooker, and ball and exercise group. Gardening and walks were facilitated outdoors as appropriate.

Recreational activities were scheduled from Monday to Thursday only. Activities occurred outside of this schedule however, they were unplanned and dependant on staff availability. Scheduling information was provided to residents in both pictorial and word formats. Recreational activity programmes were developed and implemented with resident involvement. Where residents were unable to communicate their likes and dislikes, family members supplied this information to support programme development. Individual risk assessments were completed for residents where deemed appropriate, in relation to the selection of appropriate activities. Recreational activities were appropriately resourced and were facilitated in suitable communal areas.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, monitoring, and evidence of implementation pillars.
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 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 interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

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

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. Religious services were held in Connolly hospital on a weekly basis and residents were supported to attend as appropriate. A chaplain was available to visit the approved centre as required. Care and services that were provided within the approved centre were respectful of the residents’ religious beliefs and values. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 11: Visits

(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, which was last reviewed in March 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: At the time of the inspection, visiting restrictions were not implemented for any resident. Visiting times were appropriate and reasonable, and were publicly displayed within the approved centre. A large family room was available where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult at all times, and this was publicly communicated. The visiting area was suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 12: Communication

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication, 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 interviewed were able to articulate the processes for communication, as set out in the policy.

Monitoring: No residents had restrictions on their communication at the time of the inspection. Residents’ communication needs were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, telephone, and internet unless otherwise risk-assessed with due regard to the residents’ well-being, safety, and health. Due to the severity of the residents’ illness, staff assisted residents to open mail. This was in accordance with local policy.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 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 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 interviewed were able to articulate the processes for end of life care, as set out in the policy.

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation had been complied with. Systems analysis was undertaken in the event of a sudden or unexpected death in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: Eight residents had died since the previous inspection. The end of life care provided was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected. Pain management was prioritised and managed by the clinical team.

Representatives, family, next of kin and friends were involved where appropriate, and fully supported by staff. End of life care was discussed with family members and decisions recorded in the clinical file. Following death, support was provided to other residents and staff. Notification of death was sent to the Mental Health Commission within the required 48-hour period of the death.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 15: Individual Care Plan

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in December 2017. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Residents’ ICPs were not 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. The ICP was an identifiable, uninterrupted, and composite set of notes stored within the clinical file. The ICP included allocated sections for goals, treatment, care, resources, and ICP reviews. Each resident was assessed at admission and an initial ICP was completed by the admitting clinician to address immediate needs of the resident. Within seven days of admission, a comprehensive ICP was developed by MDT members following assessment. Assessments included medical, psychiatric, psychosocial history, medication history, current physical health, risk assessment, and communication abilities.

Each ICP was discussed and agreed with the resident and their designated representative as appropriate. All ICPs identified the assessed needs, goals, care and treatment, and resources for each resident. All residents were assigned a key worker which ensured continuity in the implementation of the ICP. ICPs were reviewed and updated on a three monthly basis. Due to the severity of illness, many residents were not provided with a copy of their ICPs; however, designated representatives were informed of any changes.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
**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 December 2017. The policy included all of the requirements of the Judgement Support Framework.

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

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

**Evidence of Implementation:** The therapeutic services and programmes provided by the approved centre were evidenced based, but they did not meet the assessed needs of the residents, as documented in their individual care plans. Physical and psychosocial needs were not always met, as the approved centre did not have access to a social worker, a dietitian, a physical health occupational therapist, or a psychologist. Where a resident required a therapeutic service or programme that was not provided, the approved centre did not arrange for the service to be provided by a qualified health professional in an appropriate location.

A list of therapeutic services and programmes was provided in the approved centre and available to residents. Therapeutic services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. A record was maintained of participation and outcomes achieved in residents individual care plans and clinical records.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that each resident had access to a range of therapeutic services in accordance with their individual care plan, 16(1).
Regulation 18: Transfer of Residents

| COMPLIANT |
| Quality Rating | Satisfactory |

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in December 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 not maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

**Evidence of Implementation:** The clinical file of one resident who was transferred to another facility was inspected. An assessment of the resident, including an individual risk assessment relating to the transfer and the resident’s needs was completed. The resident was transferred under emergency circumstances and communications with the receiving facility were documented and followed up with a letter of referral. Copies of all records relevant to the resident transfer were retained in the resident’s clinical file. The approved centre did not maintain a checklist to ensure comprehensive resident records were transferred to the receiving facility.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education, 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 in relation to the provision of general health services and the response to medical emergencies, which was last reviewed in December 2017. The policies and procedures addressed requirements of the Judgement Support Framework, with the following exceptions:

- The referral process for residents’ general health needs.
- The documentation requirements in relation to general health assessments.

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: National screening programmes were not applicable to the profile of residents. 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 trolley and staff had access to an automated external defibrillator (AED). Emergency equipment checks were completed weekly. Records were available of medical emergencies and care provided in the approved centre.

Resident’s general health needs were assessed upon admission to Sycamore Unit and on an on-going basis. All residents received a six-monthly general health assessment or were assessed as indicated by the residents’ specific needs. All general health assessments included a physical examination. Of the clinical files inspected, not all general health assessments included a review of family or personal history, a record of body mass index (BMI), weight, waist circumference, blood pressure, smoking status, nutritional status, medication, and dental health. Residents on antipsychotic medication received an annual assessment of blood lipids, glucose regulation and electrocardiogram. Records were available demonstrating residents’ completed general health checks and results, including records of any clinical testing.

The clinical files inspected showed that not all residents received appropriate general health care interventions in line with individual care plans. Adequate arrangements were not in place for routine access to general health services, such as dietetics and physical health occupational therapy.

The approved centre was non-compliant with this regulation for the following reasons:
a) Adequate arrangements were not in place for access by residents to general health services and for their referral to other health services including dietetics and physical health occupational therapy, 19(1)(a).

b) Six monthly general health assessments were inadequately completed and, in all cases, did not reference the following: family/personal history, Body Mass Index, weight and waist circumference, blood pressure, smoking status, nutritional status, medication review and dental health, 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 policy in relation to the provision of information to residents, which was last reviewed in January 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. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents and their representatives were provided with an information booklet at admission which included the following information: housekeeping arrangements, including arrangements for personal property and mealtimes, complaints procedures, visiting times, advocacy access, resident’s rights, and details of the multi-disciplinary team.

Residents and representatives were provided with written and verbal information on diagnosis as appropriate. Information was provided to residents on the likely adverse effects of treatments including the risks and potential side-effects. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident. The information provided was evidenced based. If required, residents had access to interpretation and translation services.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in December 2016. 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 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 not been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: All residents were called by their preferred name. The general demeanour of staff and the manner in which staff addressed and communicated with residents was appropriate and respectful. Staff were discrete when discussing the resident’s condition and treatment needs. All residents were wearing clothing that was respectful to their privacy and dignity.

In consideration of the resident profile and associated risk, bathrooms and toilets did not have locks on the inside of the door. Where residents shared a bedroom, all bed areas had bedside curtains to ensure privacy was not compromised. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
### 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 February 2019. The policy included all of the requirements of the Judgement Support Framework.

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

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

**Evidence of Implementation:** All communal rooms within the approved centre were appropriately sized and residents had access to personal space. Externally, residents had access to a large sensory garden. There was appropriate ventilation, lighting, and heating throughout the approved centre. Signage and visual aids were used throughout the premises to support resident orientation. Hazards, including large open spaces, slippery floors, hard and sharp edges, and hard or rough surfaces were minimised in the approved centre. Ligature points were not minimised; however, this was not deemed necessary due to the resident profile at the time of inspection.

The approved centre was not kept in a good state of repair and the following issues were noted: holes in the walls where fixtures had been removed, scuff marks on the walls at many doorways, discoloured linoleum in one bathroom, unclean windows, and a broken curtain rail. A programme of general and decorative maintenance was not maintained. A cleaning schedule was implemented and the approved centre was clean, hygienic, and free from offensive odours. Where faults are identified, this was communicated through an appropriate maintenance reporting process. Rooms were centrally heated; however, room temperature could not be controlled within individual rooms. Current national infection
control guidelines were followed. Back-up power was available to the approved centre in event of a power outage.

Communal rooms, including the sitting room and dining room, had minimal furnishings and décor. This imparted a stark appearance which was not conducive to the well-being and comfort of residents. There were a sufficient number of toilets and showers and all toilets were accessible, identifiable, and appropriate for wheelchair use. The approved centre did not have a dedicated examination room; examination of residents generally took place at the residents’ bedside. There was a designated sluice room, cleaning room and linen storage room. The approved centre lacked adequate storage facilities and at the time of inspection, the unoccupied single bedroom was in use as storage area. Clothing was sent to Connolly Hospital for laundry services. Remote or isolated areas of the approved centre were monitored appropriately.

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

a) Premises were not maintained in a good decorative condition and the following issues were noted: holes in the walls where fixtures had been removed, scuff marks on the walls surrounding multiple doorways, discolouration of linoleum, unclean windows throughout the premises, and a broken curtain rail 22(1)(a).

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

c) The condition of the overall approved centre environment was not developed and maintained with due regard to the specific needs and well-being of residents. Communal rooms, including the sitting room and dining room, were minimally furnished, imparting a stark appearance, 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 policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in January 2018. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had 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 contained dedicated space for routine medications, once off medications, and medications prescribed on an “as required” basis. Each MPAR was labelled with two resident identifiers and recorded the following specific information: medication allergies, generic medication names and preparations, frequency of administration, medication dose, the administration route, record of medication administration, date of initiation, and date of discontinuation. All entries to the MPAR were legible, written in black ink and included a prescriber’s signature and a Medical Council Registration number. Medication was reviewed and rewritten at least six-monthly. All prescriptions which required change were rewritten by the medical practitioner.

Appropriate practices were implemented for the receipt, administration, and storage of controlled drugs. Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident’s pharmacist. Where a medication was refused or withheld, this was documented in the MPAR and clinical file. Directions to crush medications were only accepted from the resident’s medical practitioner. A blanket instruction to crush medications was applied to all MPARs and was not specifically documented in each case. Consultation with a pharmacist concerning the type of preparation to be used was via telephone consultation only.

Medications storage areas were clean and free from litter, dust, pests, spillages, and damp. All medications were stored appropriately. Medication fridge temperatures were monitored daily. All medications dispensed to residents was stored securely in locked storage units. A system of stock rotation was implemented to avoid accumulation of old stock. An inventory of medications was conducted on a
monthly basis which checked the following: name and dose of medication, quantity of medication, and expiry date. Medications that were no longer required were stored in a secure manner, segregated from other medication and returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality assessment was rated 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 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 written operational policies and procedures and Connolly Hospital Safety Statement in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in February 2019. The safety statement was last reviewed in April 2018.

The policy and safety statement addressed requirements of the Judgement Support Framework, with the following exceptions:

- Specific roles are allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to its staffing requirements. The approved centre’s staffing policy was last reviewed in February 2019. The Connolly Hospital Policy for Staff Training and Development was last reviewed in 2015. The policies combined addressed the requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities in relation to staffing processes within the approved centre.
- The job description requirements.
- Staff performance and evaluation requirements.

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

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

Evidence of Implementation: There was an organisation chart to identify the leadership, management structure, and lines of authority and accountability within the approved centre. 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 not on duty and in charge at all times. Records from the preceding eight-week period showed that a registered psychiatric nurse was not on duty on three occasions from 16.40-20.00 and one occasion from 07.45-20.00.

The numbers and skill mix of staffing were insufficient to meet the assessed needs of residents, as the approved centre did not provide access to services from a variety of health professionals including a physical health occupational therapist, a social worker and a psychologist. Access to a dietitian was provided for urgent referrals only and there were no routine assessments or review for any resident. Staff were recruited and selected in accordance with the approved centre’s policy and procedure for
recruitment, selection and appointment. All staff had the appropriate qualifications to perform their jobs. The approved centre did not have a written staff plan.

The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance was available to staff throughout the approved centre.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training was completed for staff. Staff received training in line with the assessed needs of the resident group profile. Training topics included manual handling, infection control, dementia care, incident reporting, protection of vulnerable adults and dignity. Opportunities were made available to staff by the approved centre for further education. A cycle of in-service training was completed by appropriately trained individuals. Facilities and equipment located at Connolly Hospital were utilised for training and education purposes.

Not all health care staff had up-to-date mandatory training in the following areas: Basic Life Support, fire safety, management of violence and aggression, and the Mental Health Act. The table below highlights the percentages of staff per department who are trained in each of the five mandatory pillars.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
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<td>Nursing (32)</td>
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<tr>
<td>Occupational Therapy (2)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sycamore Unit</td>
<td>CNM2/CNM1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RGN</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>0.2 WTE</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>OTA</td>
<td>0.5 WTE</td>
<td>0</td>
</tr>
</tbody>
</table>

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Occupational Therapy Assistant (OTA), Whole time equivalent (WTE)*
The approved centre was non-compliant with this regulation for the following reasons:

a) The registered proprietor did not ensure that the skill mix of staff was sufficient to meet resident needs, as the approved centre did not provide access to a variety of health professionals including a physical health occupational therapist, a social worker, a psychologist and a dietitian, 26(2).

b) The registered proprietor did not ensure that there was an appropriately qualified staff member on duty and in charge of the approved centre at all times, 26(3).

c) The registered proprietor did not ensure that all staff had up-to-date mandatory training in Basic Life Support, fire safety and management of violence and aggression, 26(4).

d) The registered proprietor did not ensure that all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in February 2019. The policy addressed the requirements of the Judgement Support Framework, with the following exceptions:

- The record required to be created for each resident.
- The required content for each resident record.
- Those authorised to access and make entries in the residents’ records.
- The destruction of records.
- General Safety and security measures in relation to records.

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

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

Evidence of Implementation: All residents’ records were secure, up to date and in good order, and were constructed, maintained and used in accordance with national guidelines and legislative requirements. All records were physically stored together in a securely locked area within the approved centre. A record was initiated for every resident within the approved centre and was reflective of the resident’s current status and the care and treatment being provided. Resident records were maintained in a logical sequence and using an identifier that was unique to the resident. Only authorised staff had access and made entries into resident records.

All records were written legibly in black indelible ink. Entries were factual, consistent and did not contain jargon. Each entry was signed and dated but not always timed. Not all pages in the clinical file were consistently labelled using two resident identifiers. The approved centre maintained a record of all medical and nursing signatures used in the resident record. All errors in the record were corrected appropriately. Documentation of food safety, health and safety, and fire inspections were maintained in
the approved centre. Records were retained and destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure accuracy of all clinical records. Not all documented entries were timed and not all pages were labelled with two resident identifiers, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in January 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 not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. All policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines. Upon approval, policies and procedures were communicated to all staff.

The operating policies and procedures required by the regulation were all reviewed within a three-year period. Obsolete versions of policies and procedures were retained but removed from possible access by staff. The format of all policies was standardised and included a policy title, reference number, document owner, approver, reviewer, policy scope, implementation date and review date. All generic policies used were appropriate to the approved centre and were accompanied by a written statement adopting the policy.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of Mental Health Tribunals, which was last reviewed in January 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 could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: Mental Health Tribunals were held in facilities located within the Department of Psychiatry at Connolly Hospital. The approved centre provided adequate resources to support the Mental Health Tribunal Process. Staff were available to accompany and assist patients to attend or engage in the tribunal process if required.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

The policy did not address the following:

- The confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.

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

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was analysed. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints available in the approved centre and their contact details were displayed publicly. A consistent and standardised approach was implemented for the management of all complaints. Complaints could be lodged verbally, in writing, via e-mail, by telephone or via complaint form. Residents had access to an advocacy service and contact details for the local advocate were displayed within the approved centre.
Information concerning the complaints management process was documented in the resident information booklet.

All complaints, oral or written were investigated promptly and handled appropriately and sensitively. All minor complaints were documented in a minor complaints log and addressed by staff locally. Minor complaints that could not be resolved were escalated to the nominated person and recorded in a complaints log. Records indicated that timeframes for complaint investigation, resolution, and response were all achieved. The complainant was informed of the investigation process and outcome and their response was documented. All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner.

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

COMPLIANT
Quality Rating Satisfactory

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had four separate written documents and procedures in relation to risk management. The approved centre’s risk management policy was last reviewed in January 2018. The Connolly Hospital Safety Statement was last reviewed in April 2018. The Sycamore Unit Evacuation Plan was last reviewed in 2015. The Missing/Abducting Patient policy was last reviewed in February 2018. The policies and associated documents combined included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Not all 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. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

Evidence of Implementation: The person with responsibility for risk was identified and known by all staff. Risk management procedures actively reduced identified risk to the lowest practicable level. The risk register included clinical risks and health and safety risks. Individual risk assessments were completed upon resident admission, resident transfer, mechanical restraint, and in conjunction with medication requirements or administration. Structural risks were removed or effectively mitigated. Ligature points were not minimised but this was considered unnecessary due to the resident profile.
There was multidisciplinary involvement in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre was appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. Serious incidents were reviewed at the Sycamore Unit Management meetings; however, clinical incidents were not reviewed by the multidisciplinary team at their regular team meetings. Trend analysis of incidents was undertaken by the risk manager and six-monthly reports of all incidents were provided to the Mental Health Commission. There was an emergency plan in place that specified responses by staff to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education, monitoring, and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

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

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

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

INSPECTION FINDINGS

Evidence of Implementation: Mechanical restraint was applied to one resident in the approved centre. In this case, mechanical restraint was only used to address identified clinical need and when less restrictive alternatives were assessed as unsuitable. The mechanical restraint was ordered by the registered medical practitioner under supervision of the consultant psychiatrist.

Clinical records documented the following details: the enduring risk of harm to the resident, the less restrictive alternative implemented, the type of mechanical restraint used, the duration of the restraint and the order, the situation in which the mechanical restraint was applied, and the review date.

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

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

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

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In both cases, there was documented evidence that the responsible consultant psychiatrist had assessed the patients’ capacity to consent to receive treatment. In both cases, the result of the assessment was that the patient was deemed not capable of providing consent to treatment. A Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed in both cases and documented the following details:

- The names of the medications prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient including:
  - The nature and purpose of the medications.
  - Effects of medications, including risks and benefits and any views expressed by the patient.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
Approval by a consultant psychiatrist

Authorisation by a second consultant psychiatrist

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

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

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

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

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

Discharge was not inspected against as no resident had been discharged since the last inspection.

Processes: The approved centre had separate written policies in relation to admission and transfer.

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

Transfer: The transfer policy, which was last reviewed in December 2017, included all of the policy-related criteria for this code of practice.

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

Monitoring:

Admission: An audit had not been completed on the implementation of and adherence to the admission policy.

Transfer: An audit had been completed on the implementation of and adherence to the transfer policy.

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. An admission assessment was completed and included the following elements: presenting problem, past psychiatric history, medical history, family history, current and historic medication, social and housing circumstances, current mental health state, risk assessment, full physical examination, and any other relevant information.

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

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

a) Not all relevant staff had signed the policy logs indicating that they had read and understood the admission and transfer policies, 9.1.

b) Audit had not been completed on the implementation of and adherence to the admission policy, 4.19.
### Appendix 1: Corrective and Preventative Action Plan

#### Regulation 16: Therapeutic Services and Programmes

<table>
<thead>
<tr>
<th>Reason ID: 1000093</th>
</tr>
</thead>
<tbody>
<tr>
<td>The registered proprietor did not ensure that each resident had access to a range of therapeutic services in accordance with their individual care plan, 16(1).</td>
</tr>
</tbody>
</table>

<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>Executive Clinical Director to establish working group with Management of Connolly Hospital to address deficit of therapeutic Services.</td>
<td>Presence of staff working in Unit</td>
<td>Establishment of Working Group is realistic and achievable, ensuring therapeutic services for each resident will be budget and recruitment dependent.</td>
<td>31/12/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Ongoing meetings of working group between Mental Health Service and Connolly Hospital Management to address future difficulties as they arise.</td>
<td>Presence of staff working in Unit. Audit ICPs Quarterly.</td>
<td>Establishment of Working Group is realistic and achievable, ensuring therapeutic services for each resident will be budget and recruitment dependent.</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>
## Regulation 19 General Health

### Reason ID: 10000094

Adequate arrangements were not in place for access by residents to general health services and for their referral to other health services including dietetics and physical health occupational therapy, 19(1)(a).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Executive Clinical Director to Establish Working Group with senior management of Connolly Hospital to address ongoing issues.</td>
<td>Quarterly Audits on ICPs identify therapeutic deficiencies.</td>
<td>Establishment of Working Group is Achievable and realistic however provision of therapeutic services will be budget and recruitment dependent.</td>
<td>30/09/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Executive Clinical Director to Establish Working Group with senior management of Connolly Hospital to address ongoing issues.</td>
<td>Quarterly Audits on ICPs identify therapeutic deficiencies.</td>
<td>Establishment of Working Group is Achievable and realistic however provision of therapeutic services will be budget and recruitment dependent.</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>

### Reason ID: 10000095

Six monthly general health assessments were inadequately completed and, in all cases, did not reference the following: family/personal history, Body Mass Index, weight and waist circumference, blood pressure, smoking status, nutritional status, medication review and dental health, 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>Corrective Action</td>
<td>Issued new physical health assessment proforma form. All post dated general health assessments completed.</td>
<td>Quarterly Audit Monitored by Local QPS committee.</td>
<td>Achievable and realistic.</td>
<td>01/07/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Use of new proforma general health assessment form. At new NCHD induction</td>
<td>Quarterly Audit Monitored by Local QPS committee.</td>
<td>Achievable and realistic.</td>
<td>01/10/2019</td>
</tr>
</tbody>
</table>
to be reminded of
general health
assessments. Ward
diary to be used to
remind NCHDs of
when patient reviews
are due.
**Regulation 22: Premises**

**Reason ID : 10000096**

Premises were not maintained in a good decorative condition and the following issues were noted: holes in the walls where fixtures had been removed, scuff marks on the walls surrounding multiple doorways, discolouration of linoleum, unclean windows throughout the premises, and a broken curtain rail 22(1)(a). A programme of routine maintenance and renewal of fabric and decoration of the premises was not developed and implemented, 22(1)(c).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Connolly Hospital Estate Department to be contacted regarding repair of ward. Specific issues raised were highlighted and photographed as part of the request.</td>
<td>Twice annual audit of premises.</td>
<td>Highlighting deficits is both achievable and realistic however repairs will be budget and timeframe dependent.</td>
<td>31/07/2019</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Ongoing issues regarding maintenance of Sycamore Unit to be minuted as all Local area Management Committee Meetings and communicated to Estates in Connolly Hospital as required.</td>
<td>Twice annual audit of premises.</td>
<td>Highlighting deficits is both achievable and realistic however repairs will be budget and timeframe dependent.</td>
<td>31/12/2019</td>
</tr>
</tbody>
</table>

**Reason ID : 10000098**

The condition of the overall approved centre environment was not developed and maintained with due regard to the specific needs and well-being of residents. Communal rooms, including the sitting room and dining room, were minimally furnished, imparting a stark appearance, 22(3).
| Corrective Action | Upgrading of general furnishings will be raised with Estates in Connolly Hospital. However due to nature of residents and requirements of mobility aids (Frames/wheelchairs) furnishings in communal areas will always need to be widely distributed, and patient safety is priority in all renovations. | Twice yearly audits of premises monitored by QPS. | Achievable and Realistic to highlight issues and inform Estates Department. Renovations will be budget dependent. | 30/09/2019 | Clinical Nurse Manager; Clinical Director. |
| Preventative Action | Design of Unit and Furnishings are informed by best evidence on dementia care involving Multidisciplinary team. Need for renovations highlighted at twice yearly audit. | Twice yearly audits of premises monitored by QPS. Occupational therapist does annual environment report in addition. | Achievable and Realistic to identify deficits, renovations will be budget dependent. | 31/12/2019 | Clinical Nurse Manager; Clinical Director. |
Regulation 26: Staffing

Reason ID : 10000099

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>Executive Clinical Director to Establish Working Group with Senior Management in Connolly Hospital to address therapeutic staff deficit.</td>
<td>Measured through audits of individual resident ICPs.</td>
<td>Establishment of Working Group is realistic and achievable however resolving staffing deficit will be recruitment dependent.</td>
<td>30/09/2019</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>Corrective Action</td>
<td>Rostering of Nursing staff to ensure an appropriately qualified staff member on duty and in charge at all times, Agency staff used to cover shortages in staffing.</td>
<td>Weekly review of roster and quarterly audits.</td>
<td>Achievable and realistic.</td>
<td>16/07/2019</td>
</tr>
</tbody>
</table>

Reason ID : 10000100

The registered proprietor did not ensure that there was an appropriately qualified staff member on duty and in charge of the approved centre at all times, 26(3).
<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Ensuring an appropriate skill mix of appropriately qualified staff to unit. CNM and ADON approval of roster prior to circulation to ensure appropriate staff mix on duty at all times.</th>
<th>Weekly review of roster and quarterly audits.</th>
<th>Achievable and Realistic within the confines of recruitment difficulties. Post for RPN was advertised in Feb 2019 but remains unfilled due to lack of applicants.</th>
<th>31/12/2019</th>
<th>Assistant Director of Nursing and Clinical Nurse Manager.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason ID : 10000101</td>
<td>The registered proprietor did not ensure that all staff had up-to-date mandatory training in Basic Life Support, fire safety and management of violence and aggression, 26(4). &amp; The registered proprietor did not ensure that all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).</td>
<td>Specific Measurable Achievable/Realistic Time-bound Post-Holder(s)</td>
<td>Corrective Action</td>
<td>All staff were reminded of need to complete mandatory training. Fire Safety; MAPA and BLS training have been organised and run since inspection of unit.</td>
<td>Quarterly Audit of Mandatory training log monitored to local QPS committee.</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>All existing staff were reminded of need to complete mandatory training. Fire Safety; MAPA and BLS training have been organised and run since inspection of unit. New staff have reminders of</td>
<td>Quarterly Audit of Mandatory training log monitored to local QPS committee.</td>
<td>Availability of qualified trainers to deliver non &quot;on-line&quot; training (ie MAPA; BLS) is a limiting factor in achieving full compliance. Maintenace of appropriate staff skill mix on ward is a barrier to release staff for training activities due to small size of unit.</td>
<td>31/12/2019</td>
<td>Clinical Nurse Manager and Clinical Nurse Manager.</td>
</tr>
<tr>
<td>Mandatory training as part of their induction.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
**Regulation 27: Maintenance of Records**

**Reason ID: 10000103**

The registered proprietor did not ensure accuracy of all clinical records. Not all documented entries were timed and not all pages were labelled with two resident identifiers, 27(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></td>
<td>All staff informed and reminded of need for timing of notes and each page needs to labeled with two patient identifiers.</td>
<td>Quarterly Audits monitored by Local Area QPS committee.</td>
<td>Achievable and realistic</td>
<td>16/07/2019</td>
<td>Clinical Director; Clinical Nurse Manager.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Time-bound</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All staff informed and reminded of need for timing of notes and each page needs to labeled with two patient identifiers. Notice placed in ward station.</td>
<td>Quarterly Audits monitored by Local Area QPS committee.</td>
<td>Achievable and realistic</td>
<td>30/12/2019</td>
<td>Clinical Director; Clinical Nurse Manager.</td>
</tr>
</tbody>
</table>
## Code of Practice on Admission, Transfer and Discharge to and from an approved centre

**Reason ID : 10000091**

Not all relevant staff had signed the policy logs indicating that they had read and understood the admission and transfer policies, 9.1. & Audit had not been completed on the implementation of and adherence to the admission policy, 4.19.

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy have been updated and approved by Clinical Director. All staff being reminded to sign policy via email/handovers and Ward Rounds.</td>
<td>Audit Quarterly and monitored by QPS of local area management.</td>
<td>Achievable and Realistic</td>
<td>30/09/2019</td>
<td>Clinical Nurse Manager and Clinical Director</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All new staff to be given policies to read and sign on induction (including NCHs). Following updating of Policies all new policies are to be circulated to staff to sign</td>
<td>Audit Quarterly Monitored by Local Area QPS committee.</td>
<td>Achievable and Realistic</td>
<td>30/09/2019</td>
<td>Clinical Nurse Manager &amp; Clinical Director</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.