Ashlin Centre

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

Coimisiún Meabhair-Shláinte | Mental Health Commission

ASHLIN CENTRE

Ashlin Centre, HSE North Dublin Mental Health Services, Beaumont Road
Dublin 9

Date of Publication:
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2020 Approved Centre Inspection Report (Mental Health Act 2001)

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

Most Recent Registration Date:
16 May 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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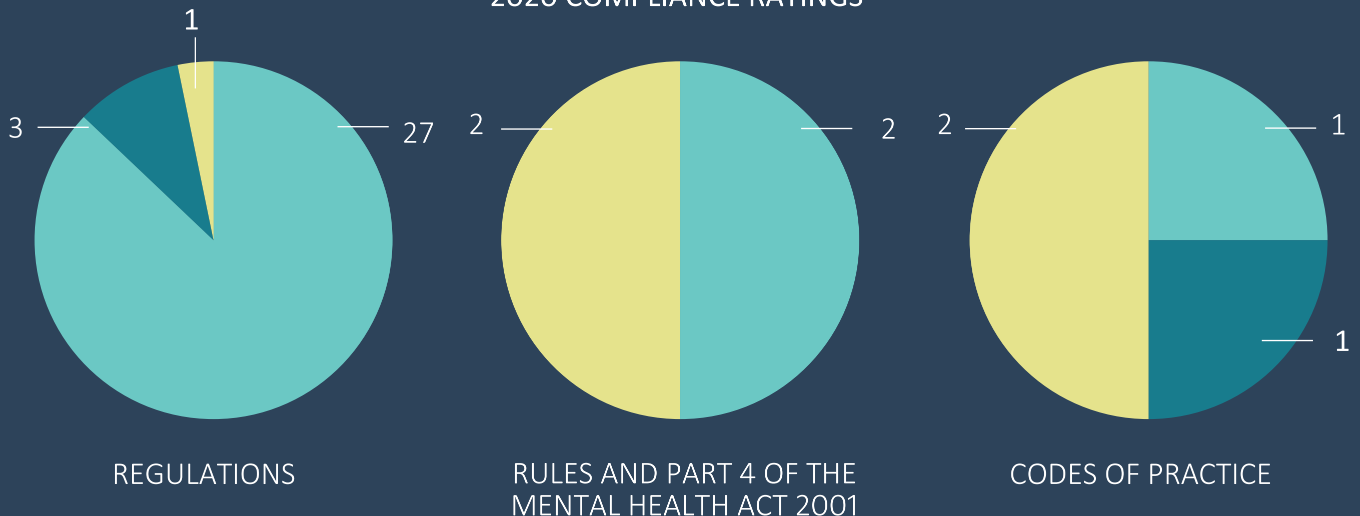
Inspection Date:
28 – 31 January 2020

Previous Inspection Date:
19 – 21 February 2019

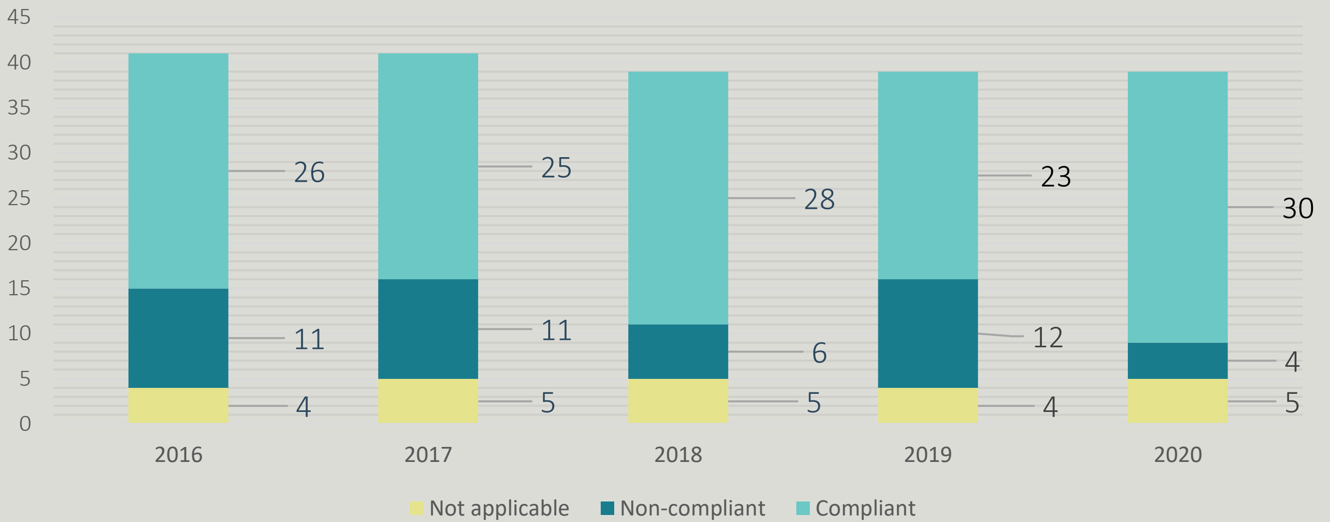
Inspection Type:
Unannounced Annual Inspection



RATINGS SUMMARY 2016 – 2020

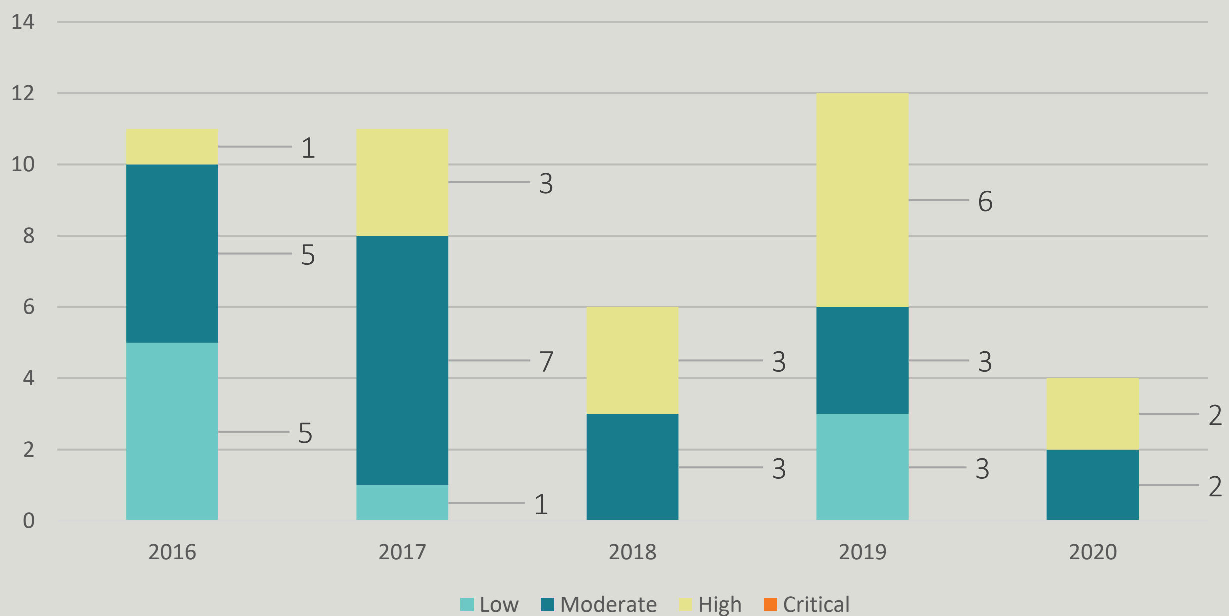
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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 2016 – 2020



Contents

1.0 Inspector of Mental Health Services – Review of Findings 6
Conditions to registration 6
2.0 Quality Initiatives 10
3.0 Overview of the Approved Centre 11
3.1 Description of approved centre 11
3.3 Reporting on the National Clinical Guidelines 13
4.0 Compliance..14
4.1 Non-compliant areas on this inspection 14
4.2 Areas of compliance rated "excellent" on this inspection..14
4.3 Areas that were not applicable on this inspection 15
5.0 Service-user Experience 16
6.0 Feedback Meeting..18
7.0 Inspection Findings – Regulations..19
8.0 Inspection Findings – Rules 67
9.0 Inspection Findings – Mental Health Act 2001 70
10.0 Inspection Findings – Codes of Practice..73
Appendix 1: Corrective and Preventative Action Plan..78
Appendix 2: Background to the inspection process 82

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

The Ashlin Centre was a 46-bed approved centre providing acute care and treatment for North Dublin Mental Health Services (NDMHS). It was located in the grounds of Beaumont Hospital. Sheehan Unit, located on the first floor, was an eight-bed facility dedicated to Mental Health services for older people (MHSOP). The Joyce Unit, located on the ground floor, was a 38-bed facility for general adult admissions and had eight high dependency beds. All accommodation comprised of single bedrooms with en suite facilities.

The approved centre served a population of over 250,000. There were 11 consultant-led sector or treating teams, with a rehabilitation team and a MHSOP team.

Ten residents had been in the approved centre for more than six months, and a number of these for greater than one year. A delayed discharge group had been convened prior to the last inspection and met fortnightly. The overall bed capacity for the previous three month period had always been below 100% for Joyce Unit and on the first day of inspection was 76%.

There had been an increase in compliance with regulations, rules and codes of practice and a significant increase in compliance with regulations rated as excellent since 2016.

Compliance Summary 2016 - 2020

	2016	2017	2018	2019	2020
% Compliance	70%	69%	82%	66%	88%
Regulations Rated Excellent	7	3	5	5	17

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

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

Finding on this inspection: The approved centre was not in breach of Condition 1. However, the audits of Individual Care Plans did not reflect or concur with the findings on inspection. The approved centre was non-compliant with Regulation 15: Individual Care Plans at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically. A food temperature log sheet was maintained and monitored. Appropriate hand-washing areas were provided for catering services and appropriate personal protective equipment was used during the catering process.
- The ordering, prescription, storing and administration of medication was excellent.
- Current national infection control guidelines were followed and all areas were clean.
- Not all staff had received training in Basic Life Support, fire safety, management of violence and aggression and Children First, although, with the exception of medical staff, there had been some improvement in this mandatory training since 2019.

Appropriate care and treatment of residents

- The provision of general health care and the regular monitoring for physical illness was excellent.
- The provision of therapeutic programmes and services for residents was excellent. "Clevertouch" interactive whiteboards had been installed in Joyce Unit for staff and in Joyce and Sheehan Unit activity areas for the therapeutic and recreational use for residents.
- Staff were trained in line with the assessed needs of the resident group profile and of individual residents. This included manual handling, infection control, dementia care, end of life care, risk management, incident reporting, care for residents with intellectual disabilities, and the protection of children and vulnerable adults.
- Physical health of residents was monitored regularly and there was ready access to general medical care if required.

However:

- A sample of 10 Individual Care Plans (ICP) were inspected.
    - In two cases, the ICP was not discussed, agreed and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.
    - Not all ICP's appropriately identified the resident's assessed needs.
    - Five ICPs did not identify appropriate goals for the resident.
    - Seven ICPs did not identify the care and treatment required to meet the goals identified.
    - Four ICPs did not identify the resources required to provide the care and treatment identified.

- For four residents the ICP meeting had not been convened with a multi-disciplinary team.
- For one resident the weekly meeting had not taken place for three consecutive weeks.
- Seven ICPs did not include a risk management plan.
- One ICP did not contain a preliminary discharge plan.

Respect for residents' privacy, dignity and autonomy

- The approved centre was kept in a good state of repair externally and internally and there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. Faults or problems were communicated through the appropriate maintenance reporting process.
- There was a cleaning schedule implemented within the approved centre and it was clean, hygienic, and free from offensive odours.
- All bedrooms were single and en suite. Residents' privacy was noted to be respected throughout the inspection.
- The use of seclusion was in compliance with the Rules Governing the Use of Seclusion.

Responsiveness to residents' needs

- There was an adequate amount and frequency of recreational activities which were suited to the needs of the residents.
- Residents were allowed to communicate freely by phone or email and visiting times were clearly signposted.
- There was a choice of meals and food was well presented and nutritious.

Governance of the approved centre

- The approved centre was part of the HSE's Community Healthcare Organisation, Dublin North City and County (CHO-DNCC). The local management team North Dublin Mental Health Service (NDMHS) were responsible for the overall management and governance of the approved centre.
- A weekly 'Community Meeting' was held with the residents and staff representatives, and the minutes were documented and circulated within the approved centre. At the time of inspection, the position of area lead for mental health engagement was vacant. There was no service user representative on Management Team and the Quality and Patient Safety Committee meetings.
- National Incident Report Forms (NIRF) were inputted electronically: the Ashlin Centre was the pilot centre for this national initiative. Trends were analysed and a summary returned to the approved centre quarterly for a NIRF Risk Review of Trends Meeting.

- A risk register was maintained within the approved centre and there was a person identified and known by staff with responsibility for risk management. The Quality and Patient Safety Committee met monthly.
- There was a clinical audit cycle in the approved centre. Audits and analysis had been mainly completed by nursing management staff with support from the Mental Health Act administrator. Medical and allied health professional staff had not been involved in the clinical audit cycle in the approved centre.
- Three staff from the approved centre were on the wider Policy Procedure Protocol Group (PPPG) and, as applicable, policies had been reviewed and updated. The service had undertaken a review of all the policies to ensure standardization with the National HSE policy template.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A Physical Health Improvement Toolkit (PHIT) had been developed and implemented for use by staff with the residents. This focussed on health promotion, physical health and physical well-being. A new physical health assessment had been implemented on admission for each resident.

2. A Healthy Eating Initiative had commenced alongside a working group with nursing staff, occupational therapy, dietitian and catering staff. Changes since the last inspection included alteration in the menu and removal of sugar from the dining tables.

3. The approved centre had received a bursary award for the successful implementation of their tobacco free campus.

4. Make Every Contact Count (MECC) training, a HSE initiative, had commenced and was being delivered on-site. This had also been incorporated into the physical examination on admission and further included the tobacco free campus and smoking cessation initiatives previously implemented.

5. A gardening project had commenced with staff and residents. A greenhouse had been installed to facilitate the development of this initiative.

6. 'Clevertouch' interactive whiteboards had been installed in Joyce Unit for staff and in Joyce and Sheehan Unit activity areas for the therapeutic and recreational use for residents.

7. Medical personnel had commenced the delivery of 'Bitsize' sessional 15 minute talks on common physical health problems for staff.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Ashlin Centre was a 46-bed approved centre providing care and treatment for North Dublin Mental Health Services (NDMHS). It was located in the grounds of Beaumont Hospital but was a separate facility with different governance and reporting structures.

The purpose-built approved centre, opened in 2014. The Sheehan Unit, located on the first floor, was an eight-bed facility dedicated to Psychiatry of Old Age (POA). The Joyce Unit, located on the ground floor, was a 38-bed facility for general adult admissions. Eight beds in the Joyce Unit were deemed high dependency. All accommodation comprised of single bedrooms with en suite facilities. The approved centre had an activities area incorporating an art room, sensory room, activities kitchen, and therapy rooms. There were five internal gardens, four serving the Joyce Unit and one for the Sheehan Unit. The four gardens serving the Joyce Unit had been upgraded and replanted since the last inspection.

The approved centre served a population of over 250,000. There were 11 consultant-led sector or treating teams. These included two Kilbarrick teams, two Swords teams, two Balbriggan teams, and one team each for Darndale, Killester, and Coolock. There was a rehabilitation team and a POA team.

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

Resident Profile	
Number of registered beds	***46***
Total number of residents	**35**
Number of detained patients	11
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	10
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of the HSE’s Community Healthcare Organisation, Dublin North City and County (CHO-DNCC). The local management team North Dublin Mental Health Service (NDMHS) were responsible for the overall management and governance of the approved centre. There was an organisational chart and clear governance structures in place. Minutes of the NDMHS management team meetings were provided to the inspection team. These minutes evidenced monthly meetings with rotating

agendas that addressed: finance, governance and compliance; access and integration; quality and safety and workforce. The Quality and Patient Safety Committee meetings were also held monthly.

At the time of inspection the position of area lead for mental health engagement was vacant. Formerly, this person was a member of the NDMHS management team and would have attended Management Team and the Quality and Patient Safety Committee meetings. There was no service user representative on these committees. A representative from the Irish Advocacy Network (IAN) visited the approved centre weekly. They had informal meetings with staff and reported that, generally, issues raised by them on behalf of the residents were quickly addressed. A weekly 'Community Meeting' was held with the residents and staff representatives, and the minutes were documented and circulated within the approved centre. A Peer Support (Student) Worker had been on placement in the approved centre for three months towards the end of 2019. This had worked well and was reported as a successful initiative.

National Incident Report Forms (NIRF) were imputed electronically: the Ashlin Centre was the pilot centre for this national initiative. Trends were analysed and a summary returned to the approved centre quarterly for a NIRF Risk Review of Trends Meeting. An anonymised data basis of incidents was held within the approved centre. The Quality and Patient Safety Committee met monthly and serious reportable events (SREs) Serious Incidents (SIs) and Incident Reports and Organisational Risk Register were standing agenda items. Specific health and safety items relating to the Ashlin Centre were discussed and actioned from this forum. A risk register was maintained within the approved centre and there was a person identified and known by staff with responsibility for risk management. As applicable, risks had been escalated to the organisational risk register specific to the approved centre.

There was a clinical audit cycle in the approved centre to ensure the monitoring pillars of the *Judgment Support Framework* were actioned and documented as applicable. A number of audits scored highly and reflected the findings of the inspectors; however, this was not always the case. For example, the audit of Individual Care Plans and the audit of Maintenance of Records did not reflect or concur with the findings on inspection. Specifically, the former had been audited monthly as part of a condition on the approved centres registration. Audits and analysis had been mainly completed by nursing management staff with support from the mental health act administrator. Medical and allied health professional staff had not been involved in the clinical audit cycle in the approved centre. There was, however, a clinical audit review working group for the wider NDMHS that reported to the quality and patient safety committee.

There was an emphasis in the approved centre on staff training, particularly mandatory training. Staff had been trained as trainers, and training for the greater part was now delivered on-site. The health professionals worked collaboratively in this regard and training was primarily multi-disciplinary. On the week of the inspection, fire safety, management of violence and aggression, and Make Every Contact Count (MECC) had been facilitated and delivered for staff on-site. Some staff were facilitated to pursue post graduate diplomas, Master in Science (M.Sc.) and other educational training. 'Bitsize Learning' in the form of 15 minute sessions were facilitated by medical personnel to staff in the approved centre. These were short presentations on common physical health problems. Three staff from the approved centre were on the wider Policy Procedure Protocol Group (PPPG) and, as applicable, policies had been reviewed and updated. The service had undertaken a review of all the policies to ensure standardization with the National HSE policy template. The

approved centre worked to ensure that staff had signed to indicate that they had read and understood relevant policies.

Ten residents had been in the approved centre for more than six months, and a number of these for greater than one year. The service sought to manage this and were seeking alternative, more suitable placements in line with individual assessed needs. A delayed discharge group had been convened prior to the last inspection and met fortnightly. Residents with more complex needs and who had been assessed as requiring more specialised services were also discussed at management team meetings. Despite a proportion of the inpatient population being in the approved centre greater than 6 and 12 months, the overall bed capacity for the previous three month period had always been below 100% for Joyce Unit.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 15: Individual Care Plan	✗	Moderate	✗	High	✓		✗	High	✗	High
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate
Regulation 27: Maintenance of Records	✗	Low	✓		✓		✓		✗	High
Codes of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✗	Moderate	✗	Moderate	✗	Low	✗	Moderate

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

4.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 14: Care of the Dying
Regulation 16: Therapeutic Services and Programmes
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 21: Privacy
Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines
Regulation 25: Use of CCTV
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals
Regulation 31: Complaints Procedures

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre had not admitted any children since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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

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

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

The inspection team met with four residents and a family member. All commented positively about the staff, the food, the premises and the activities available. Two residents made specific reference to the good provision of physical care in the approved centre.

Twelve completed service-user questionnaires were returned. Six residents ticked to indicate that on admission to the approved centre a member of staff had explained what was happening in a way that was understood. This section was left blank for two, 'never' for two and 'cannot remember' was commented for two. Five service-users indicated that staff 'always' gave information regarding diagnosis and care and treatment, three indicated 'sometimes' for this question with a further two indicating 'never'. Two were not completed for this question.

Nine completed forms indicated that the resident knew who their multi-disciplinary team members were with four of the nine indicating that they were 'always' involved in setting goals for their individual care plan, five stated 'sometimes' involved and two stated 'never'. Eight forms indicated that the resident understood their individual care plan with two indicating 'no' for this question and a further two were not completed.
Most residents indicated that they always felt able to discuss their worries or concerns with a staff member with the remaining indicating that they did not have worries or concerns. Eleven residents indicated that they were happy with how staff talked to them. All indicated that they had space for privacy and their privacy and dignity was respected. Eight residents ticked that they 'always' felt safe in the approved centre, two indicated 'sometimes' for this question, one indicated 'never' and one had not been completed.

On a scale of 1-10, with 1 being poor and 10 being excellent, three residents rated 10 out of 10 for overall experience of care and treatment, four residents rated 8-9, two residents rated 7 and one rated 6. A further two had not been completed.

The Irish Advocacy Network (IAN) representative visited the approved centre weekly. There was a notice naming the IAN contact and details. A member of the inspection team spoke with the IAN representative to discuss issues and positive aspects as reported by residents. The food was reported to be excellent and in particular how the approved centre catered for special diets. The presence of the social worker in the approved centre and access by residents to social work was reported very positively. Residents had also reported positively on their physical care needs, information on medication and diagnosis and the range of activities available throughout the week.

Areas of concern reported by service users to the advocate included the approved centre now being a tobacco free campus. Service users had expressed that while the groups were very good they were not always cognisant of the different levels of recovery. It was acknowledged that that while the bedrooms were generally locked during the day, considerations for access to the bedrooms were made on a case by case basis. Lastly residents had suggested through the advocate that legal representatives and visiting consultant psychiatrists notify the resident in advance of the time they will be in attendance.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Clinical Director
- General Manager and Registered Proprietor Nominee
- Head of Service Mental Health
- Service Manager
- Area Engineering Manager
- Senior Social Worker
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 2 x 2
- Assistant Director of Nursing
- Occupational Therapy Manager
- Mental Health Act Administrator
- Principal Psychology Manager
- Pharmacist

Apologies were received on behalf of the Area Director of Nursing and the Principal Social Worker, both of whom were represented at the meeting.

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

7.0 Inspection Findings – Regulations

EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Approved centre menus were approved by a dietitian 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, and had at least two choices for meals. Hot meals were provided on a daily basis, and food, including modified consistency diets, were presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition. Hot and cold drinks were offered to residents regularly and a source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre.

For residents with special dietary requirements, an evidence-based nutrition assessment tool was used and weight charts were implemented, monitored, and acted upon for residents, where appropriate. Residents, their representatives, family, and next of kin were educated about residents' diets as part of the approved centre's Physical Health Improvement Toolkit (PHIT) programme, specifically in relation to any contraindications with medication. Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Intake and output charts were maintained for residents, where appropriate.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in March 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Food preparation, handling, storage, distribution, and disposal controls.
- Adhering to the relevant food safety legislative requirements.
- The management of catering and food safety equipment.

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

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

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

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

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

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

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents were entitled to bring personal possessions with them, the extent of which was agreed at admission. On admission, the approved centre compiled a detailed property checklist with each resident, property was safeguarded when the approved centre assumed responsibility for it. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

The property checklist was updated on an ongoing basis, in line with the approved centre's policy, was kept separately to the resident's individual care plan (ICP), and was available to the resident. The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Where money belonging to a resident was handled by staff, signed records of the staff issuing the money was retained: where possible, this was counter-signed 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 ICP and in accordance with the approved centre's policy.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and weekends. Information was provided to residents in an accessible format, which was appropriate to their individual needs, and which included the types and frequency of appropriate recreational activities available within the approved centre. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement: comprehensive minutes of community meetings were maintained and these provided the basis for the development of the activities programmes.

Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. Resident decisions on whether or not to participate in activities were respected and documented, as appropriate. The recreational activities provided by the approved centre were appropriately resourced, though sufficient opportunities were not provided for indoor and outdoor activities as the gym was not available for use at the time of the inspection and the garden was too small for exercise opportunities. Communal areas were provided that were suitable for recreational activities. Documented records of attendance were retained for recreational activities in group records or within the resident's clinical file, as appropriate.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in January 2020. The policy included all 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. Facilities were provided within the approved centre for residents' religious practices. Ministers of the Eucharist attended the unit and residents had access to multi-faith chaplains. Residents also had access to local religious services and were supported to attend mass in Beaumont Hospital, if deemed appropriate following a risk assessment. Care and services provided within the approved centre were respectful of the residents' religious beliefs and values and any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Visiting times were publicly displayed and were appropriate and reasonable. Separate visitors' rooms were provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting the approved centre were accompanied at all times to ensure their safety and this was communicated to all relevant individuals publicly. The visiting rooms were suitable for children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents had access to mail, e-mail, internet, telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and documented in the individual care plan. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

Regulation 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Monitoring: A log of searches was maintained. Each search record had not been systematically reviewed to ensure that the requirements of the regulation had been complied with.

Evidence of Implementation: The resident search policy and procedure was communicated to all residents risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Resident consent was sought prior

to all searches and request for consent and the received consent were documented. Where consent was not received, this was documented and the process relating to searches without consent was implemented. Residents were informed by those implementing the search of what was happening during a search and why.

A minimum of two clinical staff were in attendance at all times when searches were being conducted and searches were implemented with due regard to the resident's dignity, privacy, and gender: at least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every search of a resident and every property search was available. In one search examined, while two staff were recorded as having undertaken the search, their names were not recorded.

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

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying. The policy was last reviewed in March 2018. The policy and protocols included all 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: Documented analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: Documentation relating to the sudden death of a resident in the approved centre since the last inspection was examined. The sudden death was managed in accordance with legal requirements and with the resident’s religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends. Support was given to other residents and staff following the resident’s death. The death was notified to the Mental Health Commission as soon as was practicable and no later than within 48 hours 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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

Evidence of Implementation: Ten ICPs were examined during the inspection process. The ICPs were a composite set of documents and included allocated space for goals, treatment, care, resources required, reviews, were stored within the clinical file, and were identifiable, uninterrupted, and were not amalgamated with progress notes. Each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address immediate needs of the resident. In three cases, the resident's ICP was not developed by the MDT following a comprehensive assessment, while one ICP was not developed by the MDT within the required seven days of admission.

The comprehensive, evidence-based assessments included: medical, psychiatric, and psychosocial history; medication history and current medications; a current physical health assessment; a detailed risk assessment; social, interpersonal, and physical environment-related issues, including resilience and strengths; communication abilities, and; educational, occupational, and vocational history. In two cases, the ICP was not discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. Not all ICP's appropriately identified the resident's assessed needs. Five ICPs did not identify appropriate goals for the resident and seven ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the resident's care and treatment. Four ICPs did not identify the

resources required to provide the care and treatment identified. For four residents the ICP meeting had not been convened with a multi-disciplinary team. For one resident the weekly meeting had not taken place for three consecutive weeks.

In all cases, a key worker was identified to ensure continuity in the implementation of a resident's ICP. However, seven ICPs did not include a risk management plan, while one ICP did not contain a preliminary discharge plan. All ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. There was no documentation in two ICPs to indicate that the resident had access to the ICP, was kept informed of any changes or was offered a copy of their ICP, including any reviews. When a resident declined or refused a copy of their ICP, this was recorded, including the reason, if given.

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

a) Three ICPs were not developed by the resident's MDT.
b) There was no evidence of resident involvement in the development of ICPs in two cases.
c) Five ICPs inspected did not contain specific and appropriate goals for the residents.
d) Seven ICPs did not adequately identify the care and treatment required to meet identified goals.
e) Four ICPs did not identify the resources required to provide the care and treatment identified.
f) Four ICPs were not reviewed by the resident's MDT.
g) One ICP was not reviewed weekly in an acute setting.
h) One ICP was not developed within seven days of admission.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes, which was last reviewed in January 2020. The policy included all requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, and met the assessed needs of the residents, as documented in their individual care plans. A list of all therapeutic services and programmes provided in the approved centre was available to residents, including on a noticeboard.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes, which were held in a separate, dedicated room containing facilities and space for individual and group therapies. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services or programmes in residents' individual care plans or clinical files.

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

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in September 2019. The policy included all requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre was examined on inspection. Communication records with the receiving facility were documented and available on inspection, including agreement of resident receipt prior to transfer. Documented verbal communication and liaison took place between the approved centre and the receiving facility prior to the transfer that detailed the reasons for transfer, the resident's accompaniment requirements on transfer, and the resident's care and treatment plan, including needs and risk. The resident consented to the transfer. An assessment of the resident was completed prior to the transfer, including individual risk assessment relating to the transfer and the resident's needs. This was documented and provided to the receiving facility.

Full and complete written information for the resident was transferred when they moved from the approved centre to the other facility. Information was sent in advance or accompanied the resident upon transfer, to a named individual. A resident transfer form and a letter of referral containing a list of current medications was included in the information issued as part of the transfer documentation. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility and copies of all records relevant to the resident transfer were retained in the resident's clinical file.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the provision of general health services, which was last reviewed in May 2018. The approved centre had policy and procedures for responding to medical emergencies, which was last reviewed in January 2020. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Residents' take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED), on which weekly checks were completed. Records were available of medical emergencies within the approved centre and the care provided. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans (ICP).

Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly general health assessments, five of which were examined, documented a physical examination, family and personal history, blood pressure, smoking status, dental health, a medication review, nutritional status, as well as body-mass index, weight, and waist circumference.

For residents on antipsychotic medications, there was an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Residents could access national screening programmes according to age and gender, including Breast Check, cervical screening, retina check, and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre and residents had access to smoking-cessation programmes.

The approved centre had developed a Physical Health Improvement Toolkit (PHIT) and there was emphasis on educating and imparting knowledge on physical ailments and illnesses to include national screening services.

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 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in January 2020. The policy and procedures included all requirements of the *Judgement Support Framework*.

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

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

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

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Where applicable, the justification for restricting information regarding a resident's diagnosis was documented in the resident's clinical file.

The information documents provided by or within the approved centre were evidence-based and were appropriately reviewed and approved prior to use. The approved centre had developed specific booklets on different illnesses that were presented in an easy-to-read and understandable format. Medication information sheets, as well as verbal information from staff including a pharmacist, were provided in a format appropriate to the residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Excellent**

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 January 2020. The policy included all requirements of the *Judgement Support Framework*.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

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

Evidence of Implementation: Residents were called by their preferred name and the general demeanour of staff and the manner in which they addressed residents was respectful. Staff were discreet when discussing a resident's condition or treatment needs and sought residents' permission before entering their rooms. All residents wore clothes that respected their privacy and dignity.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas and 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 excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in August 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the approved centre’s utility controls and requirements.

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

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

Evidence of Implementation: Residents had access to personal space and appropriately sized communal rooms were provided. There was suitable and sufficient heating: rooms were centrally heated, with guarded pipework and radiators, though the heating could not be controlled in the resident’s own room. Rooms were sufficiently lit and ventilated, and both private and communal spaces were suitably sized and furnished to remove excessive noise. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp

edges, and hard or rough surfaces, were minimised in the approved centre, as were ligature points to the lowest practicable level.

The approved centre was kept in a good state of repair externally and internally and there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. There was a cleaning schedule implemented within the approved centre and it was clean, hygienic, and free from offensive odours. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed and back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre. Toilets were accessible, clearly marked, and close to day and dining areas. Wheelchair accessible toilet facilities were identified for use by visitors who required such facilities, and there was at least one assisted toilet per floor. The approved centre had a designated sluice room, laundry room, and cleaning room. The approved centre also had appropriately sized lifts, dedicated therapy and examination rooms. Suitable furnishings were provided to support resident independence and comfort, as were assisted devices to address resident needs. Remote or isolated areas of the approved centre were monitored.

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

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

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication. The policy was last reviewed in July 2019. The policy included all requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were inspected. The MPARs detailed: two appropriate resident identifiers; the generic name of the medication and preparation; the names of medications and preparations written in full; the dose given; the administration route for the medication; a record of any allergies or sensitivities to any medications, including if the resident has no allergies; the frequency of administration, including the minimum dose interval for "*as required*" (PRN) medication, and; dedicated space for routine, once-off, and PRN medication. All of the MPARs examined also contained a record of every medication administered to and refused by the resident, a clear record of both the date of initiation and the date of discontinuation for each medication, the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident, and the signature of the medical practitioner for each entry.

All entries in the MPARs were legible and written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's

care or condition. This was documented in the clinical file. No prescription was altered where a change was required. Instead, where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner.

Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident's pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration and expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. When a resident's medication was withheld, the justification was noted in the MPAR and documented in the clinical file. Where a resident refused medication, this was documented in the MPAR and clinical file and communicated to medical staff.

Schedule 2 controlled drugs were checked by two staff members, one of whom was a registered nurse, against the delivery form and details were entered on the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book and, following administration, the details were entered in the controlled drug book and signed by both staff members. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were clean and free from damp, mould, litter, dust, pests, and from spillage or breakage. Medication storage areas were incorporated in the cleaning and housekeeping schedules and neither food nor drink was stored in areas used for the storage of medication.

Medication dispensed or supplied to a resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as a refrigerator. The medication trolley remained locked at all times and secured in a locked room. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. A system of stock rotation was implemented, to avoid accumulation of old stock and an inventory of medications was conducted on a monthly basis that checked the name and dose of medication, the quantity of medication, and the expiry date. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

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

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in September 2019. It also had an associated safety statement, dated February 2019. The policy and the safety statement included all requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in May 2018. The policy addressed all requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre.

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented.

Evidence of Implementation: There were clear signs in prominent positions throughout the approved centre where CCTV cameras or other monitoring systems were located. A resident was monitored solely for the purposes of ensuring the health, safety, and welfare of that resident. CCTV cameras used to observe a resident were incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form, and did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they began to act in a way that compromised their dignity. The use of CCTV or other monitoring systems had been disclosed to the Mental Health Commission.

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

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The policy did not address the frequency of training needed to provide safe and effective care and treatment in accordance with best contemporary practice.

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

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

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre's staff. 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. The numbers and skill mix of staffing were sufficient to meet resident

needs. All staff were recruited, selected, and vetted in accordance with the approved centre's policy and procedure for recruitment, selection, and appointment. Information from referees was also sought. Staff had the appropriate qualifications to do their job and an appropriately qualified staff member was documented on duty and in charge at all times.

There was no written staffing plan for the approved centre. Where agency staff were used, there was a comprehensive contract between the approved centre and licensed staffing agency used that set out the agency's responsibilities in relation to confirmation of registration, identity, indemnity, staff training, and arrangements for responding to concerns or complaints.

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. Both orientation and induction training was completed for staff. Not all healthcare professionals were up to date in fire safety, Basic Life Support and the management of violence and aggression. Not all healthcare professionals had completed the mandatory training for the Mental Health Act 2001 and Children First. This is detailed in the training record table below. Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. This included manual handling, infection control, dementia care, end of life care, risk management, incident reporting, care for resident's with intellectual disabilities, and the protection of children and vulnerable adults.

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

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

Staff Training Table

Profession	Basic Life Support		Fire Safety		Mgmt. of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (40)	35	87.5%	36	90%	34	85%	40	100%	38	95%
Medical (38)	26	68%	31	82%	26	68%	15	39%	23	61%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (3)	2	66%	2	66%	3	100%	3	100%	3	100%
Psychologist (5)	0	0%	2	40%	2	40%	5	100%	5	100%

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

Staff in Approved Centre			
	Staff Grade	**Day**	**Night**
	Assistant Director of Nursing	1 WTE (9-5)	
	Clinical Nurse Manager 3	1	1
	Clinical Nurse Manager 2 (Physical Health)	1	
	NCHD	1	1

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Joyce	Clinical Nurse Manager 2	1	
	Registered Psychiatric Nurse	6	6
	Occupational Therapist	1	
	Social Worker	1	
	Health Care Assistant	2	
	Activity Nurse	1	
	Activity HCA	1	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Sheehan	Clinical Nurse Manager 2	1 WTE (9-5)	
	Clinical Nurse Manager 1	1	
	Registered Psychiatric Nurse	1	2
	Occupational Therapist	0.2 WTE	
	Health Care Assistant	1	1
	NCHD	1 (9-5)	

In-reach to Approved Centre*			
	Staff Grade	**Day**	**Night**
	Consultant Psychiatrist	13	
	Non Consultant Hospital Doctor	22	
	Occupational Therapist	14	
	Social Worker	14	
	Psychologist	12	

Whole time equivalent (WTE)

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA) Non Consultant Hospital Doctor (NCHD)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

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

a) **Not all healthcare professional staff were up to date with mandatory training of fire safety, Basic Life Support and the management of violence and aggression, 26(4).**
b) **Not all healthcare professional staff had completed the mandatory Children First training, 26(4).**
c) **Not all healthcare professional staff had completed the mandatory Mental Health Act training, 26(5).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

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

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

The policy did not included the process for making a retrospective entry in residents' records

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. 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 been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: A record was initiated for every resident assessed or provided with care or services by the approved centre. Though resident records were secure and up-to-date, not all were in good order and well maintained. All resident records were physically stored together, where possible, and

were maintained using an identifier that was unique to the resident. The records were not developed and maintained in a logical sequence or in good order, as some had loose pages.

Resident records were accessible to authorised staff only and staff had access to the data and information needed to carry out their job responsibilities. Residents' access to their records was managed in accordance to the Data Protection Acts and only authorised staff made entries in residents' records, or specific sections therein. Records were written legibly in black, indelible ink and were readable when photocopied. Entries were factual, consistent, and accurate and did not contain jargon, unapproved abbreviations, or meaningless phrases. Entries also included the date and was followed by a signature. However, not all entries noted the time using the 24-hour clock.

There was no evidence the approved centre maintained a record of all signatures used in the resident record. All entries made by student nurses or clinical training staff were countersigned by a registered nurse or clinical supervisor. Where an error was made, this was scored out with a single line and the correction written alongside with the date, time, and initials: no correction fluid was used. A number of the clinical files examined did not record two appropriate resident identifiers on all documentation.

Where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title. Where information or advice was given over the phone, this was documented as such by the member of staff who took the call and the person giving the information or advice was clearly identified. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre. Records were retained or destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

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

a) **Resident records contained loose pages, 27(1).**
b) **Resident's records were not always legible, 27(1).**
c) **Two appropriate resident identifiers were not recorded on all documentation, 27(1).**
d) **Resident's records did not record the chart volume number, which hindered ease of retrieval, 27(1).**

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented 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

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in January 2020. It included all requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, including services users, as appropriate. The operating policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved and communicated to all relevant staff.

All required operating policies and procedures were reviewed within the mandatory three year time-frame. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. The format of policies was standardised and included the title of the policy, the reference number and revision of the policy, the scope of the policy, the date at which the policy becomes effective, the scheduled review date, the total number of pages, as well as the document owner, approvers, and reviewers.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in January 2019. The policy and procedures included all requirements of the *Judgement Support Framework*.

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

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

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

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre and a consistent and standardised approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make complaints verbally, in writing, electronically by e-mail, over the phone, and through complaint, feedback,

or suggestion forms. The registered proprietor ensured access, insofar as was practicable, to advocates to facilitate in the participation of the resident and their representative in the complaints process.

The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. This included the provision of information about the complaints procedure to residents and their representatives at admission or soon thereafter in the form of a booklet. The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint can be made and all complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. A method for addressing minor complaints within the approved centre was provided and minor complaints were documented. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. All non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre's policy and this was documented in the complaints log.

Time frames were provided for responding to the complainant following the initial receipt of the complaint, as well as for the investigation period for complaints and their required resolution. Where time frames were not achieved or further investigation time was required in relation to the complaint, this was communicated to the complainant. Complainants were informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them and their satisfaction or dissatisfaction with the investigation findings was documented.

Where services, care, or treatment were provided on behalf of the approved centre by an external party, the nominated person was responsible for the full implementation of the approved centre's complaints management process, including the investigation process and communication requirements with the complainant. All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the relevant Data Protection Acts.

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 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 several written policies in relation to risk management and incident management procedures. The primary risk management policy and procedure was last reviewed in December 2019. The policies addressed requirements of the *Judgement Support Framework*, including the following:

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

The policies did not include a process on accidental injury to residents.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. All staff had signed the signature log to indicate that

they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

Evidence of Implementation: Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Both clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Structural risks, including ligature points, were removed or effectively mitigated.

Health and safety risks were identified, assessed, treated, reported, monitored by the approved centre in accordance with relevant legislation, and were documented in the risk register. Individual risk assessments were completed prior to and during resident seclusion, physical restraint, in conjunction with medication requirements or administration, resident transfer and discharge, as well as at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. While the multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes, this was not clearly documented within the individual care plan (ICP) document and, on occasions, was left blank. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with the information provided anonymous at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the main entrance to the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated January 2020. The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion.

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

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, and all furniture and fittings were of a design and quality that did not endanger patient safety. Seclusion rooms were not used as bedrooms.

Three clinical files of residents that were secluded were examined during the inspection process. In all three episodes, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to themselves or others. The use of seclusion was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in all cases, and the consultant psychiatrist (CP) was notified as soon as practicable of the use of seclusion. When seclusion was initiated in each case, it only occurred after an assessment, including a risk assessment, and the seclusion initiation was recorded in clinical file and seclusion register by the person initiating seclusion.

The seclusion order was recorded in each resident's clinical file and in the seclusion register by the RMP, who indicated the duration of the seclusion order, but which lasted no more than eight hours. The seclusion register was signed by the responsible CP or duty CP within 24 hours and a medical review of the patient took place no later than 4 hours after the commencement of the episode of seclusion. Cultural awareness and gender sensitivity was demonstrated and residents were informed of the reasons, for, duration of, and circumstances leading to discontinuation of seclusion. Each resident was under direct observation by a registered nurse for the first hour of seclusion, with continuous observation thereafter. Each resident was informed of the ending of seclusion, and the reason for ending seclusion was recorded on the clinical file in all cases. All three episodes of seclusion were reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion

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

COMPLIANT

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

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
    i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
    ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

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

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

INSPECTION FINDINGS

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

In all four cases, the patient was unable to consent to the continued receipt of medication and a *Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent to Treatment* was completed. It contained the name of the medications prescribed and a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications. In each case, the form also contained details of a discussion with the patient, including: the nature and purpose of the medications; the effects of the medications, including any risks and benefits; any views expressed by the patient; any supports provided to the patient in relation to the discussion and

their decision-making; an approval by a consultant psychiatrist, and; the 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.

Use of Physical Restraint

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated January 2020. It addressed the following:

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

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

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

Evidence of Implementation: The files of three residents that had each been physically restrained were examined during the inspection process. A designated member of staff was responsible for leading in the physical restraint and for monitoring the head and airway of the resident. In all three episodes, physical restraint was used in rare and exceptional circumstances only, and staff had first considered all other interventions to manage the resident's unsafe behaviour. The use of physical restraint was based on a risk assessment of each resident. A clinical practice form was completed in all cases by the person who initiated the use of physical restraint no later than three hours after the use of physical restraint. In each case, the clinical practice form was signed by the consultant psychiatrist within 24 hours.

In all cases, the resident was informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. Where applicable, and with the resident's consent, the resident's next of kin or representative was notified of the use of physical restraint. Staff were aware of relevant considerations in the individual care plans pertaining to each of the resident's requirements and needs in relation to the use of physical restraint.

In all episodes of physical restraint, cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint. In one case examined, a registered medical practitioner did not complete a medical examination of the resident within three hours after the start of the physical restraint. In all three cases, the episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file.

The approved centre was non-compliant with this code of practice because, in one case, the registered medical practitioner did not compete a medical examination of a resident within three hours of the start of an episode of physical restraint, 5.4.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in January 2020, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in September 2019, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in September 2019, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was coordinated by a key-worker and the plan included an estimated date of discharge, documented communication with the relevant general practitioner, primary care team, or community mental health

team, as well as a follow-up plan and a reference to early warning signs of relapse. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team (MDT), and the resident's family.

A pre-discharge assessment was completed: it addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, a comprehensive risk assessment, and a risk management plan. Family members were involved in the discharge process and there was appropriate MDT input into discharge planning. A preliminary discharge summary was issued within three days.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 26: Staffing					
Reason ID : 10001267		Not all healthcare professional staff were up to date with mandatory training of fire safety, Basic Life Support and the management of violence and aggression, 26(4). Not all healthcare professional staff had completed the mandatory Children First training, 26(4). Not all healthcare professional staff had completed the mandatory Mental Health Act training, 26(5).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Training database to be updated for each discipline and liaise with trainers to develop timetables. All relevant staff to be identifed and assigned protected time to complete online Mental Health Act Training	Training Audits	yes recommended and ongoing	30/09/2020	Heads of Discipline and relevant Line Managers
Preventative Action	Training database to be updated for each discipline and liaise with trainers to develop timetables	monthly review of staff training in each discipline	yes commenced and on goiing	30/09/2020	Heads of Discipline and relevant Line Managers

Regulation 27: Maintenance of Records					
Reason ID : 10001278		Resident records contained loose pages, 27(1). Resident's records were not always legible, 27(1). Two appropriate resident identifiers were not recorded on all documentation, 27(1). Resident's records did not record the chart volume number, which hindered ease of retrieval, 27(1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A) Residents records contained loose pages, 27(1) B) Resident's records werer not always legible, 27 (1) C) Two appropriate resident identifiers were not recorded on all documentation, 27 (1) D)Resident' s records did not record the chart volume number which hindered ease of retrieval Corrective action- All charts to record a chart volume number	A) Audit B) Audit C)Audit D)Audit	A)Yes completed B) Yes C) yes D) yes	24/09/2020	A)Ward Clerk; DN MH Service Manager B) MDT C)MDT D)Ward clerk in conjunction with team and DN MH Service Manager
Preventative Action	A) Regular Checks of all files B) all charts to be legible, Worksop/ HSEland online training on Maintenance of records to be	A) Monthly audits B) Monthly Audits C) Monthly Audits D) Monthly Audits	A) yes B) yes C) Yes D) yes	24/09/2020	A) Ward Clerk and DN MH Service Manager B)Heads of Discipline C)Heads of discipline D) Ward Clerk and DN Mental Health Service Manager

	completed by all staff C) workshops for all diciplines on maintenance records D) all clinical files required to have a volume number				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10001266		**In one case, the registered medical practitioner did not compete a medical examination of a resident within three hours of the start of an episode of physical restraint, 5.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All relevant staff made aware of the requirement	Audit	yes	31/08/2020	Heads of relevant Disciplnes
Preventative Action	Workshops for relevant staff on Code of Practice for Physical restraint Post physical restraint checklist amended	Audit following each episode of physical restraint	yes	31/08/2020	Heads of Nursing and Medical diciplines and CNM3

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".

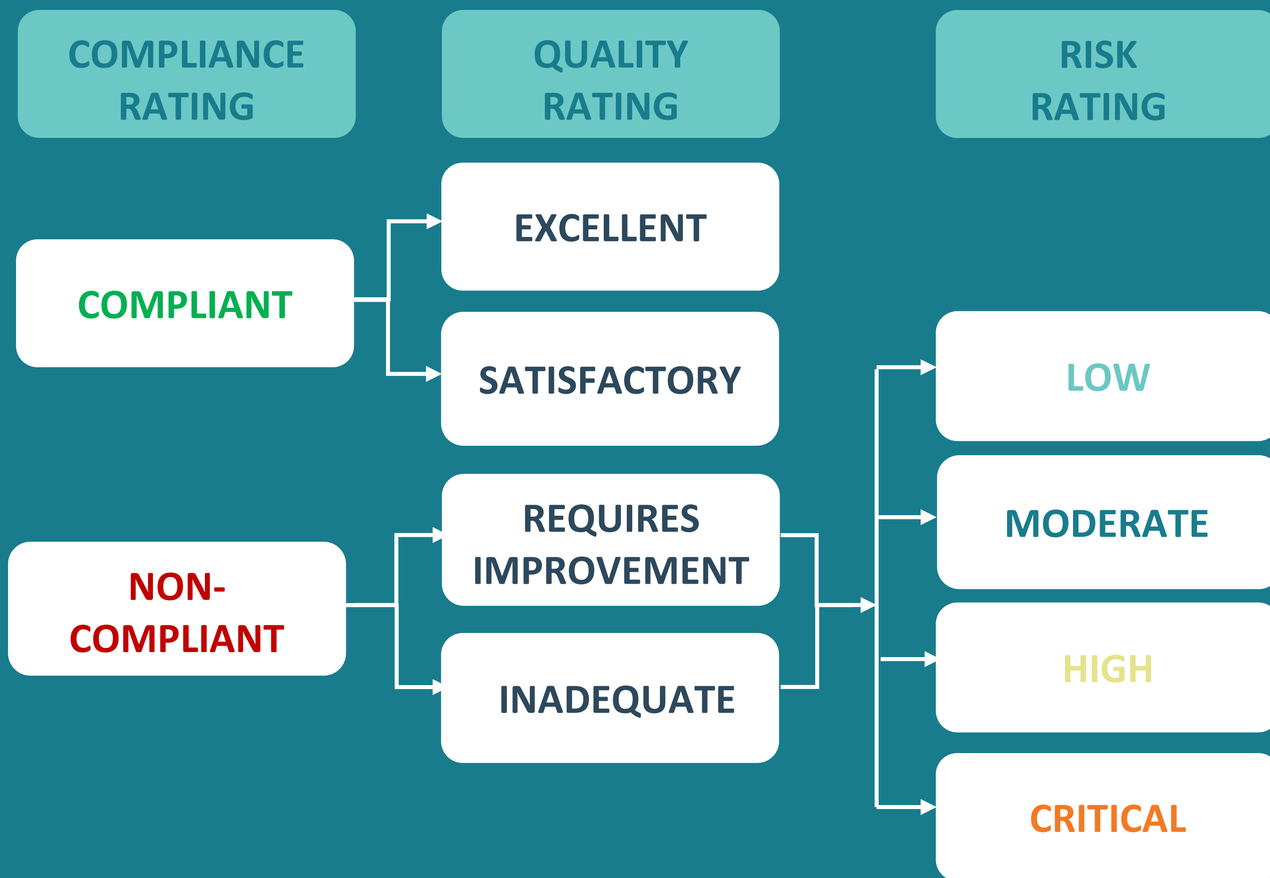
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

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.