Report of the Inspector of Mental Health Services 2014

EXECUTIVE CATCHMENT AREA/INTEGRATED SERVICE AREA	Dublin North Central, Dublin North East
HSE AREA	Dublin North East
MENTAL HEALTH SERVICE	Connolly Hospital
APPROVED CENTRE	Department of Psychiatry (DOP), Connolly Hospital
NUMBER OF WARDS	3
NAMES OF UNITS OR WARDS INSPECTED	Ash Ward Pine Ward High Dependency Unit (HDU)
TOTAL NUMBER OF BEDS	49
CONDITIONS ATTACHED TO REGISTRATION	None
TYPE OF INSPECTION	Unannounced
DATE OF INSPECTION	11 February 2014

Summary

- The DOP, Connolly Hospital was a busy acute psychiatric unit. There were clear admission criteria and care pathways. Each individual clinical file inspected contained an individual care plan (ICP). Each resident was assigned a key nurse and resident input to the ICP process was evident. Less evident in the records was family input and consultation.
- There was good provision of therapeutic services.
- There was disregard for the procedures and documentation of physical restraint and the approved centre was in breach of a number of sections of the Code of Practice on the Use of Physical Restraint in Approved Centres.
- Resident privacy was not assured in several of the bedrooms owing to broken window blinds. The provision of communal seating areas and visitors' facilities were inadequate. The courtyard area where residents could access fresh air was shabby and dirty.
- The approved centre had been obliged to admit acutely ill children on numerous occasions because no bed was available in a child and adolescent approved centre. The DOP was not a suitable environment for a child nor could it deliver optimal care and treatment. A number of beds in child and adolescent mental health units were still not fully operational.

OVERVIEW

In 2014, the Inspectorate inspected this Approved Centre against all of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The Inspectorate was keen to highlight improvements and initiatives carried out in the past year and track progress on the implementation of recommendations made in 2013. In addition to the core inspection process, information was also gathered from service user interviews, staff interviews and photographic evidence collected on the day of the inspection.

DESCRIPTION

The DOP, Connolly Hospital was a locked unit located in the lower ground floor of the main hospital building. This approved centre provided the acute in-patient psychiatric care for a population of 170,000. Pine ward was accessed via one locked door, Ash Ward was accessed via two locked doors and the HDU was accessed via three locked doors. Ash and Pine wards were laid out in long corridors with rooms on either side, in keeping with the design of the hospital's medical wards. The HDU was located at the end of Ash ward corridor and comprised a small ward with individual bedrooms and a seclusion room. Facilities for communal congregation and visitors were poor. The occupational therapy department was located adjacent to the wards and some residents could go there during the day, including being able to access a garden there. Otherwise, residents relied on a shabby central courtyard in order to get fresh air.

All units were busy and orderly at the time of inspection, with residents up and dressed and engaged in daily activities unless otherwise specified in the clinical files. Five sector teams and the rehabilitation teams all admitted residents to the approved centre. There was also a liaison team and a service for the homeless. On the day of inspection, there were 46 residents, seven of whom were detained and one resident was a child who was a voluntary resident.

CONDITIONS

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

SUMMARY OF COMPLIANCE WITH MENTAL HEALTH ACT 2001 (APPROVED CENTRES) REGULATIONS 2006

COMPLIANCE RATING	2012	2013	2014	ARTICLE NUMBERS 2014
Fully Compliant	24	22	26	
Substantial Compliance	4	7	3	9,11,27
Minimal Compliance	1	2	1	22
Not Compliant	2	0	1	21
Not Applicable	0	0	0	

PART ONE: QUALITY OF CARE AND TREATMENT SECTION 51 (1)(b)(i) MENTAL HEALTH ACT 2001

DETAILS OF WARDS IN THE APPROVED CENTRE

WARD	NUMBER OF BEDS	NUMBER OF RESIDENTS	TEAM RESPONSIBLE
Ash	22	20	General Adult Team
Pine	22	21	General Adult Team Rehabilitation Team
HDU	5	5	General Adult Team

QUALITY INITIATIVES 2013/2014

- All units in the DOP were involved in Nursing Metrics.
- There were ongoing educational sessions on “Communicating effectively with persons with mental ill health and intellectual disability”.
- An orientation and induction programme, support documentation and facilitators had been introduced for new graduate staff nurses.
- A five day training programme had been run for nurses on the “Recognition and Management of Alcohol Misuse”.
- Nursing staff had developed information booklets on, “Going Home from Hospital”, Oral Hygiene Teaching pack and Monitoring of Sleep Patterns.
- Introduction of LUNSERS assessment tool to ensure prompt detection and management of adverse effects of neuroleptic medications.

PROGRESS ON RECOMMENDATIONS IN THE 2013 APPROVED CENTRE REPORT

1. The lack of seating areas and the lack of chairs must be addressed. This is the third year in a row that the Inspectorate has made this recommendation.

Outcome: An additional number of chairs had been placed within the approved centre. There was a lack of communal seating areas and recreational space within the ward areas. Overall, the physical environment did not promote social interaction between residents.

2. Essential maintenance and painting of the approved centre must take place.

Outcome: Several ward areas had been painted and were bright and clean. Management reported that the remaining areas were scheduled to be painted. Routine maintenance work was ongoing and included the shower and toilet areas.

3. A choice of healthy options must be made available on the evening meal menu.

Outcome: The evening meal menu provided a good choice of healthy options.

4. Adequate provision for visiting must be made.

Outcome: The location and fit out of rooms did not provide an appropriate environment for visits. Visits predominantly took place on a thoroughfare corridor or within clinical office spaces.

5. CCTV must not be used in residents' bedrooms unless it is part of the resident's individual care plan or risk management plan and the resident is fully informed that he or she is being monitored by CCTV.

Outcome: CCTV was now used only to monitor corridor and entrance areas and to monitor the seclusion room in the HDU. Residents were informed of its use, especially in the seclusion room, and notices were prominently posted.

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND SECTION 60, MHA 2001

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

Article 4: Identification of Residents

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Two nurses administered medication. Identity bracelets were routinely provided for residents.

Article 5: Food and Nutrition

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Fresh drinking water was readily accessible to residents via water coolers within the ward areas. A sufficient supply of drinking cups was provided. The menu was posted in each dining room and provided an excellent choice of meats, fish and vegetarian meal options. Special diets such as a diabetic or low fat diet were well catered for. The input of a dietician was evident in several individual care plans. Residents made their meal choice at the hot servery.

Article 6: Food Safety

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The most recent Environmental Health Officer's report was available for inspection. A number of items requiring attention had been identified. These included the replacement of floor covering, maintenance of wall surfaces and repair of a washbasin. Management advised that the maintenance work was scheduled.

Article 7: Clothing

The registered proprietor shall ensure that:

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*		X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X		

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had a contingency plan in the event that a resident did not have a sufficient supply of personal clothing. The DOP daily routine was for residents to be up and about and dressed in day attire. One resident in Pine Unit was in night attire and this was documented as part of their individual care plan.

Article 8: Residents' Personal Property and Possessions

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

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

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

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this*			

	Article.			

Justification for this rating:

There was an up-to-date policy regarding residents' personal property and possessions. A property checklist was completed at the time of admission. Safe storage was provided for valuables if required, however, residents were encouraged not to retain such items whilst in hospital, but to send them home. Each resident had a bedside locker and storage cupboard. These were not lockable. There had been incidences of personal belongings going missing. The approved centre responded appropriately on each occasion. Individual lockers would be useful.

Article 9: Recreational Activities

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X	X	X

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The design and layout of the wards in the DOP did not facilitate recreation or social interaction. So, despite there being a supply of books, table games, art materials and DVDs, a table tennis table and a Fuβball table, there was little evidence of use.

Ash ward had one small, narrow sitting room with eight chairs lined up arm to arm along one wall. A television was mounted high at the end of the room on the opposite wall.

Pine ward had two small, narrow sitting rooms. There were eight chairs in each, lined up arm to arm against one wall. There was a television in one room.

The HDU had a single small room which was variously used as the thoroughfare to the courtyard smoking area, as the dining room, as a sitting room, as a television room and as an activity room. There was no other seating space within the HDU.

In an effort to offset the lack of recreational space within the wards, the occupational therapy (OT) department was used as a recreational space at the weekend.

Article 10: Religion

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

Residents were facilitated in the practice of their religion insofar as reasonably practicable. A contact list of mainstream churches and local resources were maintained in the approved centre. Connolly Hospital had an oratory and chaplaincy service.

Article 11: Visits

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

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

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

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	**X**	**X**	**X**

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The facilities for visitors were poor, and there was no sense of families and visitors being welcomed and catered for. This was, in part, owing to the fact that the DOP was located in a general hospital whose design and layout was targeted at acutely unwell medical and surgical patients.

There was no visitor's room within the DOP. Visitors were accommodated on a thoroughfare corridor between Ash and Pine wards. Seating comprised hospital style chairs pushed up against the wall on one side of the corridor. There was no effort to cluster chairs around coffee tables or to enhance the space with plants or screen dividers. There were no signs posted to indicate to visitors that this space was designated for their use, no directions as to where to locate drinks or lavatories. The walls were devoid of art or decorative features. There were two rooms off this corridor that were used for clinical staff meetings during the day and staff advised that these could be opened and made available for visits if required. Again, their layout and decor was unwelcoming and was not a family friendly space. The DOP was a locked unit. Some residents could use the small coffee shop on the main hospital concourse to meet with visitors.

The visiting hours were the same as the main Connolly Hospital, 1700h to 2000h Monday to Friday and 1400h to 1600h, 1700h to 2000h at weekends. Whilst it is important to maintain the integrity of a core therapeutic day for residents, it is vital to facilitate family and social supports and relationships. Staff advised that reasonable flexibility was applied for visits. This should be clearly communicated to residents and families, especially in the HDU. There was an up-to-date policy on visits.

Breach: 11(1),(4)

Article 12: Communication

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

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on communication. Residents could send and receive post unopened. Residents in Ash and Pine wards retained their personal mobile phone unless otherwise specified in their individual care plan. In the HDU, mobile phones were held by nursing staff but residents could access them on request. Residents were also facilitated in making and receiving phone calls on an office phone.

Article 13: Searches

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

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

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

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

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

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

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

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE				
LEVEL OF COMPLIANCE	**DESCRIPTION**	**2012**	**2013**	**2014**
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on the carrying out of searches, with and without consent, and in relation to the finding of illicit substances. No person resident in the approved centre had been searched.

Article 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE				
LEVEL OF COMPLIANCE	**DESCRIPTION**	**2012**	**2013**	**2014**
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on the care of residents who are dying. All residents who were dying would be transferred to the appropriate medical service in the main hospital. There had been no deaths in the approved centre in the previous calendar year.

Article 15: Individual Care Plan

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*		**X**	**X**
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	**X**		

Justification for this rating:

The DOP was fully compliant with the required standard for this Article.

All the individual clinical files inspected in Ash and Pine wards and in the HDU contained excellent individual care plans (ICPs). The ICPs addressed comprehensive domains of care, with well specified goals, interventions and who was responsible for each, including those aspects for which the resident was responsible. Residents usually signed their ICP and it was recorded whether a resident wished to retain a written copy of their ICP or not. The ICPs were regularly reviewed and

updated by the multidisciplinary team (MDT).

The integrity of the ICPs in many instances might have been enhanced with the inclusion of a resident's own perspective, and family input as appropriate. Where the progress notes featured a resident's comments, and also communication with family members, central to the care and treatment of the resident, these was not necessarily incorporated into the ICP record.

Article 16: Therapeutic Services and Programmes

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*			**X**
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		**X**	

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*	**X**		

Justification for this rating:

The ICPs specified the therapeutic provision and treatment required for each resident. The inspectors encountered several residents who were in the process of consulting their individualised therapeutic timetables as they got organised for the day ahead. Inspection of individual clinical files evidenced good input from a range of health and social care professionals. Occupational therapy (OT) records provided a clear picture of the engagement and progress of each individual. OT intervention was clearly focussed on individual assessment, rehabilitation and recovery. The clinical files contained good records for social work and clinical psychology input also. Dietetic and

physiotherapy input was provided as needed also.

Article 17: Children's Education

The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The DOP had a contingency plan for the provision of education to a child resident if required. There was one child resident on the day of inspection, however, the child's individual care plan stated no educational input was required.

Article 18: Transfer of Residents

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre had a policy on the transfer of residents. A transfer form was completed by nursing staff and all relevant clinical information accompanied a resident on transfer.

Article 19: General Health

(1) The registered proprietor shall ensure that:

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

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on responding to medical emergencies. There was a procedure in place to prompt upcoming six-monthly physical reviews and physical reviews were recorded on a special green form. All residents who had been in the DOP for a period in excess of six months had been physically examined.

Article 20: Provision of Information to Residents

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The DOP had an up-to-date policy on the provision of information to residents. There was a booklet outlining housekeeping arrangements in the approved centre. Information was posted on the notice boards in relation to therapeutic activities, the independent advocacy service and local self help and community groups. Information was available on medications and diagnoses.

Article 21: Privacy

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X		
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*		X	

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			X

Justification for this rating:

Bedroom windows had slatted blinds fitted. In several instances the blinds were broken with panels and pulleys missing. The upshot was that some residents were required to sleep in beds that were open to oversight from wards on floors above, from the DOP courtyard or from external public pathways. Some residents were required to use the lavatory or shower room for privacy whilst changing their clothes. Management reported that a company had been contracted to replace the broken blinds.

A whiteboard in the dining rooms of Ash and Pine wards provided details of key nurses assigned to each resident. Inspectors informed staff that posting residents' full names on this board did not afford privacy to residents.

Breach: 22

Article 22: Premises

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

(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.

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*			
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE				
LEVEL OF COMPLIANCE	**DESCRIPTION**	**2012**	**2013**	**2014**
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*	**X**	**X**	**X**
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There were a number of aspects of the DOP environment that were not satisfactory.

Connolly Hospital was a smoke free campus, however, this did not extend to the DOP. There was a smoking gazebo in the courtyard shared by Ash and Pine wards and in the small yard of the HDU. On the day of inspection, both smoking areas were unacceptable. Dirty tin buckets overflowing with cigarette butts were scattered in the vicinity of the smoking gazebos. Cigarette ends were strewn throughout the courtyard. These open air spaces were bleak and dismal, featuring dark concrete paving, dark wooden seating which was well worn and some of which was broken and a couple of sad looking planters. The inspection report of 2013 made similar comments. Twelve months on, the issue had not been rectified. The entire area required attention to make it into a suitable environment for residents. There was a well-kept garden space attached to the OT department in which a gardening programme was available.Not all residents were able to leave the ward area to avail of this.

The design and layout of seating areas was not appropriate to the needs of mental health residents. The communal seating areas were small and cramped, a limited number of chairs fitted in each sitting room and these were lined up arm-to-arm along one wall. A television provided the focal point in two of the sitting rooms. Two other potential sitting rooms were used as access routes to the courtyard and were cold and breezy. Recreational equipment, including a table tennis table, was placed in these rooms but the space was unsuitable for such a purpose whilst being used for access.

The DOP was clean and recent painting of internal walls had brightened up the wards. Maintenance work was scheduled to be carried out in some showers to replace stained floor covering, chipped and stained walls, a ceiling tile and a broken lavatory seat. In the HDU the reinforced glass panel in one door was cracked and required replacement. Inspectors inquired about the process for submitting maintenance requests and tracking outcomes and timeframes. The records shown to inspectors were not clear in this regard.

The dining rooms in Ash and Pine wards were well furnished, bright, clean and featured attractive art work.

Storage space and shelving was in short supply within the DOP which meant that bed tables were

being used to store some residents' personal belongings in a laundry room.

Breach: 22(1)(a),(c),(2)(3)

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

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

(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).

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on the prescribing, ordering, storing and administration of medication. The clinical rooms were inspected and were in good order. Medication sheets were clear, legible, signed and dated. Administration of medication was in order.

Article 24: Health and Safety

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The DOP had up-to-date policies on health and safety.

Article 25: Use of Closed Circuit Television (CCTV)

(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 anytime on request.

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X		X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE				
LEVEL OF COMPLIANCE	**DESCRIPTION**	**2012**	**2013**	**2014**
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*		**X**	
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on the use of CCTV. CCTV was used on corridor and entrance areas. CCTV might be used to monitor a resident in seclusion and this was well notified by way of large posters.

Article 26: Staffing

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

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

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

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

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

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

WARD OR UNIT	STAFF TYPE	DAY	NIGHT
Ash	CNM3	shared	shared
	CNM2	1	0
	RPN	4	3
	HCA	1	0
Pine	CNM3	Shared	Shared
	CNM2	1	0
	RPN	4	3
HDU	RPN	3	2

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*			X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*	X	X	

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Health Service Executive (HSE) policies on human resource management applied. The number and skill mix of staff were appropriate to meet the assessed needs of residents. There were no clinical psychology records in the individual clinical files inspected but staff advised that clinical psychology input was available where required. The staff training log was provided to inspectors and was up to date. Inspection of individual clinical files showed that residents had ready access to health and social care professionals.

Article 27: Maintenance of Records

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

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

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

(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 is outside the scope of these Regulations which refer only to maintenance of records pertaining to these areas.

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			X

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on records. Clinical files were well structured with colour coded dividers for different records. Whilst this generally facilitated easy access to information, there were several instances of records not being filed in the right section or in chronological order. In a number of files there were loose pages.

The required records in relation to food safety, fire inspections and health and safety were all available for inspection.

Breach: 27 (1)

Article 28: Register of Residents

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Register of Residents met the requirements of Schedule 1 to the Regulations.

Article 29: Operating policies and procedures

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

All policies related to the Regulations were up to date and inspected.

Article 30: Mental Health Tribunals

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The approved centre cooperated fully with Mental Health Tribunals. A suitable room was provided for this purpose and patients who required assistance to attend were facilitated by staff.

Article 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE				
LEVEL OF COMPLIANCE	**DESCRIPTION**	**2012**	**2013**	**2014**
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There was an up-to-date policy on complaints. Information about how to make a complaint was posted on notice-boards in the DOP. There was a nominated person to deal with complaints within the approved centre. In addition to the Health Service Executive's *Your Service Your Say* complaints procedure, there was a local protocol for dealing with verbal complaints within the DOP. A complaints log was maintained in each ward. All complaints were reviewed by management and a record of response and outcome was maintained. This record was available for inspection.

Article 32: Risk Management Procedures

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE				
LEVEL OF COMPLIANCE	**DESCRIPTION**	**2012**	**2013**	**2014**
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

There were up-to-date risk management policies which addressed the aspects identified in this Article. Risk assessment was completed at the time of admission and inspection of individual clinical files showed that risk was reviewed on an ongoing basis and risk management was integral to ICPs.

Article 33: Insurance

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The DOP was indemnified by the State Claims Agency.

Article 34: Certificate of Registration

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

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Fully compliant	*Evidence of full compliance with this Article.*	X	X	X
Substantial compliance	*Evidence of substantial compliance with this Article but additional improvement needed.*			

UNSATISFACTORY PERFORMANCE

LEVEL OF COMPLIANCE	DESCRIPTION	2012	2013	2014
Minimal compliance	*Effort has been made to achieve compliance with this Article but significant improvement is still needed.*			
Not compliant	*Service was unable to demonstrate structures or processes to be compliant with this Article.*			

Justification for this rating:

The Certificate of Registration was displayed inside the entrance of the DOP.

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

SECLUSION

Use: Seclusion was used in the approved centre. The seclusion room was located in the HDU.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	X			
3	Orders		X		
4	Patient dignity and safety		X		
5	Monitoring of the patient	X			
6	Renewal of seclusion orders	X			
7	Ending seclusion	X			
8	Facilities	X			
9	Recording		X		
10	Clinical governance			X	
11	Staff training			X	
12	CCTV	X			
13	Child patients	NOT APPLICABLE			

Justification for this rating:

The clinical file of one current resident who had been secluded and the seclusion register were inspected. The seclusion register was completed in full for the most part, but in one instance, there was no indication as to whether the resident's next of kin had been informed. In at least six cases of seclusion, the resident was secluded in refractive clothing. In all but one of these cases, there was no documentation of risk assessment in the clinical files that indicated its use. There was evidence in the clinical file that the resident was examined by a medical practitioner at intervals throughout the period of seclusion. The seclusion room was quite spacious. There were two small windows at a height, and as these were frosted, there was limited light. There was a lavatory and sink en suite and an intercom system enabled the resident in seclusion to communicate with nursing staff. There was a CCTV camera in situ and this was monitored in the nurses' office. There were signs indicating its use. The episode of seclusion was documented in the resident's clinical file and a copy of the Register was placed in the clinical file. In one instance, the copy was not placed in the relevant resident's file.

The approved centre had an up-to-date policy on the use of seclusion. However, this policy did not identify who may carry out seclusion. Inspection of the seclusion register showed that security personnel from Connolly Hospital were involved in carrying out seclusion. There was no evidence that security personnel had received training in the use of seclusion in an approved centre.

Breach: 3.7**,** 4.2, 9.3, 10.2 (a), (b), 11.1(a), (e)

Electroconvulsive Therapy (ECT) (DETAINED PATIENTS)

Use: ECT was not administered in the approved centre. On the day of inspection, no detained patient was receiving ECT in another hospital.

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

PHYSICAL RESTRAINT

Use: Physical restraint was used in the approved centre.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
1	General principles	X			
5	Orders				X
6	Resident dignity and safety		X		
7	Ending physical restraint		X		
8	Recording use of physical restraint			X	
9	Clinical governance			X	
10	Staff training		X		
11	Child residents	NOT APPLICABLE			

Justification for this rating:

There was one instance of physical restraint in Ash ward in 2014 to date. The Clinical Practice Form Book was examined and the order for restraint was adequately completed. A copy of this order was not placed in the individual clinical file as required. The individual clinical file noted the order for physical restraint but did not make reference to whether a physical examination had been completed after the episode, nor did it state if next of kin had been notified.

In Pine ward two residents had been physically restrained. The clinical practice forms had been signed and placed in the clinical files. However, in one case, the form was not correctly dated by the consultant psychiatrist and in the other case, had been signed in excess of 24 hours after the physical restraint had been commenced. The episode of physical restraint in one case was not recorded in the clinical file. The reason why next of kin was not informed of the episode of physical restraint in one case was not recorded in the clinical file. Neither resident was given the opportunity to discuss the episode of physical restraint with members of the multidisciplinary team. There was no evidence that the multidisciplinary team had reviewed the episodes of physical restraint. These breaches of the Code of Practice were unsatisfactory.

In the HDU, the clinical file of one resident who had been physically restrained and the Clinical Practice Form Book were inspected. The episode of restraint was documented in the resident's

clinical file but the relevant section of the Clinical Practice Form for Physical Restraint was not completed in respect of notification of next of kin. In relation to another resident, section 17 of the Clinical Practice Form was not completed by the consultant psychiatrist. In respect of other residents, a number of completed Clinical Practice Forms were still in the register and had not been placed in the clinical files.

The physical restraint policy was not in date. The staff training log for the therapeutic management of aggression and violence was up to date. The Clinical Practice Form Book records indicated that Health Care Assistants (HCA) and security personnel had assisted in the application of physical restraint on a number of occasions. The DOP policy did not address the use of security personnel in this regard, nor was there evidence that these staff had been trained. In addition, neither security personnel nor HCAs had access to, and were not aware of, a resident's individual care plan and their involvement was therefore in breach of the Code of Practice on the Use of Physical restraint.

Breach: 5.7(c), 5.8, 6.1, 7.2, 8.1, 9.2(a), 9.2(b), 9.2(d), 9.3, 10.1(e)

ADMISSION OF CHILDREN

Description: One child was resident in the approved centre at the time of inspection. Clinical staff reported that four children had been admitted since January 2014 to the date of inspection. Two child admissions had been notified to the Mental Health Commission**.**

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	**Admission**				X
3	**Treatment**	X			
4	**Leave provisions**	NOT APPLICABLE			

Justification for this rating:

The approved centre staff strove to provide interim care and treatment to the child whilst awaiting a place in a child and adolescent in-patient approved centre. The child was provided with one-to-one nursing care and single room accommodation. The approved centre was not suitable for the admission of children either in environment or in therapies available.

Breach: 2.5

NOTIFICATION OF DEATHS AND INCIDENT REPORTING

Description: No deaths had occurred in the approved centre within the last calendar year.

SECTION	DESCRIPTION	FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
2	**Notification of deaths**	**NOT APPLICABLE**			
3	**Incident reporting**	**X**			
4	**Clinical governance (identified risk manager)**	**X**			

Justification for this rating:

A summary of incidents was notified on a quarterly basis to the Mental Health Commission. The incident log was inspected and was in order. There was a named risk manager with responsibility for the approved centre. The DOP was fully compliant with Article 32 on Risk Management.

Electroconvulsive Therapy (ECT) FOR VOLUNTARY PATIENTS

Use: ECT was not administered in the DOP. No resident was receiving ECT in another hospital.

ADMISSION, TRANSFER AND DISCHARGE

Part 2 Enabling Good Practice through Effective Governance

The following aspects were considered: 4. policies and protocols, 5. privacy confidentiality and consent, 6. staff roles and responsibility, 7. risk management, 8. information transfer, 9. staff information and training.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

There were up-to-date policies on admission, transfer and discharge. Policies addressed the needs of particular categories of resident such as older persons, children and the homeless. Staff roles and responsibilities were clearly defined and staff training was up to date. The approved centre was fully compliant with Article 32 on Risk Management and with Article 18 on the Transfer of Residents.

Part 3 Admission Process

The following aspects were considered: 10. pre-admission process, 11. unplanned referral to an Approved Centre, 12. admission criteria, 13. decision to admit, 14. decision not to admit, 15. assessment following admission, 16. rights and information,17. individual care and treatment plan, 18. resident and family/carer/advocate involvement, 19. multidisciplinary team involvement, 20. key-worker, 21. collaboration with primary health care community mental health services, relevant outside agencies and information transfer, 22. record-keeping and documentation, 23. day of admission, 24. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
	X		

Justification for this rating:

In Ash ward the individual clinical files showed evidence of a clear admission process and comprehensive assessment. In the main records were well completed, care in recording the identity of the informant for a collateral history was required in one instance. All admission records contained a clear initial care plan.

In Pine ward the clinical file showed evidence of a good admission process with clear and adequate assessments recorded. Referral letters were documented and there was evidence of family involvement where indicated. Information was readily available for the residents. Each resident had an individual care plan.

In the HDU, there was generally a good admission process and risk assessments were documented on admission; however, in one instance, there was no record of a physical examination having been carried out.

The approved centre was fully compliant with Article 15 on Individual Care Planning.

Breach: 15.3

Part 4 Transfer Process

The following aspects were considered: 25. Transfer criteria, 26. decision to transfer, 27. assessment before transfer, 28. resident involvement, 29. multidisciplinary team involvement, 30. communication between Approved Centre and receiving facility and information transfer, 31. record-keeping and documentation, 32. day of transfer.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
NOT APPLICABLE			

Justification for this rating:

On the day of inspection, staff reported that no current resident had been transferred elsewhere for care and treatment.

Part 5 Discharge Process

The following aspects were considered: 33. Decision to discharge, 34. discharge planning, 35. pre-discharge assessment, 36. multi-disciplinary team involvement, 37. key-worker, 38. collaboration with primary health care, community mental health services, relevant outside agencies and information transfer, 39. resident and family/carer/advocate involvement and information provision, 40. notice of discharge, 41. follow-up and aftercare, 42. record-keeping and documentation, 43. day of discharge, 44. specific groups.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

The decision to discharge was made by the responsible consultant psychiatrist with input from the MDT. The clinical file of one resident in Ash ward who had been discharged and subsequently re-admitted was inspected. There was evidence that the discharge was planned and discussed with the resident. The resident's next of kin was also informed. Follow-up arrangements had been put in place for the resident prior to discharge. Communication had been made with the GP and other relevant healthcare staff.

HOW MENTAL HEALTH SERVICES SHOULD WORK WITH PEOPLE WITH AN INTELLECTUAL DISABILITY AND MENTAL ILLNESS

Description: One resident had an intellectual disability and a mental illness.

The following aspects were considered: 5. policies, 6. education and training, 7. inter-agency collaboration, 8. individual care and treatment plan, 9.communication issues, 10. environmental considerations, 11. considering the use of restrictive practices, 12. main recommendations, 13. assessing capacity.

Level of compliance:

FULLY COMPLIANT	SUBSTANTIALLY COMPLIANT	MINIMAL COMPLIANCE	NOT COMPLIANT
X			

Justification for this rating:

There was a policy on the management of residents with an intellectual disability and a mental illness. Staff training had been completed. One resident in Ash ward had an intellectual disability. The resident had a severe and enduring mental illness and had not previously been engaged with disability services. There was an ICP in place. There was no resident with an intellectual disability and mental illness in Pine ward.

2.5 EVIDENCE OF COMPLIANCE WITH SECTIONS 60/61 MENTAL HEALTH ACT 2001 (MEDICATION)

SECTION 60 – ADMINISTRATION OF MEDICINE

Description: No detained patient had been detained for a period in excess of three months and therefore section 60 was not applicable.

SECTION 61 – TREATMENT OF CHILDREN WITH SECTION 25 MENTAL HEALTH ACT 2001 ORDER IN FORCE

Description: The child was a voluntary admission and so section 61 did not apply.

SECTION THREE: OTHER ASPECTS OF THE APPROVED CENTRE

SERVICE USER INTERVIEWS

No residents wished to speak to the inspectors.

APPLICATION OF THE QUALITY FRAMEWORK - MENTAL HEALTH SERVICES, AS IT APPLIES TO APPROVED CENTRES, IN THIS INSPECTION

Theme 1 Provision of a holistic seamless service and the full continuum of care provided by a multidisciplinary team

Admissions were generally via sector teams or the emergency department in Connolly Hospital. Admissions were appropriate and inspection of individual clinical files indicated active case management with discharge planning integral to the ICP process from the outset. This meant that admissions were as brief as possible and care was given to appropriate community placement thus optimising recovery. The therapeutic services and programmes for in-patients provided a good balance between self-care, productivity and leisure, with psycho-education and relapse prevention. The service had established links with housing and other social agencies in the community.

Theme 2 Respectful, empathetic relationships are required between people using the Mental Health Services and those providing them

The approved centre informed residents of their rights as required with both written and verbal information being provided by the key nurse. The information leaflet about the DOP was presented in a user friendly format. The independent advocate visited the DOP on a weekly basis and met with detained residents in particular but was also available to meet other residents. Certain aspects of the care environment conveyed a lack of meaningful regard for residents' experiences, namely, the lack of privacy, the lack of adequate communal seating areas and the shabby condition of the courtyard. OT and social work facilitated residents in relation to community integration, in accessing services and in pursuing activities in the community. The OT department had introduced a football programme in conjunction with a local football association.

Theme 3 An empowering approach to service delivery is beneficial to both people using the service and those providing it

The DOP had a policy on the provision of information to residents .Each resident was assigned a key nurse and residents were provided with information in relation to diagnosis and medications. Each resident had an ICP. The service regularly audited the ICPs. The therapeutic programme provided for residents included recovery oriented interventions and some residents were encouraged to attend community based activities as part of their transition from hospital to home.

Theme 4 A quality physical environment that promotes good health and upholds the security and safety of service users

The physical environment in the DOP was unsatisfactory from a number of aspects and did not always provide privacy or convey respect and consideration to residents or visitors. A number of bedrooms were open to view from outside and did not provide adequate privacy for residents whilst in bed. The building was designed to accommodate medical patients and adequate provision had not been made for visitors or for communal seating areas where residents could relax and congregate. The courtyard spaces were dirty owing to unsightly metal buckets for cigarette butts and to the cigarette ends strewn about the paving. This did not convey respect for residents, and being the designated open air space for the wards, was particularly disrespectful to non-smokers.

The dining rooms were well furnished and attractive paintings brightened up the space. The menu provided an excellent choice of nutritious meals.

Theme 5 Access to services

Inspection of individual clinical files showed that residents were routinely provided with follow-up appointments in the community.

Theme 6 Family/chosen advocate involvement and support

The clinical records in the individual clinical files contained limited information about family consultation, with residents' consent, in relation to care and treatment. The collateral part of the admission assessment was often brief and was not always clear as to the identity of the informant.

Theme 7 Staff skills, expertise and morale are key influences in the delivery of a quality mental health service

Throughout the inspection visit, staff presented as professional and confident in their respective roles. Each of the wards was quiet and orderly and residents were up and dressed and engaged in daily activities except where their treatment plan indicated otherwise. In relation to any inquiries by inspectors, staff impressed as being knowledgeable about each individual under their care. The training log was up to date and supervision was in place for clinical staff.

In terms of non clinical staff being educated in relation to mental illness and its impact on individuals, it was noted that Connolly Hospital security personnel, who assisted in the application of physical restraint within the DOP, were not trained in this regard.

The service regularly conducted audits on care provision.

Theme 8 Systematic evaluation and review of mental health services underpinned by best practice, will enable providers to deliver quality services

The structures and processes in relation to governance were robust. Bed management and strategic service planning were evident. It was clear that there was good interdisciplinary working and there was a clinical committee engaged in the development of evidence based therapies and treatment.

OVERALL CONCLUSIONS OF THIS INSPECTION

The approved centre provided a good standard of clinical care and treatment. Admissions to the DOP were via Connolly Hospital emergency department or sector teams. There was evidence of bed management and a clear care pathway. All of the clinical files inspected contained ICPs. There was an active therapeutic programme and the majority of residents were up and about and engaged in daily activities at the time of the inspection.

The physical environment was not conducive to optimal care. A painting and bathroom refurbishment programme was underway and those areas that had been painted or repaired were bright and clean. The courtyard (the designated open air space for the wards) was dirty and in an unacceptable state. The approved centre had done nothing to address this issue which was also highlighted in the 2012 inspection report. Additional chairs had been provided for residents to sit on, however, there was still an insufficient supply to ensure all residents had somewhere other than their beds to sit. The lack of privacy afforded to residents in some bedrooms was unacceptable. This was the case because some of the window blinds were broken.

The DOP had one child resident on the day of inspection. There had been 14 child admissions in 2013 and four child admissions thus far in 2014. The approved centre strove to provide care and treatment to child admissions and ensured one-to-one nursing care, however, the DOP was unsuitable for child admissions.

It was very unsatisfactory that there were so many breaches of the Rules governing the use of seclusion and the Code of Practice on the use of physical restraint. There appeared to be a disregard for the procedures and documentation of physical restraint after the episode had been terminated. The use of HCAs and security personnel in the practice of both seclusion and physical restraint should be reviewed.

RECOMMENDATIONS 2014

1. Physical restraint should only be used in accordance with the Code of Practice on the Use of Physical Restraint.

2. The policy on the use of physical restraint should clearly identify who may carry out physical restraint.

3. The service must have a policy on the use of seclusion which clearly states who may be involved in seclusion. Seclusion must be used in accordance with the Rules Governing the Use of seclusion and Mechanical Means of Bodily Restraint.

4. The DOP must ensure compliance with Article 21 Privacy.

5. The area provided for visitors must be set out in a manner appropriate for this purpose, including signage.

6. The courtyard area must be well maintained and clean.

7. There must be sufficient seating for residents in Ash ward.

8. Clinical records must be well maintained.