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Sycamore Unit, Connolly Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

SYCAMORE UNIT, CONNOLLY HOSPITAL

Sycamore Unit, Connolly Hospital,
Blanchardstown, Dublin 15

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

Approved Centre Type:
Psychiatry of Later Life

Most Recent Registration Date:
6 June 2019

Conditions Attached:
None

Registered Proprietor:
HSE

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

Inspection Team:
Dr Enda Dooley, MCRN 004155, Lead Inspector
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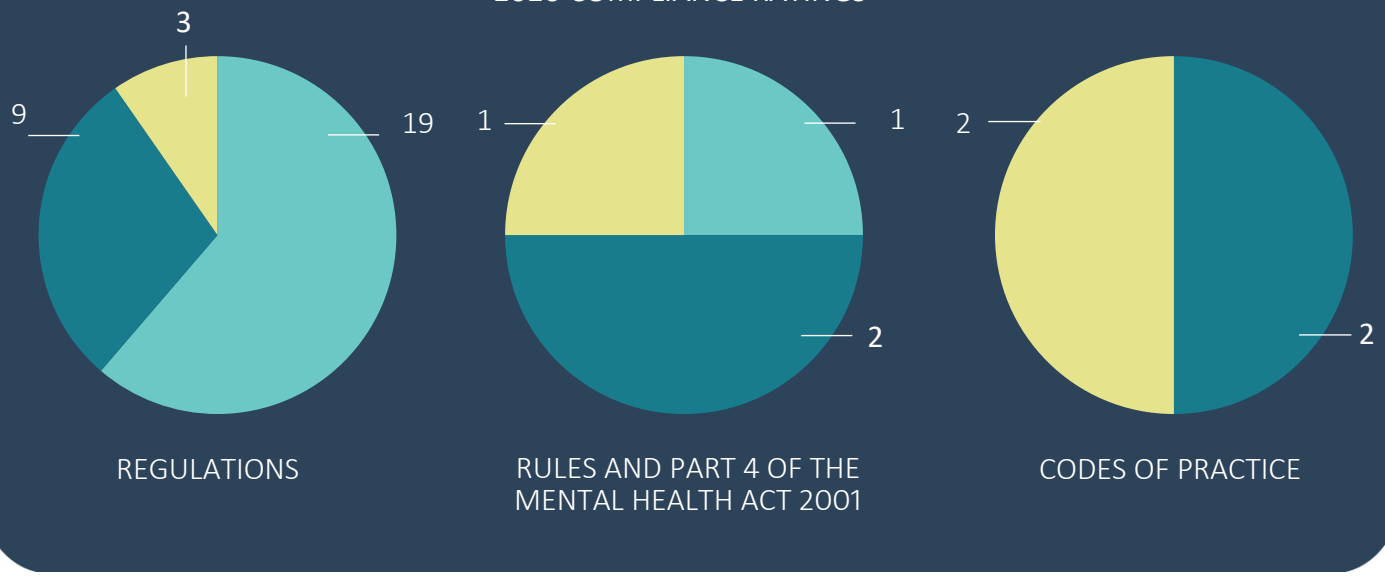
Inspection Date:
25 – 28 February 2020

Previous Inspection Date:
26 – 28 February 2019

Inspection Type:
Unannounced Annual Inspection

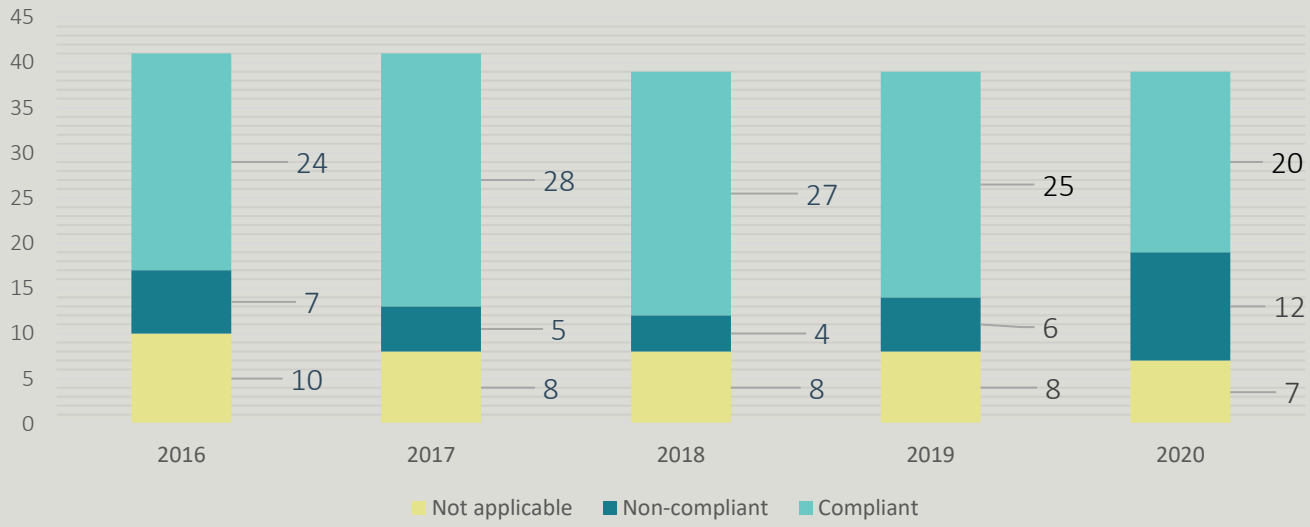
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

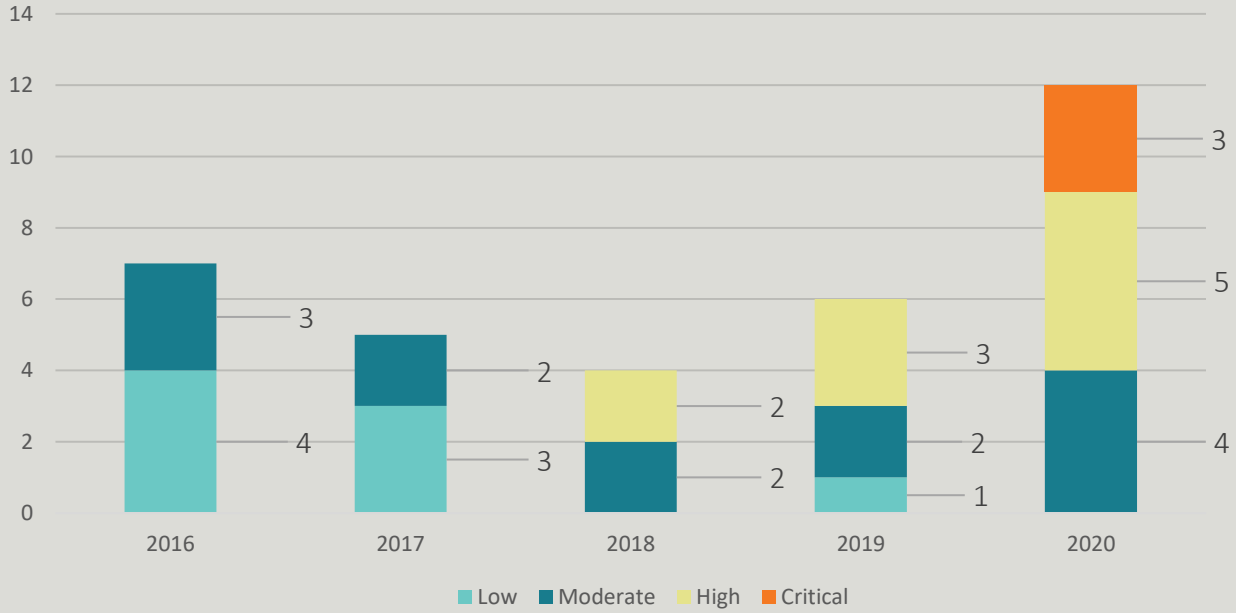
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

Sycamore Unit was located within the grounds of Connolly Hospital and occupied a single story building built in the mid twentieth century. The approved centre was registered to accommodate up to 25 residents under the care of the North Dublin Psychiatry of Later Life service. Admissions to the centre had been suspended in 2019 and there were 15 residents at the time of the inspection.

The approved centre was a self-contained single story building consisting of a long central corridor with bedrooms and day facilities off this corridor. The current 15 residents were accommodated in four communal bedrooms, each with an attached bathroom.

It was an unsuitable building to provide in-patient mental health services for older people, especially people with dementia. The lack of required physical and psychosocial care was unacceptable and put the well-being of residents at risk. As such, the Sycamore Unit was unfit for the purpose of providing in-patient care for elderly people.

There was a significant decrease in compliance with regulations, rules and codes of practice since 2019. Three non-compliances were rated critical risk: Regulation 16: Therapeutic Services and Programmes, Regulation 22: Premises and non-compliance with Part 4 of the Mental Health Act Consent to Treatment.

Compliance Summary 2016 - 2020					
	2016	2017	2018	2019	2020
% Compliance	77%	85%	87%	81%	63%
Regulations Rated Excellent	3	6	9	4	2

Conditions to registration

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

Safety in the approved centre

- Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. Catering areas and food safety equipment were clean.

- All health care professionals were trained in the Management of violence and aggression, and the Mental Health Act 2001.

However:

- There was lack of required physical care inputs such as physiotherapy, dietetics and physical health occupational therapy which posed a risk to the general health of the residents.
- Hazards, were not minimised in the approved centre: a hard, sharp edge was exposed on a broken plastic wall protective panel; concrete in the entranceway was eroded, making the surface uneven and a potential falls hazard; a ridged surface at the entrance to the garden presented a potential falls hazard, and; a ridged surface at the end of the corridor where the building met the prefab extension also presented a falls hazard.
- The medication fridge was unlocked and stored medications were potentially accessible to unauthorised staff.
- The numbers and skill mix of staffing were not sufficient to meet resident's needs. There was no Registered Practical Nurse (RPN) within the approved centre for approximately half of the day time hours and the approved centre was operated by a cohort of nursing staff without any specialised mental health training or qualifications. An appropriately qualified staff member was not on duty and in charge at all times.
- Not all health care professionals in the approved centre were trained in Fire Safety and Basic Life Support.

Appropriate care and treatment of residents

- An evidence-based nutrition tool was used for residents with special dietary requirements.
- The six-monthly general health assessment documented a physical examination, blood pressure, smoking status, and dental health.

However:

- None of the five general health assessments included the resident's family/personal histories. One of the general health assessments did not include the resident's body-mass index, two did not include the resident's waist circumference, while one did not include the resident's weight.
- The needs of residents identified as having special nutritional requirements were not regularly reviewed by a dietitian, as the approved centre did not have access to the service.
- The lack of therapeutic services and programmes was rated as a critical risk. There was no access to physical health occupational therapist for seating needs of residents. There was also no access to physiotherapy for high falls risks, and no access to a dietitian. Adequate facilities were not available for the provision of therapeutic services and programmes and were provided in the sitting room or dining room. The unit contained a multi-sensory room which was not possible to use for half the year due to inadequate heating and insulation.

- The majority of individual care plans (ICPs) were not developed and reviewed by a comprehensive multi-disciplinary team and did not identify appropriate goals for residents. Four ICPs did not identify appropriate care and treatment required to meet goals identified. In two cases, ICPs were not updated following review, taking account of recommendations of assessments undertaken.
- Some clinical files had loose pages and torn chart cover, were not written legibly and did not reflected the resident's current status.

Respect for residents' privacy, dignity and autonomy

- Where residents shared a room, bed screening ensured that their privacy was not compromised. 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 clean, hygienic, and free from offensive odours; however, there was no programme of general or decorative maintenance.
- Mechanical restraint, Part 5, in the form of lap-belts, was carried out in compliance with the relevant Rule.

However:

- There were no single bedrooms in the approved centre. All residents were in shared bedrooms. An additional single bedroom was available for end of life or infection control purposes.
- There was not suitable and sufficient heating: the minimum temperature in bedroom areas was not 18 C and 21 C in day areas where residents sat during the day. The relaxation room was inaccessible in the winter due to the low temperature and there was also a cold draft coming through the front door where residents gathered. The heating could not be controlled internally. Instead, maintenance were contacted by staff if the heating was needed to be increased or decreased.
- The approved centre was not in a good state of repair internally or externally. There was: chipped paint throughout the unit; plaster coming of the walls in the corridor and bedroom areas; holes in the wall of the relaxation room; screw holes in the wall throughout the corridor; stained walls, lino, and sinks in the bathrooms, as well as a rusted mirror; half of all lightbulbs missing in the dining room; dirty windows throughout the unit; marked frosted glass windows along the corridor; worn furniture such as couches and chairs in the sitting room and lobby areas; stained window-sill in the lobby, and; a damaged door in the corridor. The glass doors in the unit and at the entrance provided poor insulation as a result of damaged seals.
- In relation to Part 4 of the Mental Health Act Consent to Treatment, the statutory Form 17 did not, as required, document the precise medications being prescribed. This oversight was brought to the attention of the service but had not been addressed by the conclusion of the inspection.
- The failure to record and document the use of physical restraint compromised residents' dignity and autonomy. The approved centre stated that physical restraint had not been used since the last inspection despite incident reports documenting a significant number of aggressive episodes the response to which, outlined a degree of physical restraint to safely manage these incidents.

Responsiveness to residents' needs

- 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. Residents had at least two choices for meals. Food, including modified consistency diets, was well presented.
- The approved centre provided access to recreational activities appropriate to the resident group profile; walking, TV, music, and garden access.

However:

- The approved centre did not provide suitable furnishings to support resident independence and comfort; the sitting room and dining room had limited features and furnishings, giving them a stark appearance unsuitable for elderly residents with dementia.

Governance of the approved centre

- Sycamore Unit, while located on the Connolly Hospital Blanchardstown campus, was part of the North Dublin City and County Community Healthcare Organisation (CHO). The approved centre was overseen by two governance systems – Dublin North City Mental Health Services (NDMHS) which had oversight of personnel and services except for nursing staffing and estate management which were the responsibility of Connolly Hospital Blanchardstown (CHB).
- The poor governance of Sycamore Unit was of concern. It was apparent that the split governance system led to uncertainty and confusion regarding responsibility for operational staffing and maintenance. This had a detrimental effect on the therapeutic and psychosocial inputs necessary to safeguard the physical and psychological wellbeing of this resident population with impaired capacity and cognition. Due to long-standing governance issues affecting the provision of mental health services within Connolly Hospital a joint forum had been set up in November 2019 to seek to resolve the various conflicts and uncertainties.
- It was apparent from minutes provided that governance issues relating to Sycamore Unit did not feature within the consideration of the hospital Executive Management Team, the Quality and Safety Executive Committee, and the Health and Safety Committee.
- Review of the risk register indicated that there was no active process of review of risks specific to Sycamore and, where appropriate, their escalation to a suitable forum. Current risks relating to both overall staffing and also to lack of decorative maintenance of the centre did not appear to be incorporated or risk assessed within the available risk processes.
- Admissions to the approved centre had been suspended due to an on-going inability to recruit nurses and to maintain an appropriate therapeutic balance between psychiatric and general nurses. In addition, residents did not have access to a variety of clinical services necessary to promote and maintain physical and psychosocial functioning.
- While the approved centre documented that an active audit process was maintained, this was not the case. It was apparent that what were termed audits lacked detail regarding the population

included, issues reviewed, action plans arising, and re-audit process. In many cases the audits consisted of statements of fact rather than active examination and review of relevant processes.

- While staff training plans were documented to facilitate suitable training, not all health professionals had up to date mandatory training. A number of new initiatives in the falls and ulcer prevention areas had been introduced accompanied by staff training.
- While the current resident cohort lacked capacity to be actively involved in their personal care there was little documentary evidence of family or other advocate input on behalf of residents.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. An End of Life care plan had been developed and was being implemented in Sycamore.

2. A 'Pressure Ulcer to Zero' programme had been initiated to assess residents and minimise the risk of ulcer development.

3. A Falls Safety Cross initiative had been developed to monitor and lessen the risk of falls among the resident population.

4. Suction toothbrushes were introduced to lessen risk due to the impaired swallowing ability of residents.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Sycamore Unit was located within the grounds of Connolly Hospital and occupied a single story building dating from the mid twentieth century. The approved centre was registered to accommodate up to 25 residents under the care of the North Dublin Psychiatry of Later Life service. Admissions to the centre had been suspended in 2019.

The approved centre was a self-contained single story building consisting of a long central corridor with bedrooms and day facilities off this corridor. The current 15 residents were accommodated in four communal bedrooms, each with an attached bathroom. One unused bedroom was currently used for storage. An additional single bedroom was available for end of life or infection control purposes. The unit contained a multi-sensory room which, the inspection team were informed, it was not possible to use for half the year due to inadequate heating and insulation.

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

Resident Profile	
Number of registered beds	***25***
Total number of residents	**15**
Number of detained patients	1
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	15
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Sycamore Unit, while located on the Connolly Hospital Blanchardstown campus, was part of the North Dublin City and County Community Healthcare Organisation (CHO). The approved centre was overseen by two governance systems – Dublin North City Mental Health Services (NDMHS) which had oversight of personnel and services except for nursing staffing and estate management which were the responsibility of Connolly Hospital Blanchardstown (CHB).

It was apparent from the outset of this inspection that the split governance system led to uncertainty and confusion regarding responsibility for operational staffing and maintenance. This had a detrimental effect on the therapeutic and psychosocial inputs necessary to safeguard the physical and psychological wellbeing of this resident population with impaired capacity and cognition.

The inspection team were provided with a variety of committee minutes relating to various aspects of governance within Connolly Hospital. These included minutes of the hospital Executive Management Team,

the Quality and Safety Executive Committee, and the Health and Safety Committee. While pertinent to issues within the broader hospital it was apparent that governance issues relating to Sycamore Unit did not feature within the consideration of these various groups.

Minutes of the Sycamore Unit Management Committee meetings were also provided. This group met every 1-2 months and was composed of clinical staff associated with approved centre. The committee considered a variety of issues relating to the operation and governance of the centre including safety, risk, staffing, and training. Due to long-standing governance issues affecting the provision of mental health services within Connolly Hospital a joint forum had been set up in November 2019 to seek to resolve the various conflicts and uncertainties. This group had met on two occasions to date (most recently 10 February) and minutes of these meetings were provided.

Review of the risk register indicated that there was not an active process of review of risks specific to Sycamore and, where appropriate, their escalation to a suitable forum. Current risks relating to both overall staffing and also to lack of decorative maintenance of the centre did not appear to be incorporated or risk assessed within the available risk processes.

Currently, admissions to the approved centre had been suspended due to an on-going inability to recruit nurses and to maintain an appropriate therapeutic balance between psychiatric and general nurses. In addition residents did not have access to a variety of clinical services necessary to promote and maintain physical and psychosocial functioning. These included social work, physiotherapy, dietetics, and physical health occupational therapy.

While the approved centre documented that an active audit process was maintained it was apparent that this process lacked detail regarding the population included, issues reviewed, action plans arising, and re-audit process. In many cases the audits consisted of statements of fact rather than active examination and review of relevant processes.

While staff training plans were documented to facilitate suitable training it was apparent based on information provided by the service that not all health professionals had up to date mandatory training. Staff were facilitated to engage with a variety of non-mandatory training opportunities and a number of new initiatives in the falls and ulcer prevention areas had been introduced accompanied by staff training.

While the current resident cohort lacked capacity to be actively involved in their personal care there was little documentary evidence of family or other advocate input on behalf of residents. No documented complaints had been received since the previous inspection.

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 in 2018 and 2019 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	✗	Moderate	✓		✓		✗	High
Regulation 16: Therapeutic Services and Programmes	✓		✓		✗	High	✗	High	✗	Critical
Regulation 19: General Health	✓		✓		✗	High	✗	High	✗	High
Regulation 22: Premises	✓		✓		✓		✗	Moderate	✗	Critical
Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines	✓		✓		✓		✓		✗	High
Regulation 24: Health and Safety	✓		✓		✓		✓		✗	Moderate
Regulation 26: Staffing	✓		✓		✗	Moderate	✗	High	✗	High
Regulation 27: Maintenance of Records	✓		✗	Moderate	✓		✗	Low	✗	Moderate
Regulation 32: Risk Management Procedures	✗	Moderate	✓		✓		✓		✗	Moderate
Part 4 Consent to Treatment	✓		✓		✓		✓		✗	Critical
Code of Practice on the Use of Physical Restraint		Not Applicable	✓		✓		✓		✗	High
Code of Practice on Admission, Transfer and Discharge to and from the Approved Centre	✗	Low	✗	Low	✗	Moderate	✗	Moderate	✗	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 6: Food Safety
Regulation 10: Religion

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 13: Searches	As the approved centre did not conduct searches, as per local policy, this regulation was not applicable.
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, 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 Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, 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. During the course of the inspection posters were displayed inviting the residents to talk to the inspection team. In addition, leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.

Due to the impaired capacity and cognitive ability of the resident population no resident was able to engage with the inspection process. No family member or other advocate sought to engage with the inspection process.

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:

- General Manager, Mental Health (Registered Proprietor)
- General Manager, Connolly Hospital
- Executive Clinical Director
- Clinical Director
- Director of Clinical Services
- Senior Occupational Therapist
- Assistant Director of Nursing
- Staff Nurse

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The service confirmed the long-standing difficulties regarding governance. They also outlined the efforts that had been made to recruit clinical staff and the on-going failure to resolve this issue.

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 **Satisfactory**

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

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

Monitoring: An annual audit had not been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: The approved centre used a minimum of two resident identifiers, including the resident name, photograph, and date of birth. However, due to the impaired capacity and cognition of residents, priority was placed on photographs for identification purposes. Identifiers, including name and photograph, were person-specific and did not include room number or physical location. Name and photograph were used prior to administering medications, undertaking medical investigations, and providing other health care services. In addition, an appropriate resident identifier was used before the provision of therapeutic services and programmes. Where residents had the same or a similar name, coloured stickers were available from the Admissions Office.

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 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in February 2019. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

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

For residents with special dietary requirements, an evidence-based nutrition tool was used. Furthermore, weight charts were implemented, monitored, and acted upon for residents, where appropriate. However, the needs of residents identified as having special nutritional requirements were not regularly reviewed by a dietitian, as the approved centre did not have access to the service.

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 and evidence of implementation pillars.

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Excellent**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food 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 protective equipment was available and was used during the catering process. There was suitable and sufficient catering equipment, and there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Furthermore, hygiene was maintained to support food safety requirements. Catering areas, and associated catering and food safety equipment, were appropriately cleaned. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Satisfactory**

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

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

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. A record of residents wearing nightclothes during the day was maintained and monitored. No residents were wearing nightclothes at the time of this inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing, and such clothing was clean and appropriate to their needs. Additionally, 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 unless specified otherwise in their individual care plan. Also, residents had an adequate supply of individualised clothing.

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 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in February 2019. The policy included all of the requirements of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The resident was entitled to bring personal possessions with them; the extent of which was agreed at admission, and which was outlined in the information booklet. A residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the residents' monies, valuables, personal property, and possessions, as necessary. Property books were signed by two staff, ensuring that the access to and use of resident monies were overseen by two members of staff. Where money belonging to the resident was handled by staff, signed-records in the form of maintained receipts were retained. Where possible signed records were counter-signed by the resident or their representative.

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

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

Monitoring: A record was not maintained of the occurrence of planned recreational activities. 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; walking, TV, music, and garden access. Staff facilitated recreational activities subject to availability. In addition, the approved centre provided access to recreational activities on weekdays and during the weekend. Information was provided to residents in an accessible format, which was appropriate to their needs. This information included the types and frequency of appropriate recreational activities available within the approved centre.

Each resident was assessed prior to involvement in activities to ensure safe participation. Resident decisions on whether or not to participate in activities was respected and documented, as appropriate. In addition, residents had access to internal space within the unit and also an adjoining garden area. Documented records of attendance were not retained for recreational activities in group records or within 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 and evidence of implementation pillars.

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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: a priest visited the approved centre once each month and subsequently as required. None of the residents were physically or mentally well enough to attend church services. Facilities were provided within the approved centre for residents' religious practices, insofar as was practicable. Residents also had access to multi-faith chaplains. Care and services that were provided within the approved centre were respectful of the residents' religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. Additionally, the resident was facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Visiting times in the approved centre were publicly displayed: within the information booklet and on a sign at the front door. Visiting times were also appropriate and reasonable. A separate visitors' room or visiting area was 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; visits occurred beside the resident's bed, in the dining room, and in the visitor's room. Appropriate steps were taken to ensure the safety of residents during visits; it was noted on inspection however that the visitor's room had a temperature of 18 degrees which was not adequate, and a heater was sourced from the main hospital to alleviate this. Children visiting were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly. The visitor's room was also suitable for visiting children.

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 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in February 2019. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Resident communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, e-mail, Internet, telephone, or any device for the sending/receiving of messages/goods unless otherwise risk assessed with due regard to the residents' well-being, safety, and health. Residents could make calls out of the approved centre or families could ring in to the phone located in the nurse's station. There was no portable phone in the approved centre.

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 **Satisfactory**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to care of the dying. The policy was last reviewed in February 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for ensuring that the approved centre was informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).

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

Monitoring: End of life care provided to residents was not systematically reviewed to ensure Section 2 of the Regulation had been complied with. Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The clinical files of two residents who had died in the approved centre, including one resident who died unexpectedly, were examined. With regards to the expected death, the physical, emotional, social, psychological, and spiritual end of life care were detailed in the resident's progress notes. Pain management was prioritised and managed during end of life care and advance directives relating to end of life care as well as DNAR orders and associated documentation were evidenced in the clinical file. Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of residents was protected and the representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care.

The sudden death of one resident was managed in accordance 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. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

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

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

Monitoring: Residents' ICPs were not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: The ICPs of ten residents were reviewed. The ICP was a composite set of documents, and included sections for goals, treatment, care, and resources required with space for reviews. It was stored within the clinical file, and was identifiable and uninterrupted.

In the case of a resident admitted since the last inspection the ICP was not developed by the MDT following a comprehensive assessment, within seven days of admission: only nursing and medical had attended the MDT meeting. Additionally, the ICP was not discussed, agreed where practicable, and drawn up with the participation of the resident and their family or representative: there was no evidence on inspection that any of the family members involved were at any of the review meetings, and residents did not generally attend due to significant cognitive impairment.

A total of ten ICPs were reviewed. There was a failure to systematically identify the resident's assessed needs; needs and goals had been amalgamated into one section, therefore no distinction was made. The ICPs also did not identify appropriate goals for the residents. Goals were not reflective of resident needs, they often read as statement of current status or care provided, and entries were sometimes difficult to read. In four cases, the ICP did not identify the care and treatment required to meet the goals identified, or the responsibility for implementing the care and treatment. Care and treatment listed was often very generic and similar in scope for all residents. In two cases it was noted that the ICP in question did not

accurately reflect the recommendations of a Speech and Language Therapy (SALT) assessment undertaken or direct the reader to look for the Speech and Language Therapy (SALT) care plan. The ICP identified the resources required to provide the care and treatment identified.

A key worker was not identified in any of the care plan to ensure continuity in the implementation of the resident's care plan. None of the ICPs inspected referred to an individual risk management plan. In nine out of ten ICPs reviewed, only nursing and medical were present. Also, not all ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances and goals.

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

a) **The majority of ICPs were not developed and reviewed by a comprehensive multi-disciplinary team.**
b) **ICPs did not identify appropriate goals for residents.**
c) **Four ICPs did not identify appropriate care and treatment required to meet goals identified.**
d) **In two cases ICPs were not updated following review, taking appropriate account of recommendations of assessments undertaken.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Inadequate

Risk Rating CRITICAL

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

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

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis by senior management as part of the risk assessment process identifying deficits in provision. Documented analysis had not 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 not appropriate and did not meet the assessed needs of the residents; there was no access to physical health Occupational Therapist for seating needs of residents. There was also no access to physiotherapy for high falls risks, or to a dietitian. The therapeutic services and programmes provided by the approved centre were evidence based. However, the therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents: optimal physical and psychosocial functioning was not achieved due to the lack of a physical health Occupational Therapist, physiotherapist, and dietitian.

Where a resident required a therapeutic service or programme that was not offered internally, the approved centre did not arrange for the service to be provided by an approved, qualified health professional in an appropriate location. Adequate and appropriate resources and facilities were not available for the provision of therapeutic services and programmes. Therapeutic services and programmes were provided in the sitting room area or dining room area when not in use. A record was maintained of participation and engagement in and outcomes achieved in therapeutic services and programmes in residents' individual care plans or clinical files.

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

a) **The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes in accordance with his/her individual care plan, 16 (1).**

b) **The registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16 (2).**

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

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

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

Evidence of Implementation: Communication records with the receiving facility were documented and available on inspection. An assessment of the resident was completed prior to transfer, including individual risk assessment relating to the transfer and the resident's needs, and clinical information and chart were provided. Full and complete written information for the resident was transferred when they moved from the approved centre to another facility. A letter of referral, including a list of current medications, and the resident transfer form were issued, with copies retained 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. Furthermore, 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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 general health policy was last reviewed in February 2019. The medical emergencies policy was last reviewed in February 2019. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED). 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. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than six months.

At a minimum, the six-monthly general health assessment documented a physical examination, blood pressure, smoking status, and dental health. None of the five general health assessments included the resident's family/personal histories. One of the general health assessments did not include the resident's body-mass index, two did not include the resident's waist circumference, while one did not include the resident's weight.

For residents on antipsychotic medication, there was an annual assessment of their glucose regulation (fasting glucose/HbA1c), blood lipids, an electrocardiogram (ECG), and their prolactin. Adequate

arrangements were not in place for residents to access general health services and for their referral to other health services; there was no access to a dietitian, physical occupational therapist, and physiotherapist, except an orthopaedic physiotherapist. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing such as lab results. Residents in the approved centre could access national screening programmes that were available 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. Residents also had access to smoking cessation programmes and supports.

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

a) **Five six-monthly general health assessments did not include the resident's family/personal history, 19(1) (b).**
b) **One six-monthly general health assessments did not include the resident's BMI, 19(1)(b).**
c) **Two six-monthly general health assessments did not include the resident's waist circumference, 19(1)(b).**
d) **One six-monthly general health assessment did not include the resident's weight, 19(1)(b).**
e) **Four six-monthly general health assessments did not include the resident's nutritional status, 19(1)(b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of information to residents. The policy was last reviewed in February 2019. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed the care and services. The booklet was in large print and easily readable, ensuring it was in a required format to support resident needs. The booklet contained housekeeping arrangements, including arrangements for personal property and mealtimes; visiting times and arrangements; details of relevant advocacy and voluntary agencies; and residents' rights. Residents were provided with details of their multi-disciplinary team. In addition, residents were provided with written and verbal information on diagnosis, unless, in the treating psychiatrist's view, provision of such information may be prejudicial to the resident's physical or mental health, well-being, or emotional condition.

Information was provided to residents on the likely adverse effects of treatments, including the risks and other potential side-effects. The content of the medication information sheets included information on

indications for use of all medications to be administered to the resident including any possible side-effects. Furthermore, residents had access to interpretation and translation services, as required.

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

Regulation 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. 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 not been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had not been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: There was evidence of the policy relating to resident privacy and dignity being implemented throughout the approved centre, including but not limited to the following: residents were called by their preferred name; the general demeanour of staff; the manner in which staff address and communicate with residents; staff appearance and dress; staff ensured that no ageist, racist, sexist, or other inappropriate comments or "jokes" were made; staff discretion when discussing the resident's condition or treatment needs; staff seeking the resident's permission before entering their room, as appropriate; and all residents wore clothes that respected their privacy and dignity e.g. no soiled clothing, inappropriate size or type of emergency clothing.

There were no single rooms for routine use in the approved centre: locks were removed from all bathrooms due to the resident profile. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Furthermore, rooms were not overlooked by public areas, and if so, the windows had opaque glass. Noticeboards did not display resident names or other identifiable information. Also, residents were facilitated to make private phone calls.

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 22: Premises

NON-COMPLIANT

Quality Rating Inadequate

Risk Rating CRITICAL

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

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

Monitoring: The approved centre had completed a hygiene audit. 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. However, there was not suitable and sufficient heating: the minimum temperature in bedroom areas was not 18 C (65 F) and 21 C (70 F) in day areas and in bedrooms where residents sat during the day. This resulted in the relaxation room being inaccessible in the winter due to the low temperature; there was also a cold draft coming through the front door where residents gathered. Rooms were ventilated through windows and vents in the bathrooms. Private and communal areas were suitably sized and furnished to remove excessive noise. Appropriate picture signage and sensory aids were provided to support resident orientation needs.

Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were not minimised in the approved centre: a hard, sharp edge was exposed on a broken plastic wall protective panel; concrete in the entranceway was eroded, making the surface uneven and a potential falls hazard; a ridged surface at the entrance to the garden presented a potential falls hazard, and; a ridged surface at the end of the corridor where the building met the prefab extension also presented a falls hazard.

The approved centre was not in a good state of repair internally or externally. For example, there was: chipped paint throughout the unit; plaster coming of the walls in the corridor and bedroom areas; holes in the wall of the relaxation room; screw holes in the wall throughout the corridor; stained walls, lino, and sinks in the bathrooms, as well as a rusted mirror; rotting lino in the sluice room and student nurses' office; half of all lightbulbs missing in the dining room; dirty windows throughout the unit; marked frosted glass windows along the corridor; worn furniture such as couches and chairs in the sitting room and lobby areas; stained window-sill in the lobby, and; a damaged door in the corridor. The glass doors in the unit and at the entrance provided poor insulation as a result of damaged seals.

The heating could not be controlled internally. Instead, maintenance were contacted by staff if the heating was needed to be increased or decreased. Therefore, resident could not control the heating within their own rooms. Where faults or problems were identified in relation to the premises, this was not communicated through the appropriate maintenance reporting process. The broken lightbulbs in the dining room had not been reported to maintenance, nor had complaints about the heating and temperature within the unit.

The approved centre was clean, hygienic, and free from offensive odours; however, there was no programme of general or decorative maintenance. There was a sufficient number of toilets and showers for residents in the approved centre. All resident bedrooms were appropriately sized to address the resident's needs. However, the approved centre did not provide suitable furnishings to support resident independence and comfort; the sitting room and dining room had limited features and furnishings, giving them a stark appearance. The approved centre provided assisted devices and equipment to address resident needs: examples include a hoist, wheelchair commodes, shower seats, beds, and handrails.

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

a) **A programme of routine maintenance and renewal of fabric and decoration of the premises was not developed and implemented, 22 (1) (c).**
b) **Premises were not maintained in good structural and decorative condition, 22 (1) (a).**
c) **The condition of the overall approved centre environment was not developed and maintained with due regard to the specific needs and well-being of residents because communal rooms, including the sitting room and dining room, were minimally furnished, imparting a stark appearance, 22(3).**

d) **The condition of the physical structure and the overall approved centre environment was not 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 because the visitors' room and snoezelen (sensory) room was below the recommended temperature of 21 Degrees Celsius in day areas, 22(3).**

e) **The condition of the physical structure and the overall approved centre environment was not 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 because hazards, including sharp edges, hard or rough surfaces were not minimised in the approved centre, 22(3).**

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

Training and Education: Not all nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. 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 not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: All entries in the MPAR 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. Prescriptions were not altered where a change was required, instead, where there was any 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 directions of the prescriber, and any advice provided by that resident's pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration; expired medications were not administered. A clear record of the date of discontinuation for each medication was not recorded in two of the MPARs examined.

Schedule 2 controlled drugs were checked by two members of staff (one of which who was a registered nurse) against the delivery form and details were entered on the controlled drug book. Direction to crush medication was only accepted from the resident's medical practitioner. However, due to blanket instructions to crush medication, the medical practitioner did not provide a documented reason why medication was to be crushed. There was no direct pharmacist input to the approved centre. Pharmacy

advice was available by phone. Medication storage areas were free from damp and mould, clean, free from litter, dust and pests and free from spillage or breakage. Food and drink was not stored in areas used for the storage of medication. However, medication dispensed or supplied to the resident was not stored securely in a refrigerator; while all cupboards and trollies containing medication remained locked, the refrigerator was not; while the fridge was lockable, there was no access to a key on inspection.

The medication administration cupboards remained locked at all times and in a securely locked room, accessed via swipe card only. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. An inventory of medications was conducted on a monthly basis, which checked the name and dose of medication, the quantity of medication, but not 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 non-compliant with this regulation for the following reasons:

a) **Two MPARs did not record the date of discontinuation of each medication, 23(1).**
b) **The medication fridge was unlocked and stored medications were potentially accessible to unauthorised staff, 23(1).**
c) **Documented reasons for the crushing of medication in each individual case were not recorded in each case, 23 (1).**

Regulation 24: Health and Safety

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in February 2019. The safety statement was last reviewed in April 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The approved centre's compliance with health and safety legislation, including the reporting requirements.
- The content of the health and safety statement.

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

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

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

The approved centre was non-compliant with this regulation because the approved centre did not have a Safety Statement which had been updated on an annual basis so as to meet the requirements of the HSWA 2005, 24 (2).

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements. The policy was last reviewed in February 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the evaluation of training programmes.

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

Evidence of Implementation: The numbers and skill mix of staffing were not sufficient to meet resident's needs. There was no Registered Practical Nurse (RPN) within the approved centre for approximately half of the day time hours and the residents did not have access to the services of a physical health OT, social worker, psychologist, and dietitian. In addition, residents did not have access to the services of a physical health occupational therapist, social worker, psychologist, and dietitian. The approved centre was operated by a cohort of nursing staff without any specialised mental health training or qualifications. An appropriately qualified staff member was not on duty and in charge at all times. Induction training was completed for staff.

Not all health care professionals in the approved centre were trained in Fire Safety and Basic Life Support. All health care professionals were trained in the Management of violence and aggression, and the Mental Health Act 2001. 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: manual handling; infection control and

prevention, including sharps, hand hygiene techniques, and use of Personal Protective Equipment (PPE); dementia care; care for residents with intellectual disability; end of life care; resident rights; risk management – individual, organisational, and care and treatment provision as appropriate to staff role; recovery-centred approaches to mental health care and treatment; incident reporting; and protection of children and vulnerable adults. All staff training was documented, and staff 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 of achievement. In-service training was completely by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training. The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Mgmt. of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (14)	14	100%	14	100%	13	93%	14	100%	14	100%
Medical (4)	2	50%	1	25%	4	100%	4	100%	4	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (0)	-	%	-	%	-	%	-	%	-	%
Psychologist (0)	-	%	-	%	-	%	-	%	-	%
HCA (13)	11	83%	11	83%	11	83%	n/a	n/a	13	100%

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

Staff in Approved Centre

	Staff Grade	Day	Night
Sycamore	Clinical Nurse Manager 2	-	-
	Registered Psychiatric Nurse	1**	2
	Registered General Nurse	3	-
	Health Care Assistant	3	2
	Occupation Therapist	0.2	-
	OT Assistant	0.5	-
	Social Worker	-	-
	Psychologist	-	-

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Assistant Director of Nursing	1	-
Consultant Psychiatrist	2	-
Non Consultant Hospital Doctor	2	-
Occupation Therapist	-	-
Social Worker	-	-
Psychologist	-	-

Whole time equivalent (WTE)

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

**Presence of RPN dependent on rostered availability. A number of shifts had no RPN rostered.

Registered Psychiatric Nurse (RPN), Registered General Nurse (RGN), Health Care Assistant (HCA)

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

a) **The registered proprietor did not ensure that the number and skill mix of staff was appropriate to meet resident's needs as access to a variety of health professionals including social worker, psychologist, dietitian, and physical health occupational therapist was not provided, 26 (2).**
b) **The registered proprietor did not ensure that there was an appropriately qualified member of staff on duty and in charge of the approved centre at all times, 26 (3).**
c) **The registered proprietor did not ensure that all staff had up to date mandatory training in Basic Life Support and Fire Safety, 26 (4).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 in relation to the maintenance of records. The policy was last reviewed in February 2019. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the required content for each resident record.

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

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

Evidence of Implementation: Not all residents' records were up to date, in good order and used in accordance with national guidelines and legislative requirements. In two cases reviewed resident records were not reflective of the residents' current status and the care and treatment being provided. Resident records were maintained using an identifier that was unique to the resident or some other effective method. Resident records were also developed and maintained in a logical sequence. However, records were not maintained in good order: on inspection, loose pages were noted in two files together with a ripped chart cover. In one case the record was not written legibly in black indelible ink, rendering it unreadable when photocopied.

Each entry included the date and each entry was followed by a signature. Each entry did not note the time using the 24-hour clock. The approved centre maintained a record of all signatures used in the resident record. Where an error was made, no date, time, or signature was used. Two appropriate resident identifiers were recorded on all documentation. 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) **Not all records reflected the resident's current status, 27(1).**
b) **Not all records were maintained in good order as they had loose pages and torn chart cover, 27(1).**
c) **Not all records were written legibly, 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 **Satisfactory**

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 February 2019. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures of the approved centre were developed with input from clinical and managerial staff and in consultation with all relevant stake holders (including service users), as appropriate. The operating policies and procedures of the approved centre incorporated relevant legislation, evidence-based best practice and clinical guidelines. In addition, the operating policies and procedures of the approved centre were appropriately approved, and communicated to all relevant staff. The following operating policies and procedures were required to be reviewed within three years for compliance with this regulation: Regulation 8: Residents' Personal Property and Possessions; Regulation 11: Visits; Regulation 19: Responding to Medical Emergencies; Regulation 26: Staffing; and Regulation 32: Risk Management Procedures.

Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. The format of policies and procedures was standardised and included: the title of the policy and procedure; reference number and revision of the policy and procedure; document owner; approvers; reviewers, where applicable; scope of the policy and procedure; and the total number of pages in the policy and procedure. The format did not however include the date at which the policy would be implemented (effective from).

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

(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 February 2019. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre provided private facilities to support the Mental Health Tribunal process. The approved centre also provided adequate resources to support the Mental Health Tribunal process. Furthermore, 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 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 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the management of complaints. The policy was last reviewed in February 2019. The policy addressed all of the requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

Evidence of Implementation: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. This was in the form of an information booklet. The complaints procedure, including how to contact the nominated person, was publicly displayed. When the nominated person was not based in the approved centre, contact details were publicly displayed via

a poster. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether written or oral, 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. All complaints (that were not 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.

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

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Inadequate
Risk Rating MODERATE

(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 a written policy in relation to risk management and incident management procedures, which was last reviewed in February 2019. The policy addressed all of the requirements of the *Judgement Support Framework*, with the exception of specification of the methods for controlling risks associated with suicide and self-harm.

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. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

Monitoring: The risk register was not reviewed at least quarterly to determine compliance with the approved centre's risk management policy. 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, the clinical risk manager, was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were identified within the risk register. A number of risks were documented relating to staffing. Health and safety risks and corporate

risks were documented within the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessment were completed prior to and during the following: mechanical restraint; at admission to identify individual risk factors, including general health risks, risk of absconding, risk of self-harm etc. Risk was also assessed in relation to resident transfer and in conjunction with medication requirements or administration. The clinical team was involved in the development, implementation, and review of individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre 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. However, a record was not maintained of such 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. Information provided was anonymous at resident level. There was an emergency plan that specified responses by the approved centre staff to possible emergencies, and the emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because the Risk Management policy did not specify precautions in place to control the risk of suicide and self-harm, 22 (2) (c).

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. The certificate was displayed prominently inside the front door of 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 Mechanical Restraint

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

Evidence of Implementation: On inspection, one case of mechanical restraint was examined. Mechanical restraint for enduring risk of harm to the self or others was only used to address identified clinical needs. Mechanical restraint was used only when less restrictive alternatives were unsuitable. Additionally, it was ordered by the registered medical practitioner (RMP) under supervision of the consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf. In the case of mechanical restraint, there was an enduring risk of harm to the self or others, and less restrictive alternatives were implemented without success. The clinical file also contained contemporaneous records that specified the following: the type of mechanical restraint; the situation in which mechanical restraint was being applied; the duration of the restraint; the duration of the order; and the review date.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NON-COMPLIANT

Risk Rating CRITICAL

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 file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. The policy was up-to-date, last updated in February 2019. Following administration of medication for a continuous period of three months, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent. Due to the assessed incapacity of the patient to consent to treatment the procedures under the Act were deemed necessary. However, the statutory Form 17 did not, as required, document the precise medications being prescribed and consented to. There was confirmation of the assessment of the patient's inability to understand the nature, purpose, and likely effects of the medications.

This oversight was brought to the attention of the service but had not been addressed by the conclusion of the inspection.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because the Form 17 authorising the continued administration of medication did not, as required, document the specific medications prescribed to the resident.

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 HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2019. It addressed the following:

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

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

Evidence of Implementation: The failure to record and document the use of physical restraint compromised residents' dignity and autonomy. The approved centre stated that physical restraint had not been used since the last inspection despite incident reports documenting a significant number of aggressive episodes the response to which, outlined a degree of physical restraint to safely manage these incidents. The systematic failure to document the process as such was a breach of Section 8 – Recording the Use of Physical Restraint.

The approved centre was non-compliant with this code of practice because the systematic failure to document any episode of PR which may have occurred (and incident reports confirm a significant number of aggressive episodes involving residents which, in all likelihood, necessitated some form of PR by staff) was a breach of Section 8 of the Code: Recording the Use of Physical restraint.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in February 2019, included all of the policy-related criteria for this code of practice.

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

Training and Education: There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policy.

Monitoring: There was no evidence presented to confirm that an audit of admission or transfer processes had been undertaken.

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 keyworker. An admission assessment was completed and included the following elements: presenting problem; past psychiatric history; family history; medical history; current and historic medication; social and housing circumstances; current mental state; risk assessment; and any other relevant information. A full physical examination also took place. The resident's daughter was involved in the admission process as the resident did not have capacity.

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

Discharge: As the approved centre did not discharge residents this element was considered non-applicable.

The approved centre was non-compliant with this code of practice because audits of the implementation of and adherence to the admission and transfer policies had not been documented, 4.19.

Appendix 1: Corrective and Preventative Action Plan

The Approved Centre did not provide acceptable CAPAs in time for the publication of this report.

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.

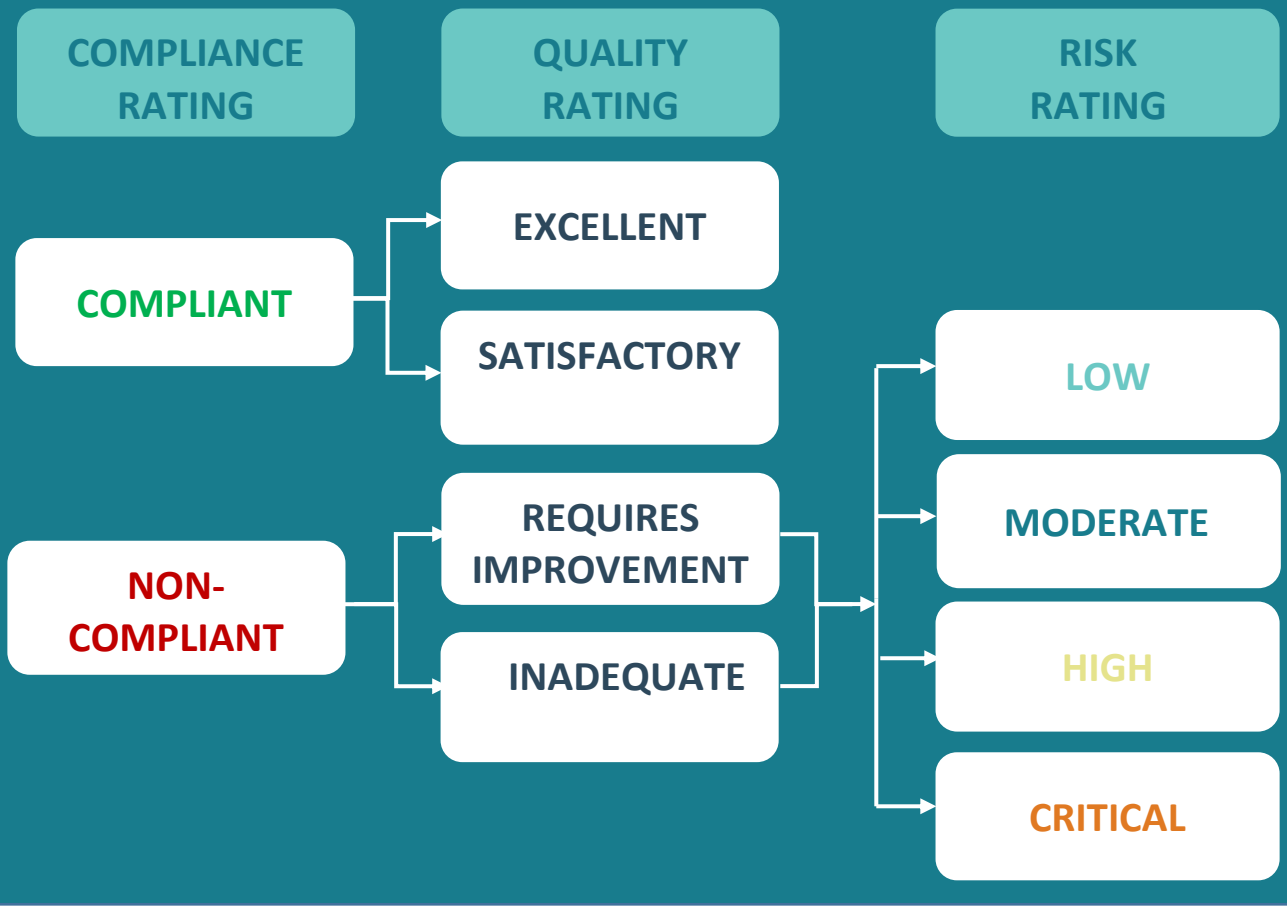
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, 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.

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
QUALITY RATINGS are generally given for all regulations, except for 28, 33 and 34.
RISK RATINGS are given for any area that is deemed non-compliant.



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.