St Gabriel's Ward, St Canice's Hospital

ID Number: AC0017

2018 Approved Centre Inspection Report (Mental Health Act 2001)

St Gabriel's Ward, St Canice's Hospital
Dublin Road
Kilkenny

Approved Centre Type:
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
1 March 2017

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, General Manager, CHO 5 Mental Health Services

Inspection Team:
Noeleen Byrne, Lead Inspector
Siobhán Dinan
Dr Susan Finnerty MCRN009711

Inspection Date:
23 – 26 April 2018

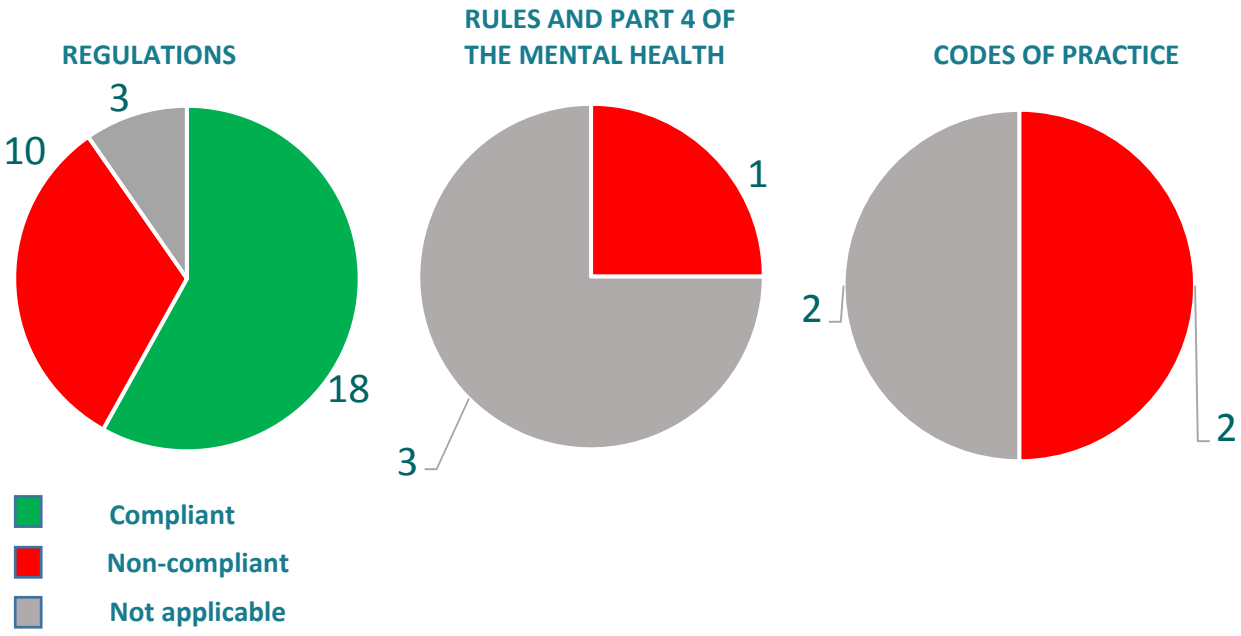
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
16 – 19 May 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
15 November 2018

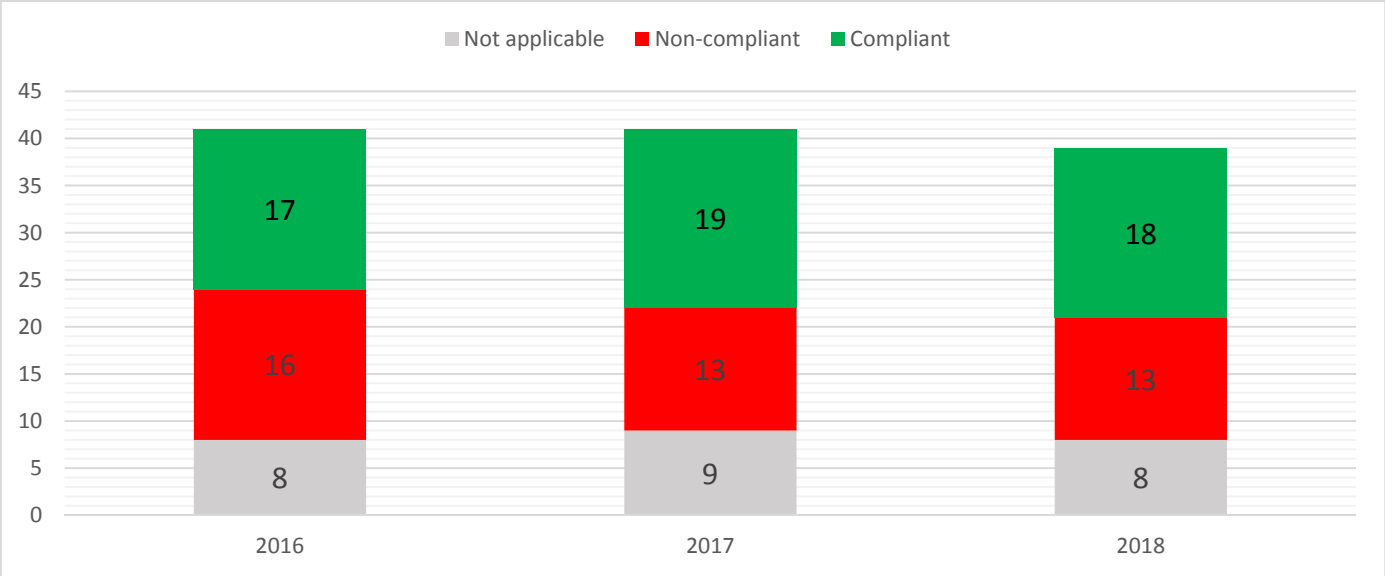
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

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

Chart 1 – Comparison of overall compliance ratings 2016 – 2018



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 – 2018

Contents

1.0 Introduction 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.

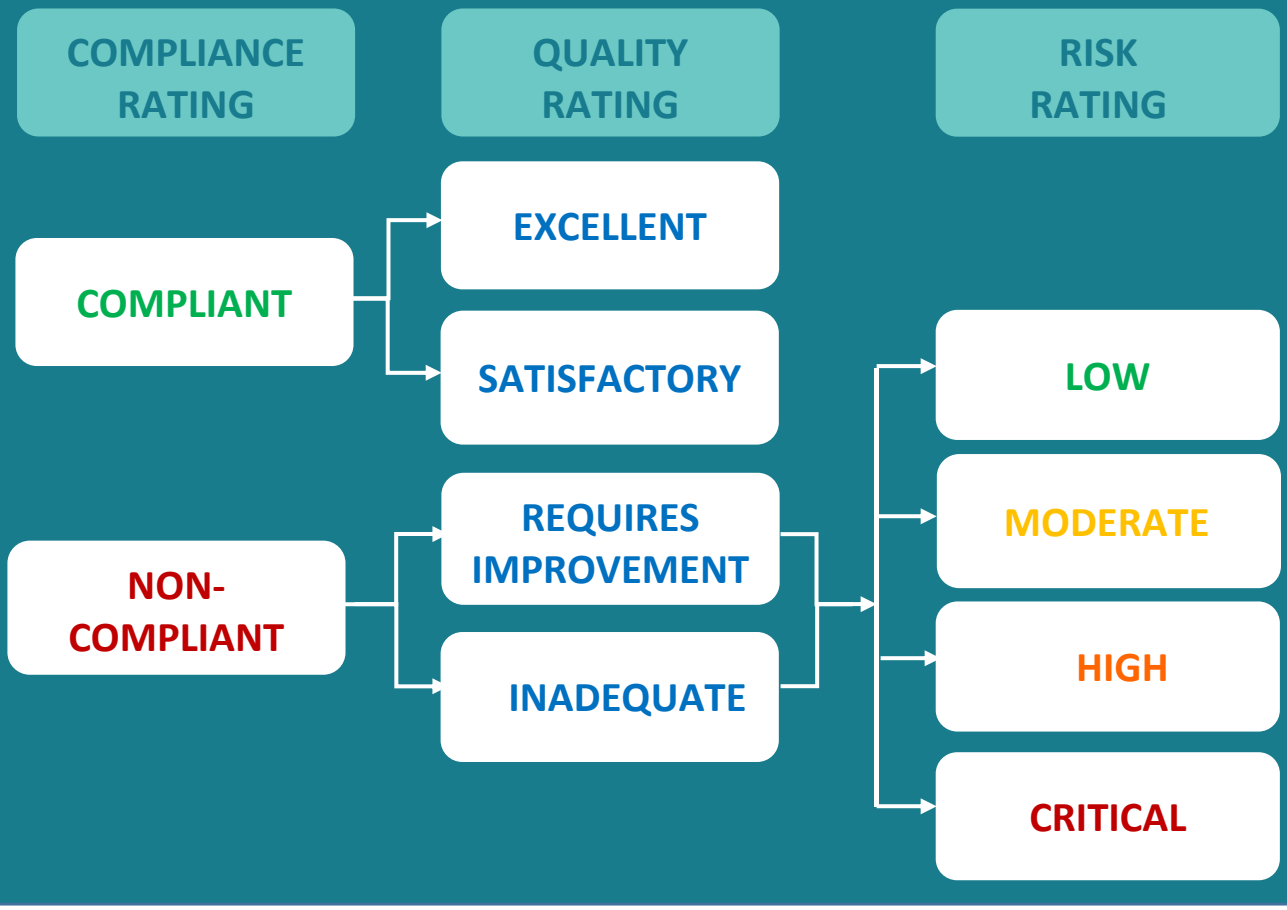
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly,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

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated Judgement Support Framework, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

In Brief

St. Gabriel's Ward was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. This building housed separate facilities and offices used by the community mental health teams. The approved centre accommodated residents under the psychiatry of later life, rehabilitation and recovery teams and community general adult mental health teams. Residents of a rehabilitation and recovery team were transferred from another approved centre and were not visited by their multi-disciplinary team (MDT). Appropriate therapeutic therapies and recreational activities had not been arranged. Senior management cited overcrowding as the reason for the admissions. They received medical and nursing inputs at St. Gabriel's.

There has been improvement in compliance with regulations, rules and codes of practice between 2016 (52%) and 2018 (62%). Two compliances with regulations were rated as excellent. The approved centre was non-compliant with Rule Governing the Use of Mechanical Restraint and this was rated critical risk.

Safety in the approved centre

Food audits were completed regularly and food areas were clean.

Medication prescriptions did not contain a signed order by a medical practitioner to crush medication, and the policy did not contain the procedure for crushing medications. There were loose pages which contained resident identifiers and clinical information and this information was not secure within the file.

The approved centre did not have a comprehensive risk management policy and the emergency plan lacked detail and did not contain adequate arrangements for responding to emergencies. Structural risks, including ligature points, were removed or effectively mitigated.

Not all health care staff were trained in fire safety, Basic Life Support, Management of violence and aggression and The Mental Health Act 2001. Staff were trained in Children First.

Appropriate care and treatment of residents

Each resident had an individual care plan (ICP) was a composite set of documents. While the ICPs reviewed included attendance of multi-disciplinary (MDT) members, two residents did not have ICPs developed until one-month post admission. There was evidence of family involvement in care plans where this was applicable. A small number of care plans did not either identify the resident's assessed needs, appropriate goals appropriate interventions or the resources required to provide the care and treatment identified.

Although a range of therapeutic programmes were available to residents, the therapeutic services and programmes provided by the approved centre did not meet the assessed needs of all the residents. The therapeutic programmes provided were appropriate for long stay residents and those in later life; however, they were not appropriate for residents requiring rehabilitation. Adequate and appropriate resources and facilities were not available to provide therapeutic services and programmes for all residents. One resident that required a functional assessment had not received it. There was no psychologist and some residents did not meet any of their MDT in the approved centre as they were residents transferred from another approved centre and, apart from medical and nursing staff, members of their MDT did not attend St Gabriel's.

Residents' general health needs were monitored and assessed at least every six months, but there was no documentation of dental health status and no evidence of routine dental assessment. Residents on anti-psychotic medication did not have an ECG and one resident required a yearly fasting glucose test which was not completed. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes as indicated.

Respect for residents' privacy, dignity and autonomy

Residents were restricted from leaving the approved centre and the entrance door was locked to ensure the safety of residents who had cognitive impairment; however, this restrictive practice was also imposed on residents who did not have cognitive impairment. The garden area was also locked but residents who were not at risk of falling were given access at all times during the day. Visitors could be received in a private area and there were no restrictions on visiting. Residents wore their own clothes and had space for storage. Residents' finances were handled appropriately.

Bed screening was insufficient and impacted on residents' privacy. Some bedrooms were overlooked by public areas with no screening. The noticeboard at the nurses' station detailed resident names, which could be seen by passers-by. There were loose pages in the clinical files, which contained resident identifiers and clinical information and, therefore, this information was not secure within the files.

There were a significant number of deficits in the use of mechanical restraint for enduring risk of harm to self or others. There was no identified clinical need for mechanical restraint documented; there was no record specifying that less restrictive alternatives were unsuitable; clinical files of the two residents did not record that less restrictive alternatives were implemented without success, the situation in which mechanical restraint was being applied, or the duration of the restraint. This non-compliance with the relevant Rule was rated critical risk. In three episodes of physical restraint, the resident was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint.

Responsiveness to residents' needs

There was a good choice of food at mealtimes and residents were assessed for nutrition status. Residents could communicate freely through mail and mobile phone but there was no access to the internet and email. Residents were free to practice their religion and there was access to multi-faith chaplains. Recreational activities were available during the week and at weekends. Information was provided to residents and their representatives at admission, including the approved centre's information booklet which detailed the care and services. The booklet was clearly and simply written. The complaints process was satisfactory. The premises were clean, well maintained and appropriately decorated.

Governance of the approved centre

St. Gabriel's ward was part of the management structure of the Community Healthcare Organisation (CHO) 5 in the HSE. The governance of CHO 5 was divided into Carlow/Kilkenny/South Tipperary and Wexford/Waterford. St. Gabriel's was part of the Carlow/Kilkenny/South Tipperary governance structure. The EMT met monthly and consisted of heads of discipline, the head of service, and the service manager. There were regular St. Gabriel's ward operational management group meetings attended by senior clinical staff and a service user representative. The Quality and Safety Executive Committee meetings were attended by clinical and managerial staff and occurred monthly.

There were clearly defined line management structures in the different disciplines. No department had staff performance appraisals. All heads of discipline had received training on clinical risk management. St Gabriel's Ward had no risk register; however, there were risk assessments and some risks that could not be managed in the approved centre were escalated to the CHO area risk register.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. New information leaflet for residents and family/carers.

2. Introduced “Timeslips and Azure”, dementia friendly arts programmes, in association with the Butler Art Gallery in Kilkenny.

3. New colourful furniture was purchased for garden room, visitors’ room and the sitting room.

4. Two staff members attended “What matters to me”, an educational and training programme for end of life care.

5. A programme to pilot to new, bright colour uniforms was underway. Research has shown bright colours have a positive effect on people with dementia. At the end of the pilot it will be decided whether or not to introduce new uniforms for all staff.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre (St. Gabriel's Ward) was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey, brick façade building erected in the 1980s. This building also housed separate facilities and offices used by the community mental health teams.

The approved centre accommodated residents under the Psychiatry of Later Life (POLL), rehabilitation and recovery teams and community general adult mental health teams. The age range of residents varied from early 50s to 100 years. There were ten residents under the care of the POLL team, four residents were under the care of the Rehabilitation and Recovery team and three residents were under the community mental health teams.

The approved centre comprised a central nurses' office, sitting room, and day area with bedroom accommodation located on an adjacent corridor. Sleeping accommodation was in single, two- or three-bed rooms with toilet and shower facilities en suite. A separate single room with no en suite facility was in use at the time of the inspection. There was an attractive garden area and residents used the garden space for smoking. Staff were observed to engage with residents in a caring and respectful manner throughout the inspection.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**17**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	11
Number of patients on Section 26 leave for more than 2 weeks	0

4.2 Conditions to registration

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

4.3 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.

4.4 Governance

St. Gabriel's ward was part of the management structure of the Community Healthcare Organisation (CHO) 5 in the HSE. The governance of CHO 5 was divided into Carlow/Kilkenny/South Tipperary and Wexford/Waterford. St. Gabriel's was part of the Carlow/Kilkenny/South Tipperary governance structure.

Minutes of the executive management team (EMT) meetings with responsibility for governance of Carlow/Kilkenny and South Tipperary mental health services were provided to the inspection team. The EMT consisted of heads of discipline, the head of service, and the service manager. They met on a monthly basis. Residents of a rehabilitation and recovery team were transferred from another approved centre and were not visited by their multi-disciplinary team (MDT). Appropriate therapeutic therapies and recreational activities had not been arranged. Senior management cited overcrowding as the reason for the admissions. They received medical and nursing inputs at St Gabriel's.

The EMT approved the extension of some operational policies. Approval was extended to the end of 2018 for policies that were due to go out of date during 2018. This was to enable the policy review group to revise all policies and put new ones in place before 2019.

There were regular St. Gabriel's ward operational management group meetings attended by senior clinical staff and a service user representative. These meetings showed clear action points and persons responsible for actions which related specifically to St. Gabriel's ward. Minutes of Quality and Safety Executive Committee meetings were also provided. These were attended by clinical and managerial staff and occurred monthly.

The inspection team sought to meet with heads of discipline during the inspection. The inspection team meet with the following individuals:

- Clinical Director
- Area Director of Nursing
- Principal Social Worker
- Principal Psychologist
- Occupational Therapy Manager

Two heads of discipline reported that they visited the approved centre approximately twice or three times a year. Nursing management visited two-monthly. There was no psychologist so the Principal Psychologist did not attend the centre except when necessary. Other heads of discipline met with the staff from their departments on a frequent basis and there were clearly defined line management structures. No department had staff performance appraisals. All heads of discipline had received training on clinical risk management. A regional Quality Health and Safety Committee had been formed with a plan in place to meet two-monthly in 2018. St Gabriel's had no risk register; however, there were risk assessments and some risks that could not be managed in the approved centre were escalated to the CHO area risk register.

4.5 Use of restrictive practices

Residents were restricted from leaving the approved centre and the entrance door was locked. This was to ensure the safety of residents who had cognitive impairment. This restrictive practice was also imposed on

residents who did not have cognitive impairment. Staff and relatives accompanied residents outside the approved centre. The garden area was also locked and residents who were not at risk of falling were given access at all times during the day.

5.0 Compliance

5.1 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 2017 and 2016 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 12: Communication	✓		✓		✗	Moderate
Regulation 15: Individual Care Plan	✓		✗	Low	✗	High
Regulation 16: Therapeutic Service and Programmes	✓		✓		✗	High
Regulation 19: General Health	✗	High	✓		✗	Moderate
Regulation 21: Privacy	✗	Moderate	✗	Moderate	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	Moderate	✗	Moderate	✗	High
Regulation 26: Staffing	✗	Moderate	✗	High	✗	High
Regulation 27: Maintenance of Records	✗	Moderate	✗	Low	✗	Moderate
Regulation 28: Register of Residents	✗	Moderate	✗	Moderate	✗	Low
Regulation 32: Risk Management Procedures	✓		✓		✗	Moderate
Section 69: The Use of Mechanical Restraint	✗	Low	✗	Moderate	✗	Critical
Code of Practice on The Use of Physical Restraint	✗	High	✗	Low	✗	Moderate
Code of Practice on the Admission, Transfer, and Discharge to and from an Approved Centre	✗	High	✗	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.

5.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 8: Residents' Personal Property and Possessions

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
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.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment 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.

6.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Area Lead from the HSE Mental Health Engagement Office was contacted but was unable to meet the inspection team.

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

The resident profile in the approved centre was primarily a population of residents in later life with a diagnosis of dementia. A family member of one resident chose to speak to the inspection team. Three service user experience questionnaires were returned by family members. Families praised the care their relatives had received. The families felt that the staff of the approved centre listened to them and respected them and their relatives. The families praised the dignity and respect shown towards their relatives by the staff, and they highlighted the caring nature of the staff.

7.0 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:

- Acting Clinical Director
- Consultant Psychiatrist x 2
- Assistant Directors of Nursing x 2
- Principal Psychology Manager
- Principal Social Worker
- Service Manager
- Clinical Nurse Manager Grade 3
- Clinical Nurse Managers Grade 2 x 2
- Senior Occupational Therapist
- Staff Nurse x 2

The Registered Proprietor, Area Director of Nursing and Occupational Therapy Manager offered apologies. 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.

8.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in April 2017. The policy addressed 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 been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. These were used before administrating medications, undertaking medical-investigations, and providing other health care services. An appropriate resident identifier was also used prior to the provision of therapeutic services and programmes.

The preferred identifiers used for each resident were detailed within each resident's clinical file. Identifiers were person-specific and appropriate to the residents' communication abilities. Appropriate identifiers and alerts were used for residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **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 December 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The management of food and nutrition for each resident within the approved centre.
- The monitoring of food and water intake.

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

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

Evidence of Implementation: The approved centre menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Since the last inspection, an element of choice had been introduced; residents' now had at least two choices for meals. Hot meals were provided on a daily basis. Food, including modified consistency diets, were presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition.

Hot and cold drinks were offered to residents regularly. A source of fresh drinking water was available to residents at all times in easily accessible locations in the approved centre.

An evidence-based nutrition assessment tool was used. Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The dietician did not see individual residents and does not accept individual referrals.

Weight charts were implemented, monitored and acted upon for residents, where appropriate. Intake and output charts were maintained for residents' where appropriate.

Residents, their representatives, family and next of kin were educated about the residents' diet.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in March 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had documented up-to-date training in food safety commensurate with their role.

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

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. Appropriate protective equipment was used during the catering process and there was suitable and sufficient catering equipment. The approved centre had proper facilities for the refrigeration, storage and serving of food.

Hygiene was maintained to support food safety requirements. Catering areas and associated catering and food safety equipment were appropriately cleaned. Food was prepared in a manner that reduced risk of contamination, spoilage and infection.

Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

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 April 2014 and had approval extended to December 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: The availability of an emergency supply of clothing for residents was not monitored. A record of residents wearing nightclothes during the day was maintained and monitored. At the time of inspection two residents were in night clothes, as indicated by their individual care plans (ICPs). All other residents were wearing day clothes.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents had an adequate supply of individualised clothing which was clean and appropriate to their needs. Residents changed out of their nightclothes during the daytime hours unless specified otherwise in their ICPs.

Appropriate emergency personal clothing was available to residents. The clothing took into account their preferences, dignity, bodily integrity, and religious and cultural practices.

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 **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to residents' personal property and possessions, which was last reviewed in July 2014 and had approval extended to December 2018. The policy included all of the requirements of the *Judgement Support Framework.*

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

Residents were entitled to bring personal possessions with him/her, the extent of which was agreed at admission. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis. The property checklist was kept separate to the resident's ICP and was available to the resident.

The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained.

Residents were supported to manage their own property, unless this posed a danger to the resident or others.

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

Regulation 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 did not have a written policy in relation to the provision of recreational activities.

Training and Education: There was no policy for staff to read, understand, or articulate.

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate for residents of psychiatry of later life (POLL). There were not sufficient activities for younger people with enduring mental illness. Access to recreational activities was facilitated on weekdays and during the weekend. The recreational activities programme was developed, implemented, and maintained with residents' involvement.

Individual risk assessments were completed for residents, in relation to the selection of appropriate activities, when it was considered appropriate. Residents' decisions on whether or not they wanted to participate in activities were respected and documented. The recreational activities provided by the approved centre were appropriately resourced. Suitable communal areas were provided for the recreational activities, and residents had opportunities to avail of indoor and outdoor exercise and physical activities. Documented records of attendance were retained within both the recreational activities group records or within the residents' clinical file.

Residents were not provided with information about the types and frequency of activities available to them within the approved centre, to meet their individual needs.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Satisfactory**

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 May 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Respecting religious beliefs during the provision of services, care and treatment.
- Respecting a resident's religious beliefs and values within the routines of daily living, including resident choice regarding involvement in religious practice.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes 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 not reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. A mass was held fortnightly in the approved centre and residents had access to multi-faith chaplains. Where deemed appropriate following a risk assessment, residents were facilitated to attend a local church daily if they wished.

Care and services that were provided within the approved centre were respectful of the residents' religious beliefs and values. Specific religious requirements were documented in each resident's clinical file. Residents were facilitated to observe or abstain from religious practices in accordance with his/her wishes.

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

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, which was last reviewed in September 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the required visitor identification methods.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 were publicly displayed and visitors were welcomed throughout the day and evening. There were no visiting restrictions for any of the residents at the time of inspection. A separate visitor's 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.

Appropriate steps were taken to ensure the safety of residents' and visitors during visits. Children visiting the approved centre were accompanied at all times to ensure their safety and this was communicated to all relevant individuals publically. The visiting area was 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 processes, training and education and monitoring pillars.

Regulation 12: Communication

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail and phone. Residents also had access to the ward cordless phone if needed. However, residents did not have access to email and internet. When deemed appropriate, individual risk assessments were completed for residents with regards to their communication and this was documented in their individual care plan.

The clinical director, or the senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe that communication may result in harm to the resident or to others.

Staff supervised the opening of mail, if there was an assessed risk. At the time of inspection, no resident has any risks associated with their external communication.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents were free to communicate by e-mail and internet. 12(4).

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the implementation of resident searches, which was last reviewed in January 2015. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

The approved centre was compliant with this regulation. As there were no searches since the last inspection, the approved centre did not receive a quality rating for this regulation. The approved centre met the processes and training and education criteria under the *Judgement Support Framework.*

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, which was last reviewed in January 2016. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for ensuring that the approved centre is 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. Systems analysis was not undertaken in the event of a sudden or unexpected death in the approved centre. Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs. This was documented in the resident's individual care plans. Religious and cultural practices were respected, insofar as is practicable. The privacy and dignity of residents was protected. This encompassed the provision of a single room within the approved centre during the provision of end of life care. Representatives, family, next of kin, and friends were involved, supported and accommodated during end of life care.

The sudden death of a 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's representatives, family, next of kin, and friends. All deaths of any resident of the approved centre, including a resident

transferred to a general hospital for care and treatment, were notified to the Mental Health Commission within 48 hours.

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

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 June 2015. 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 audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: The ICP was a composite set of documents. Allocated space/sections for goals, treatment, care, and resources required were included. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. Ten care plans were reviewed in total. All ten residents were initially assessed at admission and had initial care plans completed by the admitting clinician to address the immediate needs of the resident.

While all ten care plans reviewed included attendance of MDT members, two residents did not have ICPs developed by the MDT within seven days of admission. In both cases, the ICP was not developed until one-month post admission. There was evidence of family involvement in five care plans. It was not applicable to the other five care plans reviewed. Four ICPs did not have resident input due to each resident having a cognitive impairment. None of the ten care plans was signed by the resident for this same reason.

Two care plans did not identify the resident's assessed needs. In addition, two care plans did not identify appropriate goals and two care plans did not identify appropriate interventions. Five care plans did not identify the resources required to provide the care and treatment identified. Reasons for residents declining or refusing a copy of their ICP were recorded for nine care plans, but were not recorded in one ICP.

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

a) **Two residents did not have an ICP developed within seven days of admission.**
b) **The ICPs of two residents did not identify appropriate goals.**
c) **The ICPs of two residents did not identify appropriate interventions.**

d) **The ICPs of five residents did not identify the resources required to provide the care and treatment identified.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 did not have a written policy in relation to the provision of therapeutic services and programmes.

Training and Education: There was no policy for staff to read, understand, or articulate. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes.

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: Although a range of therapeutic programmes were available to residents, the therapeutic services and programmes provided by the approved centre did not meet the assessed needs of all the residents. The therapeutic programmes provided were appropriate for long stay residents and those in later life; however, they were not appropriate for residents requiring rehabilitation. The approved centre did not arrange for therapeutic services or programmes that were not provided internally to be provided by an approved, qualified health professional in an appropriate location. Therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of all residents.

Adequate and appropriate resources and facilities were not available to provide therapeutic services and programmes for all residents. One resident that required a functional assessment had not received it. Not all members of multi-disciplinary teams were reviewing residents in St. Gabriel's which resulted in their needs not being met.

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 or her individual care plan, 16(1).**
b) **The registered proprietor did not ensure that programmes provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents 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, which was last reviewed in October 2015. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for managing resident medications during transfer from the approved centre.
- The process for emergency transfers.

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 not 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: Full and complete written information for a resident was transferred when he/she moved from the approved centre to another facility. Information was either sent in advance or accompanied the resident upon transfer, to a named individual. Information was issued (with copies retained) as part of transfer documentation. This included a letter of referral (including a list of current medications), the resident transfer form, and required medication for the resident during the transfer process.

A checklist was not completed by the approved centre to ensure comprehensive resident records were transferred to the receiving facility.

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

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in February 2014, and had approval extended to December 2018. The policies and procedures addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The resource requirements for general health services, including equipment needs.
- The incorporation of general health needs into the resident individual care plan.
- The referral process for residents' general health needs.

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 policy.

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

Evidence of Implementation: The approved centre had an anaphylaxis pack and staff had access at all times to an Automated External Defibrillator. 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' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly general health assessments documented BMI, blood pressure, smoking status, nutritional status and medication review. There was no documentation of dental health status and no evidence of routine dental assessment. Residents on antipsychotic medication did not have prolactin levels checked as appropriate, did not have an ECG and one resident required a yearly fasting glucose test.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes as indicated.

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

a) **The registered proprietor did not ensure that residents' general health needs were assessed not less than every six months. In particular, there was no dental health assessment.**
b) **For residents on antipsychotic medication Prolactin levels were not checked as appropriate, there was no ECG, and one resident did not have a fasting glucose test as required. 19 (1b).**

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 January 2014 with approval extended to December 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for identifying residents' preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.
- The process for managing the provision of information to residents' representatives, family, and next of kin, as appropriate.

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

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

Evidence of Implementation: Required information was provided to residents and their representatives at admission, including the approved centre's information booklet which detailed the care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written.

The booklet contained details of the following: housekeeping arrangements, including arrangements for personal property and mealtimes, complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents' rights. Residents were provided with the details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

Regulation 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in January 2014, with approval extended to December 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The method for identifying and ensuring, where possible, the resident's privacy and dignity expectations and preferences.
- The approved centre's process to be applied where resident privacy and dignity is not respected

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

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

Evidence of Implementation: The general demeanour of staff and the way in which staff addressed and communicated with residents was observed to be respectful at all times. Staff were discreet when discussing the residents' conditions or treatment needs. Staff knocked and sought permission before entering residents' rooms. Residents were dressed appropriately to ensure their privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function.

Where residents shared a room, bed screening did not ensure that their privacy was not compromised. One bed curtain was missing and one bed curtain did not fully close to ensure privacy. Some bedrooms were overlooked by public areas and were not appropriately screened. Coverings for the windows were being sourced at the time of inspection. The noticeboard at the nurses' station displayed residents' names and bed location.

The approved centre was non-compliant with this regulation because:

a) **Bed screening did not ensure that residents' privacy was not compromised.**
b) **Some bedrooms were overlooked by public areas with no screening.**
c) **The noticeboard at the nurses' station detailed resident names.**

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in June 2013, with approval extended to December 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The approved centre's cleaning programme.
- The identification of hazards and ligature points in the premises.

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: Appropriately sized communal rooms were provided. In relation to temperature, there was suitable and sufficient heating with a minimum temperature in bedroom areas and day areas. Rooms were ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. Appropriate signage and sensory aids were provided to support resident orientation needs. Hazards were minimised in the approved centre. There was evidence of minimisation of ligature points to the lowest practicable level, and while some ligature points remained, they were low risk.

The approved centre was kept in a good state of repair both internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of

assistive equipment. Records of such were maintained. The approved centre was clean, hygienic, and free from offensive odours. Residents were not able to adjust the heating in their bedrooms; this was controlled by the maintenance department.

There was a sufficient number of toilets and showers for residents in the approved centre. The approved centre did not have a designated laundry room, instead being done on another part of the campus or brought home by relatives. Sheets and towels were laundered by a contracted laundry service. All resident bedrooms were appropriately sized to address the resident needs. One area of the approved centre was remote from the nurses' station and around corners and so there was no observation of this area.

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

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

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 March 2015; approval was extended to March 2019. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The process for crushing medications.
- The process for medication reconciliation.
- The process for reviewing resident medication.

The policy Administration of Medication for a period longer than 3 months. (Involuntary Service User, Section 60 Mental Health Act, 2001) contained a reference to “unwilling” to consent. This is no longer contained in the Mental Health Act.

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

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

Evidence of Implementation: All entries in the MPAR were legible. All entries in the MPAR were written in black, indelible ink. Medication was reviewed and rewritten at six-monthly intervals or more frequently, where there was a significant change in the resident’s care or condition. This was documented in the clinical file. Where an alteration was made in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs were administered by a registered nurse or registered medical practitioner.

Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident’s pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration. Expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications.

Schedule 2 controlled drugs were checked by two staff members against the delivery form and details entered on the controlled drug book. Controlled drug balance corresponded with the balance recorded in the controlled drug book. Following administration, the details were entered in the controlled drug book and signed by both staff members. Crushed medication was written at the top of the MPAR but this was not signed by the medical practitioner. There was no evidence in the MPAR as to why the medication was crushed.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. 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. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication trolley and medication administration cupboard remained locked at all times and secured in a locked room.

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

a) **There was no signed order by a medical practitioner to crush medication.**
b) **The policy did not contain the procedure for crushing medications.**
c) **Administration of Medication for a period longer than 3 months. (Involuntary Service User, Section 60 Mental Health Act, 2001) policy contained a reference to "unwilling" to consent.**

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to the health and safety of residents, staff, and visitors. The policy was last reviewed in March 2016. It also had an annual safety statement. The policy and safety statement addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Raising awareness of residents and their visitors to infection control measures.
- Response to sharps or needle stick injuries.
- Specific infection control measures in relation to infection, e.g. C. diff, MRSA, Norovirus.
- The monitoring and continuous improvement requirements implemented for the health and safety processes.

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

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

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

The approved centre was compliant with this regulation.

Regulation 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 April 2016.

The policy and procedures did not address the following:

- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The roles and responsibilities in relation to staff training processes.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

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

Evidence of Implementation: There was an organisational chart in place, which showed the leadership and management structure and the lines of authority and accountability of the approved centre's staff. Staff were recruited and selected in accordance with the approved centre's policy and procedures for recruitment, selection, and appointment. Staff had the appropriate qualifications, skills, knowledge, and experience to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.

The numbers and skill mix of staff was not sufficient to meet resident needs. There was no psychologist. Some residents did not meet any of their MDT in the approved centre as they were residents transferred from another approved centre and members of their MDT did not attend St Gabriel's. They could attend an MDT meeting in the other centre if there was sufficient staff to accompany them but in practice, this had not happened. There was no written staffing plan for the approved centre.

Not all health care staff were trained in the following:

- Fire safety
- Basic Life Support
- Management of violence and aggression
- The Mental Health Act 2001.

Staff were trained in Children First. All staff training was documented. Relevant staff in the approved centre had access to The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and the Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
	CNM2	1	
	RPN	3	2
	HCA	2	1
	Occupational Therapist	As required on individual basis	
	Social Worker		
	Psychologist	As required on an individual basis	
		0	

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

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

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, 26(4).
b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).
c) The skill mix was not appropriate to the assessed needs of the residents, 26(2)

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 June 2017. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: All residents' records were up to date, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. Resident records were reflective of the residents' status at the time of inspection and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence. In four files, there were loose pages which contained resident identifiers and clinical information and this information was not secure within the file. Resident records were maintained appropriately, meeting the requisite requirements.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorized access or use. Documentation of food safety, health and safety, and fire inspections is maintained in the approved centre.

The approved centre was non-compliant with this regulation because in four files there were loose pages which contained identifiers and clinical information.

Regulation 28: Register of Residents

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating LOW

(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

A documented register of all residents admitted to the approved centre was available. The register contained all of the required information specified in Schedule 1 of the Mental Health Act 2001 (Approved Centres) regulations 2006. It included full name, address, gender, date of birth, country of birth, next of kin/representative(s), admission date, diagnosis on admission, diagnosis on discharge and resident status i.e. voluntary or involuntary. The register of residents was made available to the Mental Health Commission, when requested.

The register did not include the discharge dates for two residents. In one case, the register detailed that a resident was discharged in error. The resident was on leave and not discharged.

The approved centre was non-compliant with section 1 of this regulation because the register of residents did not include all of the information specified in Schedule 1, specifically, it did not contain the correct date of discharge for two residents

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 June 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

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

All operating policies and procedures required by the regulations were reviewed within the required three-year time frame. The operating policies and procedures were appropriately approved and incorporated relevant legislation, evidence-based best practice and clinical guidelines. Generic policies were not used.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education 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, which was last reviewed in April 2014 and approval was extended to December 2018.

The policy did not address the following:

- The confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.
- The time frames for complaint management, including the time frame for the approved centre to respond to the complaint and for the complaint to be resolved.
- The documentation of complaints, including the maintenance of a complaints log by the nominated person.
- The process for escalating complaints that cannot be addressed by the nominated person.
- The appeal process available where the complainant is dissatisfied with the outcome of the complaint investigation.

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: No complaints had been escalated to the complaints officer since the last inspection. Therefore, the monitoring pillar of this regulation was not applicable.

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 had been

implemented for the management of all complaints. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. Residents and their representatives were facilitated to make complaints by various means including verbal, written, electronically and telephone. However, there were no complaint forms or suggestion forms available to residents. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives.

All complaints were investigated promptly, whether oral or written, and were handled appropriately and sensitively. There was no evidence to suggest that the quality of the service, care and treatment of a resident was adversely affected by reason of the minor complaint being made.

Minor complaints were dealt with at local level and were documented in a complaints/compliments folder.

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

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Quality Rating Requires Improvement

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 June 2016. This included a safety statement.

The policy did not address the following:

- The person responsible for the completion of six-monthly incident summary reports.
- The process for identification, assessment, treatment, reporting, and monitoring of organisational risks throughout the approved centre.
- Structural risks, including ligature points.
- Capacity risks relating to the number of residents in the approved centre.
- Risks to the resident group during the provision of general care and services.
- Risks to individual residents during the delivery of individualised care.
- The roles and responsibilities regarding the incident reporting process.
- The process for risk-rating incidents.
- The process for responding to specific emergencies, including, the sequence of required actions, the process for communication and the escalation of emergencies to management.

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 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: All staff were responsible for risk and there was a risk advisor. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks and health and safety risks were identified, assessed, treated, reported, monitored, and were documented in the risk register.

There was no risk register in St Gabriel's, however, risks that could not be managed in the approved centre were escalated to the area management risk register. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre. Corporate risks were documented in the risk register. The approved centre implemented a plan to reduce risks to residents while any works on the premises were ongoing.

Individual risk assessments were completed prior and during physical restraint, at admission to identify individual risk factors, resident transfer, resident discharge, and in conjunction with medication requirements or administration. 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. 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 approved centre staff to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because the approved centre did not have a comprehensive risk management policy. 32 (1)

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.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

NON-COMPLIANT

Risk Rating **CRITICAL**

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

The clinical files of two residents that were restrained by mechanical restraint were inspected. Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on his/her behalf. The clinical file contained a contemporaneous record that specified the type of mechanical restraint, the duration of the order, and the review date.

In one episode of mechanical restraint there was no identified clinical need documented. In two episodes of mechanical restraint there was no record specifying that less restrictive alternatives were unsuitable. Clinical files of the two residents did not record that less restrictive alternatives were implemented without success, the situation in which mechanical restraint was being applied, or the duration of the restraint.

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

a) **In one episode of mechanical restraint for enduring risk of harm to self or others there was no identified clinical need documented, 21.1.**
b) **In two episodes of mechanical restraint there was no record specifying that less restrictive alternatives were unsuitable, 21.2.**
c) **Clinical files of the two residents did not record that less restrictive alternatives were implemented without success, 21.5 (b), the situation in which mechanical restraint was being applied, 21.5 (d), or the duration of the restraint, 21.5 (e).**

10.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 Section 52(d) was not applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

11.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually, and it was last reviewed in June 2017. The policy addressed all of the policy related criteria of this code of practice including:

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

Training and Education: There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

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

Evidence of Implementation: Three episodes of physical restraint which had taken place since the last inspection were inspected. Physical restraint was used in rare, exceptional circumstances and in the best interests of the resident, where the resident posed an immediate threat of serious harm to self or others. Physical restraint was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered. The use of Physical restraint was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of Physical restraint and when using it.

Physical restraint was initiated by a registered medical practitioner (RMP)/registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of a resident. The consultant psychiatrist or the duty consultant psychiatrist was notified as soon as was practicable, and this was recorded in the clinical file. RMP completed a medical examination of the resident (physical examination) no later than three hours after the start of an episode of physical restraint. The order for physical restraint lasted for a maximum of 30 minutes, and was recorded in the clinical file.

The clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode. The CPF was signed by the CP within 24 hours. Staff were aware of relevant considerations in the individual care plan pertaining to the resident's requirements/needs in relation to the use of physical restraint (This may include advance directives). The completed CPF was placed in the resident's clinical file. Each episode of Physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode (excluding Saturday, Sunday, and Bank Holidays).

In three episodes of physical restraint the resident was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint. Reasons for not informing the residents

were not documented in the three individual clinical files. In all three cases, the residents' next of kin or representative was not informed of the use of physical restraint, and the explanation for not informing them was not documented in the three clinical files**.**

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

a) **There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy. 9.2 (b).**
b) **In three episodes of physical restraint the resident was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of Physical restraint. 5.8.**
c) **Reasons for not informing the residents were not documented in the three individual clinical files. 5.9.**

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 separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in June 2015, the transfer policy was last reviewed in October 2015, and the discharge policy was last reviewed in July 2015. The policies addressed all of the policy-related criteria of this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. There was a key worker system in place and the resident was admitted on the basis of a mental health illness or mental disorder. The resident's family member/carer/advocate was involved in the admission process. An admission assessment was completed, but it was inadequate. 15.1. Relevant sections of the assessment were left blank or not addressed sufficiently. The admission assessment did not include family history, social and housing circumstances, and any other relevant information (e.g. work situation, education, dietary requirements). 15.3.

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

Discharge: The clinical file of one resident who had been discharged was inspected against in relation to the discharge process. The discharge was co-ordinated by a key-worker. A discharge plan was in place as part of the individual care plan (ICP). All aspects of the discharge process were recorded in the clinical file. A discharge meeting was held and attended by the resident and their key worker, relevant members of the MDT, and the resident's family, on the day before the resident was discharged. A comprehensive pre-discharge assessment was completed; which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, and a comprehensive risk assessment and risk management plan. There was appropriate multi-disciplinary team (MDT) input into discharge planning. A preliminary discharge summary was sent to the general practitioner/primary care/CMHT within three days. Efforts were made to inform the general practitioners/primary care/of discharge within 24 hours.

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

a) **Audits had been completed on the implementation of and adherence to the admission, policy but not the transfer, and discharge policies. 4.19.**

b) **An admission assessment was completed, but it was inadequate. 15.1.**
c) **The admission assessment did not include family history, social and housing circumstances, and any other relevant information (e.g. work situation, education, dietary requirements). 15.3.**

Appendix 1: Corrective and Preventative Action Plan Template – St Gabriel's 2018 Inspection Report

Regulation 12: Communication

Report reference: Page 28

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents were free to communicate by e-mail and internet. 12(4)	*New*	Corrective Action(s): A) Wifi facilities will be made available to service users in order to be able to communicate via email and internet. Post-Holder(s) responsible: Assistant Hospital Manager	Walk through review	Achievable + realistic	January 2019
		Preventative Action(s): A) Wifi facilities will be made available to service users in order to be able to communicate via email and internet. Post-Holder(s) responsible: Assistant Hospital Manager	Walk through review	Achievable + realistic	January 2019

Regulation 15: Individual Care Plan

Report reference: Page 32 & 33

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
2. Two residents did not have an ICP developed within seven days of admission.	*New*	Corrective Action(s): An ICP has been developed for these two residents. Post-Holder(s) responsible: Sector MDT	Quarterly ICP audit	Achievable + realistic	Completed
		Preventative Action(s): An ICP will be developed within seven days of admission for all residents Post-Holder(s) responsible: Sector MDT	Quarterly ICP audit	Achievable + realistic	Completed
3. The ICPs of two residents did not identify appropriate goals.	*New*	Corrective Action(s): Appropriate goals have been developed for the two residents. Post-Holder(s) responsible: Sector MDT	Quarterly ICP audit	Achievable + realistic	Complete
		Preventative Action(s): Appropriate goals will form part of all ICP's Post-Holder(s) responsible: Sector MDT	Quarterly ICP audit	Achievable + realistic	Complete
4. The ICPs of two residents did not identify appropriate interventions.	*New*	Corrective Action(s): Appropriate Interventions have been developed for the two residents Post-Holder(s) responsible:	Quarterly ICP audit	Achievable + realistic	Complete

		Sector MDT			
		Preventative Action(s): Appropriate interventions will form part of all ICP's Post-Holder(s) responsible: Sector MDT	Quarterly ICP audit	Achievable + realistic	Complete
5. The ICPs of five residents did not identify the resources required to provide the care and treatment identified.	*Reoccurring*	Corrective Action(s): ICP's are reviewed to ensure resources necessary to meet residents needs are specified. Post-Holder(s) responsible: All members of the MDT's	Quarterly ICP audit	Achievable + realistic	Complete
		Preventative Action(s): The necessary resources to meet residents identified needs will be specified in all ICP's Post-Holder(s) responsible: All members of the MDT's	Quarterly ICP audit	Achievable + realistic	Complete

Regulation 16: Therapeutic Services and Programmes

Report reference: Page 34

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
6. Each resident did not have access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16(1).	*New*	Corrective Action(s): Approval has been granted to engage an Agency Occupation Therapist to provide therapeutic services for the residents of St Gabriel's Post-Holder(s) responsible: OT Manager	Form C agency cover	Achievable + realistic	October 2018
		Preventative Action(s): A business case will be submitted for the recruitment of a Occupational Therapist. In the interim Sector OT's will see residents on a named basis. Post-Holder(s) responsible: OT Manager	Business case	Achievable + realistic	October 2018
7. Programmes provided were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents 16(2).	*New*	Corrective Action(s): A business case will be submitted for the recruitment of a Occupational Therapist. In the interim Sector OT's will see residents on a named basis. Post-Holder(s) responsible: OT Manager	Business case	Achievable + realistic	October 2018
		Preventative Action(s): A business case will be submitted for the recruitment of a Occupational Therapist. In the interim Sector OT's will see residents on a named basis.	Business case	Achievable + realistic	October 2018

		Post-Holder(s) responsible: OT Manager			

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Regulation 19: General Health

Report reference: Page 36

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
8. The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents' general health needs were assessed not less than every six months. In particular, there was no dental health assessment.	*New*	Corrective Action(s): A. All residents have had their General health needs assessed not less than every six months. B. Residents will be offered dental health assessments. Post-Holder(s) responsible: Medical team	Copy of the residents six monthly assessment will be held in the residents HCR. Record of Dental health assessment being offered will be recorded in the residents HCR	Achievable + realistic	Six monthly
		Preventative Action(s): A. The registered proprietor will ensure that residents' general health needs are assessed not less than every six months. B. Service users will be offered dental health assessments Post-Holder(s) responsible: Medical Staff	Analysis will be completed to identify opportunities to improve general health processes.	Achievable + realistic	November 2018
9. For residents on antipsychotic medication, prolactin levels were not checked as appropriate,	*New*	Corrective Action(s): A. Residents on antipsychotic medication, will have their prolactin levels checked.	Health Care Record	Achievable + realistic	October 2018

there was no ECG, and one resident did not have a fasting glucose test as required. 19 (1b).		B. Residents on antipsychotic medication, will have an ECG as appropriate. C. Residents on antipsychotic medication, will have their fasting blood glucose levels checked. Post-Holder(s) responsible: Medical Staff			
		Preventative Action(s): A. Residents on antipsychotic medication, will have their prolactin levels checked. B. Residents on antipsychotic medication, will have an ECG as appropriate. C. Residents on antipsychotic medication, will have their fasting blood glucose levels checked. Post-Holder(s) responsible: Medical Staff	Health Care Record	Achievable + realistic	October 2018

Regulation 21: Privacy

Report reference: Page 39

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
10. Bed screening did not ensure that residents' privacy was not compromised.	*Reoccurring*	Corrective Action(s): Bed screening is in place to ensure that residents' privacy is not compromised Post-Holder(s) responsible: CNM2 / Technical services	A daily check	Achievable + realistic	Completed
		Preventative Action(s): Technical services are informed where bed screening does not meet the requirement to meet the residents privacy. Post-Holder(s) responsible: CNM2/ Technical Services	A daily check	Achievable + realistic	Completed
11. Some bedrooms were overlooked by public areas with no screening.	*Reoccurring*	Corrective Action(s): Appropriate Screening is being sourced to provide privacy to overlooked bedrooms Post-Holder(s) responsible: Technical services	Walk through review	Achievable + realistic	October 2018
		Preventative Action(s): Appropriate Screening is being sourced to provide privacy to overlooked bedrooms Post-Holder(s) responsible: Technical services	Walk through review	Achievable + realistic	October 2018

12. The noticeboard at the nurses' station detailed resident names.	*New*	Corrective Action(s): The noticeboard at the nurses' station no longer details resident names. Post-Holder(s) responsible: CNM2	Walk through review	Achievable + realistic	Complete
		Preventative Action(s): Resident initials will only be used on the notice board at the nurses station. Post-Holder(s) responsible: CNM2	Walk through review	Achievable + realistic	Complete

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

Report reference: Page 45 & 46

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
13. There was no signed order by a medical practitioner to crush medication.	*New*	Corrective Action(s): Where crushed medication is indicated for a resident, this will be documented by the prescribing doctor. Post-Holder(s) responsible: Prescribing Doctor	Quarterly medication audits.	Achievable + realistic	September 2018
		Preventative Action(s): Where crushed medication is indicated for a resident this will be documented by the prescribing doctor. Post-Holder(s) responsible: Prescribing Doctor	Quarterly medication audits.	Achievable + realistic	September 2018
14. The policy did not contain the procedure for crushing medications.	*Reoccurring*	Corrective Action(s): The policy has been reviewed to contain the procedure for crushing medications. Post-Holder(s) responsible: SECH Policy Group	Policy document	Achievable + realistic	Complete May 2018
		Preventative Action(s): The policy has been reviewed to contain the procedure for crushing medications.	Policy document	Achievable + realistic	Complete May 2018

		Post-Holder(s) responsible: SECH Policy Group			
15. The *'Administration of Medication for a period longer than 3 months. (Involuntary Service User, Section 60 Mental Health Act, 2001)'* policy contained a reference to "unwilling" to consent.	*New*	Corrective Action(s): The policy has been referred to the SECH Policy Group for review and amendment as appropriate Post-Holder(s) responsible: SECH Policy Group	Policy document	Achievable and Realistic	December 2018
		Preventative Action(s): The policy has been referred to the SECH Policy Group for review and amendment as appropriate Post-Holder(s) responsible: SECH Policy Group	Policy Document	Achievable and Realistic	December 2018

Regulation 26: Staffing

Report reference: Page 45 & 46

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
16. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, 26(4). 17. Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).	*Reoccurring*	Corrective Action(s): Staff of the approved centre are prioritised for the Autumn 2018 and Spring 2019 mandatory training sessions Post-Holder(s) responsible: Individual staff members /Heads of discipline	Audit of staff records	Achievable + realistic	March 2019
		Preventative Action(s): Staff of the approved centre are prioritised for the Autumn 2018 and Spring 2019 mandatory training sessions Post-Holder(s) responsible: Heads of discipline	Audit of staff records	Achievable + realistic	March 2019
18. The skill mix was not appropriate to the assessed needs of the residents, 26(2).	*Reoccurring*	Corrective Action(s): A Business case has been submitted for the recruitment of a psychologist.	Business Case	Achievable + realistic	December 2018

		Post-Holder(s) responsible: Service Manager			
		Preventative Action(s): A Business case has been submitted for the recruitment of a psychologist. Post-Holder(s) responsible: Service Manager	Business Case	Achievable + realistic	December 2018

Regulation 27: Maintenance of Records

Report reference: Page 47 & 48

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
19. Four files there were loose pages which contained identifiers and clinical information.	*Reoccurring*	Corrective Action(s) A) All staff will file their documentation in accordance with best practice in record keeping guidelines. B) A business case will be submitted for ward clerk Post-Holder(s) responsible: All staff who make entries in the residents HCR	File review	Achievable + realistic	September 2018
		Preventative Action(s): A) All staff will file their documentation in accordance with best practice in record keeping guidelines. B) A business case will be submitted for ward clerk Post-Holder(s) responsible: All staff who make entries in the residents HCR	File review	Achievable + realistic	September 2018

Regulation 28: Register of Residents

Report reference: Page 49

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
20. The register of residents did not include all the information specified in Schedule 1, specifically, it did not contain the correct date of discharge for two residents.		Corrective Action(s): The register of residents includes all the information requirements as specified in Schedule 1. Post-Holder(s) responsible: Team Nurse	Review of the register of residents.	Achievable + realistic	Complete
	Reoccurring	Preventative Action(s): The register of residents will include all the information requirements as specified in Schedule 1. Post-Holder(s) responsible: Team Nurse	Review of the register of residents.	Achievable + realistic	Complete

Regulation 32: Risk Management Procedures

Report reference: Page 53 & 54

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
21. The approved centre did not have a comprehensive risk management policy. 32 (1).	*New*	Corrective Action(s): The Policy was referred to the SECH policy group for review and amendment Post-Holder(s) responsible: SECH Policy Group	Risk Management Policy Revision number 01 Revised May 18 Review May 21	Yes See Risk Management Policy Revision number 01 Revised May 18 Review May 21	Complete
		Preventative Action(s): The Policy was referred to the SECH policy group for review and amendment Post-Holder(s) responsible: SECH Policy Group	Risk Management Policy Revision number 01 Revised May 18 Review May 21	Yes See Risk Management Policy Revision number 01 Revised May 18 Review May 21	Complete

Rules: The Use of Mechanical Restraint

Report reference: Page 58

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
22. In one episode of mechanical restraint for enduring risk of harm to self or others there was no identified clinical need documented, 21.1.	*New*	Corrective Action(s): The identified clinical need will be recorded in all episodes of mechanical restraint for enduring risk of harm to self or others Post-Holder(s) responsible: Consultant Psychiatrist	Yes Amended Mechanical Restraint Prescription form.	Achievable + realistic	Complete
		Preventative Action(s): The identified clinical need will be recorded in all episodes of mechanical restraint for enduring risk of harm to self or others Post-Holder(s) responsible: Consultant Psychiatrist	Use of the amended Mechanical Restraint Prescription form	Achievable + realistic	Complete
23. In two episodes of mechanical restraint there was no record specifying that less restrictive alternatives were unsuitable, 21.2.	*Reoccurring*	Corrective Action(s): A record specifying that less restrictive alternatives were unsuitable will be maintained. Post-Holder(s) responsible: Consultant Psychiatrist	Amended Mechanical Restraint Prescription form	Achievable + realistic	Complete
		Preventative Action(s): A record specifying that less restrictive alternatives were unsuitable will be maintained	Use of amended Mechanical Restraint Prescription form	Achievable + realistic	Complete

		Post-Holder(s) responsible: Consultant Psychiatrist			
24. Clinical files of the two residents did not record that less restrictive alternatives were implemented without success, 21.5 (b), the situation in which mechanical restraint was being applied, 21.5 (d), or the duration of the restraint, 21.5 (e).	*Reoccurring*	Corrective Action(s): Clinical files will include the following; 21.5 (b), the situation in which mechanical restraint was being applied, 21.5 (d), or the duration of the restraint, 21.5 (e). Post-Holder(s) responsible: Consultant psychiatrist	Yes Amended Mechanical Restraint Prescription form	Achievable + realistic	Complete
		Preventative Action(s): Clinical files will include the following; 21.5 (b), the situation in which mechanical restraint was being applied, 21.5 (d), or the duration of the restraint, Post-Holder(s) responsible: Consultant psychiatrist	Use of amended Mechanical Restraint Prescription form	Achievable + realistic	Complete

Codes of Practice: Use of Physical Restraint

Report reference: Page 61 & 62

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
25. There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy. 9.2 (b).	*Reoccurring*	Corrective Action(s): Staff involved in the use of physical restraint will be reminded to sign the policy log that they have read and understood the policy. Post-Holder(s) responsible: Individual staff/ heads of discipline	Review of signature log	Achievable + realistic	October 2018
		Preventative Action(s): Staff involved in the use of physical restraint will be reminded to sign the policy log that they have read and understood the policy Post-Holder(s) responsible: Individual staff/ heads of discipline	Review of signature log	Achievable + realistic	October 2018
26. In three episodes of physical restraint the resident was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of Physical restraint. 5.8. Reasons for not informing the residents were not documented in the three individual clinical files. 5.9.	*New*	Corrective Action(s): In episodes of physical restraint residents will be informed of reasons for, likely duration of, and circumstances leading to discontinuation of Physical restraint Post-Holder(s) responsible: Clinical staff	Audit of physical restraint policy	Achievable + realistic	Complete
		Preventative Action(s): In episodes of physical restraint Residents will be informed of reasons for, likely	Audit of physical restraint policy.	Achievable + realistic	Complete

		duration of, and circumstances leading to discontinuation of Physical restraint Post-Holder(s) responsible: Clinical Staff			

Codes of Practice: Admission, Transfer and Discharge

Report reference: Page 63 & 64

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
27. Audits had not been completed on the implementation of and adherence to the admission, policy but not the transfer, and discharge policies. 4.19.	*Reoccurring*	Corrective Action(s): An Annual Audit on the implementation of and adherence to the admission, transfer, and discharge policies will be undertaken Post-Holder(s) responsible: CNM3	Annual Audit	Achievable + realistic	1st Quarter 2019
		Preventative Action(s): An Annual Audit on the implementation of and adherence to the admission, transfer, and discharge policies will be undertaken Post-Holder(s) responsible: CNM3	Annual Audit	Achievable + realistic	1st Quarter 2019
28. An admission assessment was completed, but it was inadequate. 15.1. 29. The admission assessment did not include family history, social and housing circumstances, and any other relevant information (e.g. work situation, education, dietary requirements). 15.3.	*Reoccurring*	Corrective Action(s): ACIR assessments will be completed in full. Post-Holder(s) responsible: Clinical staff	Annual Audit	Achievable + realistic	Completed
		Preventative Action(s): ACIR assessments will be completed in full. Post-Holder(s) responsible: Clinical staff	Annual Audit	Achievable + realistic	Completed