Department of Psychiatry, Connolly Hospital

ID Number: AC0020

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry
Connolly Hospital
Blanchardstown
Dublin 15

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
7 December 2015

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Angela Walsh, Head of Mental Health Services, CHO 9.

Inspection Team:
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Inspection Date:
26 – 29 September 2017

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
18 – 21 October 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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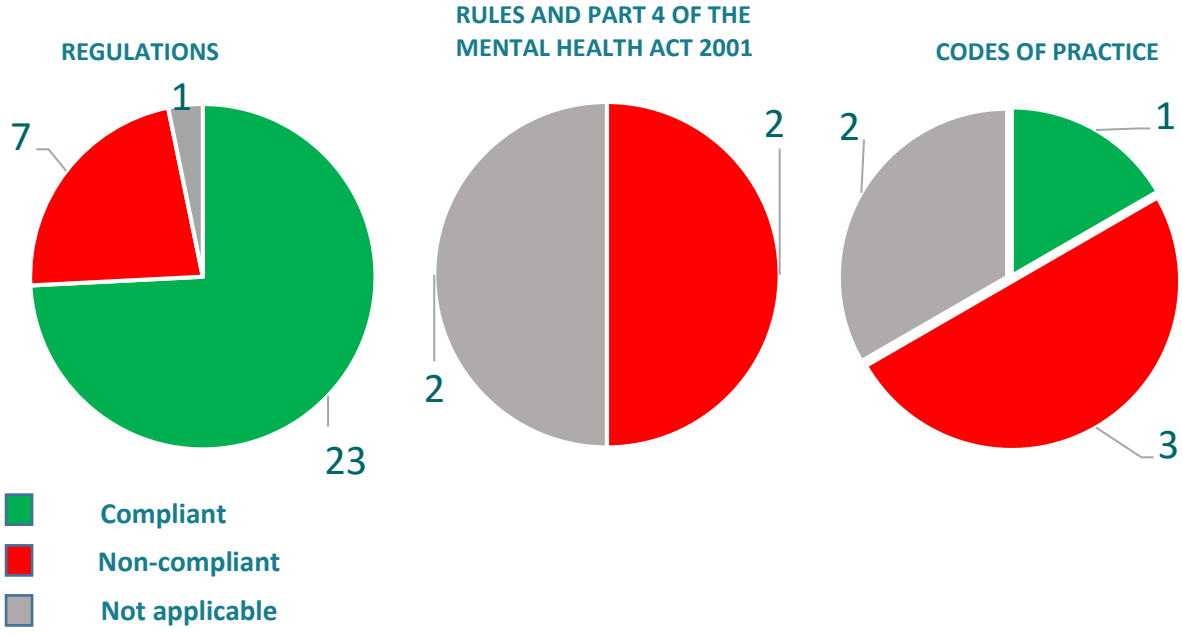
15 March 2018

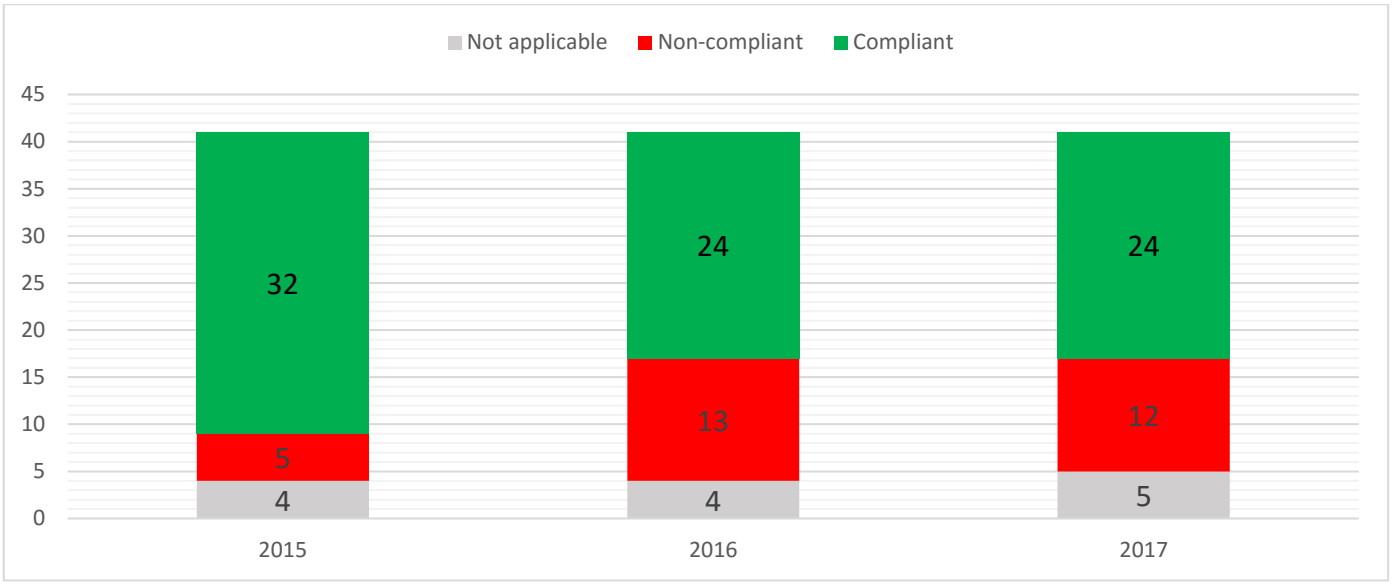
COMPLIANCE RATINGS 2017



RATINGS SUMMARY 2015 – 2017

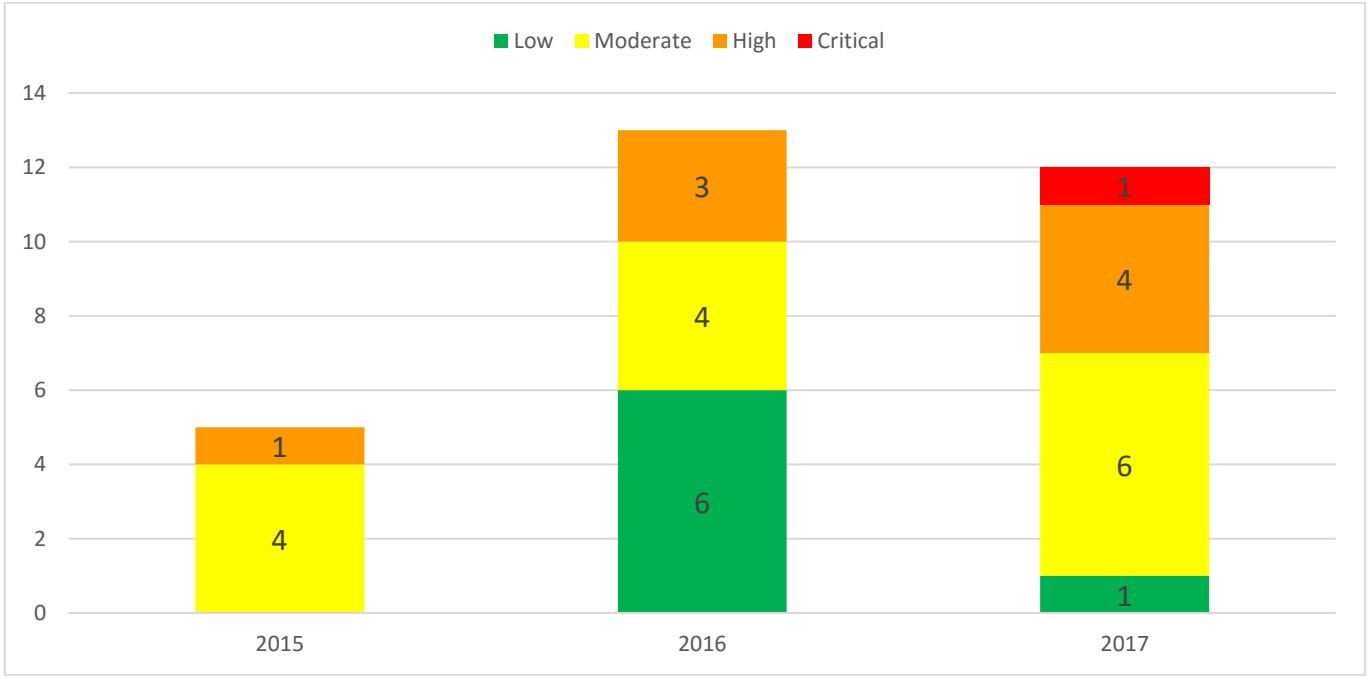
Compliance ratings across all 41 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2015 – 2017



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 2015 – 2017



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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.

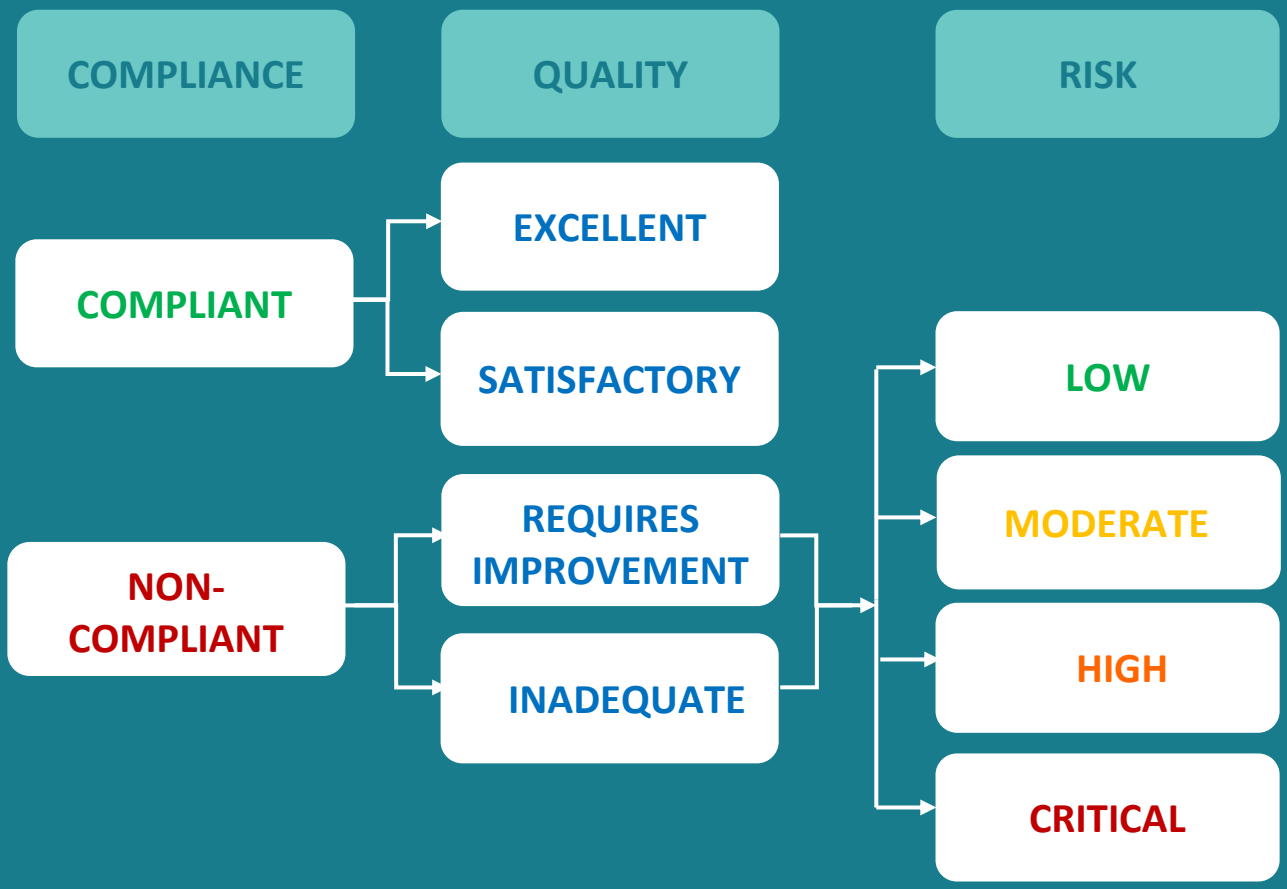
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. 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 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, realistic, achievable 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.

Safety in the approved centre

The approved centre had two policies in relation to health and safety and a series of written policies in relation to risk management. At the time of inspection, structural risks, including ligature points, were in the process of being removed, following a ligature audit. Risk assessments were completed for all residents at admission to identify individual risk factors.

At least two person-specific resident identifiers were used before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. Food safety audits were completed periodically and catering areas and associated equipment were appropriately cleaned.

There were significant deficits in the prescription of medications which could potentially lead to medication errors. This is the third consecutive year that the approved centre has been non-compliant with Regulation 23 Ordering, Prescribing, Storage and Administration of Medicines.

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staff were sufficient to address resident needs and the size and layout of the approved centre. Training records indicated that not all health care professionals had up-to-date, mandatory training in fire safety, Basic Life Support management of violence and aggression, and the Mental Health Act 2001.

AREAS REFERRED TO
Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.

Appropriate care and treatment of residents

Individual care plans were of poor standard and not compliant with Regulation 15. The range of available therapeutic services and programmes was appropriate, evidence-based, and met the assessed needs of the residents. Adequate and appropriate resources and facilities were available for therapeutic services and programmes.

A registered medical practitioner assessed residents at admission and on an ongoing basis and residents' general health needs were assessed at least every six months. Residents identified as having special nutritional requirements were not routinely reviewed by the dietitian.

Residents' records were secure, up to date, and constructed, maintained, and used in accordance with legislative requirements. Resident records were not always developed and maintained in a logical sequence and in good order and some records contained loose pages. The clinical files also indicated that records were not always maintained appropriately. One file inspected contained unsigned notes, which included inappropriate phrases among the entries.

There were 10 non-compliances with the Rules Governing the Use of Seclusion which is of concern.

The approved centre was non-compliant with Part 4 of the Mental Health Act: Consent to treatment for the third consecutive year. The inspectors found that there was no documentary evidence that the treating consultant psychiatrist had assessed one patient's capacity to understand the nature, purpose, and likely effects of the proposed treatment, there was no evidence that the patients were informed of the risks and benefits of the medications prescribed, and supports provided to the patient in relation to the discussion of the effects of medication and their decision-making were not documented in one case. This non-compliance with primary legislation was risk rated as critical.

The approved centre was compliant with the code of practice on physical restraint.

Four children were admitted to the approved centre since the previous inspection in 2016. Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre and child residents did not have access to age-appropriate advocacy services.

AREAS REFERRED TO
Regulations 5, 14, 15, 16, 17, 18, 19, 23, 25, 27, Part 4 of the Mental Health Act 2001, Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Rule Governing the Use of ECT, Code of Practice on Physical Restraint, Code of Practice on the Admission of Children, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, Code of Practice on Admission, Transfer and Discharge, service user experience, and interviews with staff.

Respect for residents' privacy and dignity

Residents were supported to keep and wear their personal clothing. All residents had an adequate supply of individualised clothing and wardrobes in which to store it. Secure facilities were provided on each ward for the safe-keeping of residents' money and personal effects.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors, and these had an override facility. Where residents shared a room, appropriate bed screening was in place to ensure that privacy was not compromised.

Residents' consent had been sought and documented when searches were carried out. A minimum of two clinical staff were in attendance at all times when the search was being conducted. The resident was informed by those implementing the search of what was happening and why, and the search was undertaken with due regard to the resident's dignity and privacy.

Non-recording CCTV was used in a manner that respected residents' privacy and dignity and was clearly signed.

AREAS REFERRED TO
Regulations 7, 8, 13, 14, 21, 25, Rule Governing the Use of Seclusion, Code of Practice on Physical Restraint, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Responsiveness to residents' needs

Residents were provided with a wide variety of wholesome and nutritious food choices within the approved centre's menus. Food, including modified consistency diets, was presented in an appealing manner. The approved centre provided a range of recreational activities appropriate to the resident group profile and activities were provided during the week and at weekends. Residents were facilitated in the practice of their religion and had access to multi-faith chaplains through the hospital chaplain.

There were designated visitors' areas, including a family room, seating pods on the main corridor, and visiting rooms on Ash and Pine Wards. Appropriate arrangements were made for residents in the high dependency unit, (HDU). Visits could take place in private. Residents had access to external communications, including personal mobile phones, mail, e-mail, and fax. Required information was provided to residents and/or their representatives at admission, in an information booklet and residents received written and verbal information about their diagnosis and indications for the use of medications, including any possible side-effects.

The approved centre was in a good state of repair, externally and internally. There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment. A cleaning schedule was implemented in the approved centre, which was clean, hygienic, and free from offensive odours.

AREAS REFERRED TO
Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.

Governance of the approved centre

The Department of Psychiatry (DOP) at Connolly Hospital, Blanchardstown, Dublin 15, was one of three approved centres for Dublin North City Mental Health Services. The approved centre was part of the HSE Community Healthcare Organisation (CHO) 9. The approved centre had a clear organisational chart to identify the leadership and management structure and the lines of authority and accountability. There were seven consultant-led teams admitting to the approved centre.

There was an incident review committee run by both of the clinical nurse managers (CNM)3 on the unit every two weeks. Incidents could be escalated up to the quality and safety meeting and then further escalated if necessary to the mental health management team meeting. The mental health management team and the quality and safety committee met monthly with an ongoing agenda of quality improvement. There was service user representation on the senior management team.

Each clinical discipline had its own governance structure with clear line management. Ash ward had input from an in-house psychologist; however, Pine ward did not have access to this service. As the psychology

department had a waiting list that exceeded three months, its in-reach service was limited at the time of the inspection. Not all heads of disciplines had training in risk management.

Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. All of the operating policies and procedures required by the regulations had been reviewed within three years.

AREAS REFERRED TO
Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Commencement of bathroom upgrades.
2. “Hello My Name Is” initiative for all staff.
3. Training in phlebotomy for staff.
4. Updated patient information leaflet.
5. Pet therapy introduced.
6. New Acute Jobs Clinic, which was a group which assists residents to source employment.
7. A new tobacco-free assessment included in the resident individual care plans.
8. A new shared computerised folder for multi-disciplinary staff to access policies and information, applicable to the approved centre.
9. Staff induction booklet was updated.
10. A new in-patient referral form was introduced.
11. A new suggestion box for recreational and therapeutic groups had been introduced.
12. A new information poster displaying Social Work services available had been introduced.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Department of Psychiatry (DOP) at Connolly Hospital, Blanchardstown, Dublin 15, was one of three approved centres for Dublin North City Mental Health Services. The approved centre was part of the HSE Community Healthcare Organisation (CHO) 9. Access to the DOP in Connolly Hospital was on the ground floor via swipe card and was clearly signposted. The reception area and corridor were large, spacious, and bright with seating pods on the corridor, which added colour to this area. The family visiting room, administration and nurse management offices, as well as the tribunal room were also along this corridor. There were two doors, one led to Ash Ward, which covered the catchment area of East and West Blanchardstown, and the other led to Pine Ward, which covered the catchment area of Cabra and Finglas. The High Dependency Unit (HDU) was based at the far end of Ash Ward, with secure access. The HDU had no private rooms for visits or where staff could talk to residents and their families in private. Suitable rooms could be provided but only outside of the HDU.

There were 21 beds in Pine ward and 5 beds in the HDU. Usually, there were 21 beds in Ash ward, but at the time of the inspection there were 17, as beds had been removed in order to complete the upgrading of bathrooms. The HDU admitted from all sectors and also from other catchment areas if admissions came through the emergency department. There were no children in the approved centre at the time of the inspection; however, children had been admitted to the approved centre since the last inspection.

At the time of the inspection two patients had been detained in the approved centre for more than three months and three residents had been in the approved centre more than six months. Both units had separate night nurses' stations. Since the last inspection, these units had introduced the "Hello My Name Is" initiative. In all three units there was clear signage in relation to availing of religious needs, interpretation services, and the availability of emergency clothing, as well as signs displaying phone numbers for the crash team, security, and fire services. There was an information display unit outside the clinical rooms where residents attended to receive their medication in private. Leaflets here provided information on mental health diagnosis and medications. Community meetings took place on the units every Sunday with a focus on improving the quality of the service provided. There was a bus service which served this hospital and a train service at the nearby Castleknock train station. At the front of the hospital, there was a shop/newsagents and there was a restaurant/coffee shop further down the corridor.

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**38**
Number of detained patients	6
Number of Wards of Court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	5

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

The Department of Psychiatry (DOP) at Connolly Hospital, Blanchardstown, Dublin 15, was one of three approved centres for Dublin North City Mental Health Services. The approved centre was part of the HSE Community Healthcare Organisation (CHO) 9. The approved centre had a clear organisational chart to identify the leadership and management structure and the lines of authority and accountability. There were seven consultant-led teams admitting to the approved centre. All of these consultant-led teams had a non-consultant house doctor (NCHD), an occupational therapist, a social worker, a psychologist, and community mental health nurses. There was no non-consultant house doctor (NCHD), on call during the day and staff had to contact the treating team NCHD, who could be offsite in outpatient departments.

There was an incident review committee run by both of the clinical nurse manager (CNM)3 on the unit every two weeks. Incidents could be escalated up to the quality and safety meeting and then further escalated if necessary to the mental health management team meeting. The mental health management team and the quality and safety committee met monthly and minutes were made available to the inspection team. Agendas were robust with an ongoing agenda of quality improvement. The quality and safety meeting had standard items on the agenda, which included review of the risk register and infection prevention and control. There were standard items on the management team meeting agendas such as staff training, service updates, service user representation, and quality and safety. The drugs and therapeutic committee also fed into these meetings. There was service user representation on the senior management team. Staff were recruited to the service via the HSE National Recruitment Policy. Information and induction training was provided by the service. There was one health care assistant in both wards. The approved centre also utilised agency staff. Ash, Pine and the HDU all had a CNM 2. Management were supportive and encouraging to staff in availing of further education, and documentation showed that the approved centre had seven staff participating in higher education.

5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 18 – 21 October 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

Regulation/Rule/Act/Code	2017 Inspection Findings
Regulation 14: Care of the Dying	Non-Compliant
Regulation 15: Individual Care Plan	Non-Compliant
Regulation 22: Premises	Non-Compliant
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Non-Compliant
Regulation 26: Staffing	Non-Compliant
Regulation 27: Maintenance of Records	Non-Compliant
Rules Governing the Use of Seclusion	Non-Compliant
Part 4 of the Mental Health Act 2001: Consent to Treatment	Non-Compliant
Code of Practice on the Use of Physical Restraint in Approved Centres	Compliant
Code of Practice Relating to Admission of Children under the Mental Health Act 2001	Non-Compliant
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	Non-Compliant
Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	Not Applicable
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Non-Compliant

5.2 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 2016 and 2015:

Regulation/Rule/Act/Code	2015 Compliance	2016 Compliance	2017 Compliance
Regulation 5: Food and Nutrition	✓	✓	✗
Regulation 14: Care of the Dying	✓	✗	✗
Regulation 15: Individual Care Plan	✗	✗	✗
Regulation 22: Premises	✓	✗	✗
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	✗	✗
Regulation 26: Staffing	✓	✗	✗
Regulation 27: Maintenance of Records	✓	✗	✗
Rules Governing the Use of Seclusion	✓	✗	✗
Part 4 of the Mental Health Act 2001: Consent to Treatment	✗	✗	✗
Code of Practice Relating to Admission of Children under the Mental Health Act 2001	✗	✗	✗
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting	✓	✗	✗
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✓	✗	✗

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.

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 16: Therapeutic Services and Programmes
Regulation 30: Mental Health Tribunals

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 Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

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

The inspection team met with eight residents on the second day of the inspection. Residents were complimentary about the food provided and said that it was "plentiful". Also, residents were complimentary about the staff and all residents interviewed were aware of their individual care plans. Residents were not happy with the quality of the showers in the units. It was noted that works were under way to replace these.

7.0 Interviews with Heads of Discipline

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

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

Each clinical discipline had its own governance structure with clear line management. The clinical director attended the unit on Mondays and Friday for ward rounds and was available to staff. All residents admitted had a bi-disciplinary assessment completed by nursing and medical staff. There was no in-patient consultant. The area director of nursing was available in the approved centre up to three days a week. The management team for CHO 9 was involved with the HSE's Connecting for Life, a national strategy to reduce suicide from 2015 to 2020. The social work department had completed an audit on delayed hospital discharges, with the findings indicating the absence of social housing as a contributory factor.

Ash ward had input from an in-house psychologist; however, Pine ward did not have access to this service. Recovery groups provided by the psychologist included the "Living Well" group. The two occupational therapists based in the therapy department of the approved centre facilitated in-house groups, including the "Acute Jobs Clinic," and attended ward multi-disciplinary team meetings. As the psychology department had a waiting list that exceeded three months, its in-reach service was limited at the time of the inspection. The mental health management team meetings had input from all heads of discipline and included discussions on quality improvement within their own area. All identified strategic aims for their teams and discussed potential operational risks within their departments. Not all heads of disciplines had training in risk management.

8.0 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:

- Clinical Director
- Area Administrator
- Area Director of Nursing
- Principal Social Worker
- Mental Health Social Worker
- Occupational Therapy Manager
- Senior Occupational Therapist
- Senior Clinical Psychologist
- Clinical Nurse Manager (CNM) 2 x 2
- CNM3 x 2
- Assistant Director of Nursing

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. Clarifications obtained at the feedback meeting have been incorporated in to the report.

9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in March 2017. It addressed requirements of the *Judgement Support Framework*, with the exception of the required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.

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

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

Evidence of Implementation: An examination of 25 clinical files indicated that at least two person-specific resident identifiers were in use in the approved centre. The identifiers, including name, address, date of birth, and health care record number, were used before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. A yellow-sticker system was in place to alert staff to the presence of residents with the same or a similar name.

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

Regulation 5: Food and Nutrition

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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 the provision of appropriate food and nutrition to residents, which was last reviewed in May 2017. It included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all 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 was undertaken to ensure that residents received wholesome and nutritious food in accordance with their needs. Analysis had not been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a wide variety of wholesome and nutritious food choices within the approved centre's menus.

Food, including modified consistency diets, was presented in an appealing manner, and hot meals were served daily. Residents were offered hot and cold drinks regularly, and they had access to a source of safe, fresh drinking water in water coolers on the wards.

The approved centre did not use an evidence-based nutrition assessment tool to evaluate residents with special dietary needs. The dietitian used the St. Andrew's Nutrition Screening Instrument (SANSI) only when residents were referred for assessment, but residents identified as having special nutritional requirements were not routinely reviewed by the dietitian. One individual care plan (ICP) inspected indicated that the resident had ongoing dietary intake issues, which had not been referred to the dietitian. Although nutritional and dietary needs were addressed in the residents' ICPs, there was no evidence that nutritional needs had been assessed and that the appropriate interventions had been provided.

Residents, their representatives, family, and next of kin were educated about residents' diets, where required.

The approved centre was non-compliant with this regulation because an identified nutritional need was not referred to the dietitian for assessment, to ensure that special dietary requirements were consistent with the resident's ICP, 5(2).

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 May 2017. It included requirements of the *Judgement Support Framework,* with the exception of the processes for managing catering and food safety equipment.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date documented training in the application of Hazard Analysis and Critical Control Point (HACCP).

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

Evidence of Implementation: The approved centre had appropriate hand-washing areas for catering staff and suitable and sufficient catering equipment. Meals were prepared in the main hospital, and appropriate facilities were available in the approved centre for the refrigeration, storage, preparation, cooking, and serving of food.

Hygiene was maintained to support food safety. Catering areas and associated equipment were appropriately cleaned. Food was not prepared on-site but was stored and served in a manner that reduced the risk of contamination, spoilage, and infection. Residents were provided with a supply of suitable crockery and cutlery.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of resident clothing was monitored on an ongoing basis, and this was documented. A record of residents wearing nightclothes during the day was maintained and monitored.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing. All residents had an adequate supply of individualised clothing and wardrobes in which to store it. Residents' clothing was observed to be clean and appropriate to their needs.

There was a supply of emergency clothing in the clinical nurse manager 3's office. The emergency clothing took account of residents' preferences, dignity, bodily integrity, and religious and cultural practices. Nightclothes were not worn by residents during the day, except in cases where a risk to the resident was identified. This was specified in residents' individual care plans.

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

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' personal property and possessions, which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Personal property logs were monitored by nursing staff. Documented analysis had been completed to identify opportunities for improving the processes around residents' personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their individual care plans (ICPs). Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided on each ward for the safe-keeping of residents' money and personal effects.

Signed property checklists were developed at admission, and these detailed each resident's personal property and possessions. The checklists were stored separately to the resident ICPs. Access to and use of resident money was overseen by two members of staff and the residents or their representatives. Where any money belonging to residents was handled by staff, signed records of the staff issuing the money were retained. Where possible, these records were countersigned by the residents or their representatives. Receipts were retained for purchases, and two members of staff reviewed the balance of accounts twice daily.

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 **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 2017. It included all of the requirement of the *Judgement Support Framework.*

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

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

Evidence of Implementation: The approved centre provided a range of recreational activities appropriate to the resident group profile, including TV, computers, books, board games, arts and crafts, knitting, gardening, a pool table, a newspaper group, a cookery group, and music, including access to musical instruments.

Activities were provided during the week in the occupational therapy suite and at weekends on the wards. A weekly schedule of recreational activities was available on each ward and was in an accessible format. Recreational activities were developed, maintained, and implemented with resident involvement. Residents' views on activities were recorded at monthly resident meetings, and efforts were made to incorporate residents' requests into the programme of activities. Where deemed appropriate, individual risk assessments were completed for residents in relation to the selection of appropriate activities.

Residents' decisions on whether or not to participate in activities were respected and documented. Opportunities were available for outdoor exercise and physical activity, and communal areas suitable for recreational activities were available. Records of resident attendance at events were maintained in the clinical files.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework.*

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

Monitoring: The policy's implementation to support residents' religious practices was reviewed every three years to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. A Eucharistic minister visited the approved centre twice a week, and residents could avail of the chapel in Connolly Hospital. Residents had access to multi-faith chaplains through the hospital chaplain. They could also access local religious services and were supported to attend, if deemed appropriate following a risk assessment.

The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes. Where relevant, religious requirements relating to the provision of services, care, and treatment in the approved centre were documented in residents' individual care plans.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which was last reviewed in May 2017. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre. There was a three visitors at a time policy in place and this was clearly signposted. Two clinical files were inspected in relation to the implementation of visiting restrictions. Both contained clear documentation of the reasons for the restrictions and clear guidance was given. All restrictions were on the basis of the resident's best interests.

There were designated visitors' areas, including a family room, seating pods on the main corridor, and visiting rooms on Ash and Pine Wards. Appropriate arrangements were made for residents in the high dependency unit, (HDU). Visits could take place in private, unless there was an identified risk to the resident or to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children were welcome when accompanied by an adult to ensure their safety. The family room was suitable for visiting children.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: Residents' communication needs and restrictions on communication were monitored on an ongoing basis by the multi-disciplinary team. Analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to external communications, including personal mobile phones, mail, e-mail, and fax. Where indicated, individual risk assessments were completed for residents in relation to their external communication and documented in their individual care plans. Where appropriate, incoming and outgoing resident communication was examined by a senior staff member if there was reasonable cause to believe that the communication may result in harm to the resident or others.

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 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in June 2017. It 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 was accommodated.
- The consent requirements of a resident regarding searches and the process for conducting 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 could articulate the processes for undertaking a search, as set out in the policy.

Monitoring: Each ward maintained a search log, but each search record was not systematically reviewed to ensure the requirements of the regulation were complied with. Documented analysis had been completed to identify opportunities for improving search processes, and a search log template had been introduced.

Evidence of Implementation: The resident search policy was communicated to residents. One clinical file was examined in relation to searches. A search form had been completed, and it indicated that risk was assessed prior to the search and that resident consent had been sought and documented. A minimum of two clinical staff were in attendance at all times when the search was being conducted.

The resident was informed by those implementing the search of what was happening and why, and the search was undertaken with due regard to the resident's dignity and privacy. The reason for the search was documented, and the staff in attendance were noted.

General written consent was sought for routine environmental searches, and a written record of environmental searches was maintained.

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

Regulation 14: Care of the Dying

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 policy in relation to care of the dying, which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework.*

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

No resident of the approved centre had received end of life care since the last inspection. One resident who had been transferred to the general hospital had died since the last inspection. The death was not notified to the Mental Health Commission within the 48-hour time frame

The approved centre was non-compliant with this regulation because the death of one resident was not notified to the Mental Health Commission within the required 48-hour time frame.

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

Training and Education: Not all Clinical staff had not signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed could 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: Resident ICPs were audited on a quarterly basis to assess compliance with the regulation. Documented analysis had been undertaken to identify opportunities for improving the individual care planning process, and a colour-coded ICP system had been introduced.

Evidence of Implementation: The ICPs of 16 residents were examined. At the time of inspection, a new ICP template was being implemented but not all residents' ICPs had been updated to the new format. Each ICP was a composite set of documents stored in the clinical file, was identifiable and uninterrupted, and was not amalgamated with progress notes. Each resident was assessed at admission and an initial care plan was put in place to address immediate needs.

Four of the 16 ICPs inspected were not developed within seven days of admission by the MDT following assessment. Two of the ICPs inspected did not contain specific and appropriate goals for the residents. One ICP did not identify the interventions required to meet the goals identified. Three ICPs did not specify appropriate resources to provide the care and treatment identified. Fourteen ICPs did not include a preliminary discharge plan. The key worker was not identified in 13 of the ICPs inspected.

The ICP was reviewed by the MDT in consultation with the resident. Some residents attended their MDT meeting, and others met with the key worker after the meeting to discuss their ICPs. Residents had access to their ICPs and were informed of any changes.

One of the ICPs inspected had not been updated following MDT review on two consecutive occasions, as indicated by the resident's changing needs, condition, circumstances, and goals. Where a resident declined or refused a copy of their ICP, this was not consistently documented.

As child admissions to the approved centre were for a short duration of between three and eight days, educational requirements did not apply.

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

a) **Four ICPs were not developed by the MDT within seven days of admission.**
b) **One ICP had not been updated following MDT review on two consecutive occasions.**
c) **Two of the ICPs inspected did not contain specific and appropriate goals for the residents.**
d) **One ICP did not specify the interventions required to meet identified goals.**
e) **Three ICPs did not identify the resources required to provide the care and treatment identified.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was last reviewed in May 2017. It 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. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of therapeutic services and programmes provided was monitored by occupational therapy staff on a quarterly basis to ensure that residents' assessed needs were met. Documented analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: The range of available therapeutic services and programmes was appropriate, evidence-based, and met the assessed needs of the residents, as indicated in their individual care plans. They included community living skills, group recovery, anxiety management, and a psychology-led "Living Well Group" on Ash Ward. Residents also had access to practical and functional programmes such as the Wellness Recovery Action Plan, the Kick Start recovery programme, and a jobs clinic, all of which sought to maintain optimal levels of physical and psychosocial functioning of residents.

A list of therapeutic services and programmes was provided to residents. Adequate and appropriate resources and facilities were available for therapeutic services and programmes, including an occupational therapy kitchen, group rooms, an activities room, a workshop, and a garden. Where residents required therapeutic services or programmes that were not provided internally, the approved centre arranged for services to be provided by an approved, qualified health professional in an appropriate location.

Records were maintained of the residents' participation in, engagement with, and outcomes achieved in therapeutic services or programmes and documented in their clinical files.

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

Regulation 17: Children's Education

NOT APPLICABLE

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

INSPECTION FINDINGS

Four children had been admitted to the approved centre since the last inspection, but their admissions were of short duration and educational requirements did not apply. Consequently, this regulation was not applicable.

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

Monitoring: The approved centre maintained a transfer log, and each transfer record was systematically reviewed to ensure that all relevant information was provided to the receiving facility. Analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred to another approved centre was inspected. The communication records with the receiving facility were documented in the clinical file. The resident's consent to the transfer was clearly documented. A pre-transfer resident assessment, including a risk assessment, was recorded and provided to the receiving facility.

All relevant information regarding the resident was transferred, including a letter of referral listing current medications, a resident transfer form, and information on required medication for the resident during the transfer. The approved centred completed a checklist to ensure comprehensive resident records were transferred to the receiving facility. Copies of all records relating to the transfer were retained in the clinical file.

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

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(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 two written policies in relation general health, a medical emergencies policy and a general health policy, both of which were last reviewed in June 2017. Together, the policies addressed requirements of the *Judgement Support Framework*, with the exception of the following:

- The resource requirements for general health services, including equipment needs.
- Resident access to national screening programmes through the approved centre.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policies. Not all clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policies.

Monitoring: Resident take-up of national screening programmes was not recorded and monitored. 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: Staff in the approved centre had access to an emergency trolley and an Automated External Defibrillator. Weekly checks were completed on emergency equipment. There had been no medical emergency in the approved centre since the last inspection.

A registered medical practitioner assessed residents at admission and on an ongoing basis. Residents received appropriate general health care interventions in line with their individual care plans. A review of the clinical files of five residents who had been in the approved centre for longer than six months indicated that residents' general health needs were assessed at least every six months. In one case, the resident had refused an assessment, and this was documented.

Records were maintained of general health checks and associated results. Where relevant, residents had access to appropriate national screening programmes. No information regarding these programmes was available in the approved centre.

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

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, which was last reviewed in June 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. Staff interviewed could articulate the processes for providing 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 was completed to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: Required information was provided to residents and/or their representatives at admission, in an information booklet. This included details of housekeeping arrangements, the complaints procedure, arrangements for personal property, visiting times and arrangements, mealtimes, relevant advocacy and voluntary agencies, and residents' rights. Residents were provided with information on their multi-disciplinary team.

Residents received written and verbal information about their diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition. Information was provided to the residents on indications for the use of medications, including any possible side-effects. The information provided by and within the approved centre was evidence-based. An information display unit was located outside the clinical room in both Ash and Pine wards.

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 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in June 2017. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: An annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were discreet when discussing resident care and treatment needs. Staff were appropriately dressed and sought permission before entering residents' rooms. Residents were observed to be wearing clothing that respected their privacy and dignity.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors, and these had an override facility. Where residents shared a room, appropriate bed screening was in place to ensure that privacy was not compromised. Residents were facilitated in making and taking private phone calls. All observation panels on doors of treatment rooms and bedrooms were appropriately screened.

Noticeboards in the approved centre did not display identifiable resident information.

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 and monitoring pillars.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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 the premises, which was last reviewed in June 2017. The policy addressed requirements of the *Judgement Support Framework,* with the exception of the approved centre's utility controls and requirements.

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

Monitoring: The approved centre had completed hygiene and ligature audits. Documented analysis had been undertaken to identify opportunities for improving the premises, leading to upgrades of the fire detection system and the bathrooms.

Evidence of Implementation: Residents had access to personal space, and appropriately sized communal areas were available. Communal areas were adequately lit to facilitate reading and other activities. Rooms were comfortably and sufficiently heated, and heating could be safely controlled in residents' rooms. Appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including outdoor areas.

The accommodation was comfortable but did not always assure resident privacy because some rooms were overlooked by public areas.

Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, had been minimised. At the time of inspection anti ligature works were under way in relation to the minimisation of ligature points. Ligatures remained in the approved centre at the time of the inspection. The inspectors were informed that these will be addressed on a phased and planned basis in coming months.

The approved centre was in a good state of repair, externally and internally. There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. Where faults or problems were identified, there was an appropriate maintenance reporting process for each ward, with clear documentation of the date and nature of the reported issues.

A cleaning schedule was implemented in the approved centre, which was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

There was a sufficient number of toilets, including accessible facilities and wheelchair accessible facilities for use by residents or visitors who required them. There were designated sluice, cleaning, and therapy/examination rooms. There was no designated laundry room in the approved centre. Residents' families took home laundry or an external laundry service was used.

Bedrooms were appropriately sized for resident needs, and suitable furnishings were provided to support resident independence and comfort.

The approved centre was non-compliant with this regulation because ligatures had not been minimised, indicating that the physical structure and overall approved centre environment were not developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, 22(3).

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in June 2017. It addressed requirements of the *Judgement Support Framework,* with the exception of the following:

- The legislative requirements to be complied with during the ordering, prescribing, storing, and administration of medication, specifically in relation to consent to treatment.
- The processes for medication management at admission, transfer, and discharge.

Training and Education: Not all nursing, medical, and pharmacy 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 ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to comprehensive, up-to-date information on all aspects of medication management. All clinical staff had received training on the importance of reporting medication incidents, errors, or near misses, and this 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: An MPAR was maintained for each resident, and 20 of these were inspected. Two appropriate resident identifiers were used on each MPAR. Names of medications were written in full, the generic names of medications were recorded, and all medications administered to residents were documented.

The frequency of administration, including the minimum dose interval for as required medication, was not recorded in one MPAR. In six of the MPARs inspected, a date of discontinuation for each medication was not recorded. In three MPARs, the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the residents was not included. The allergy section was not completed in one MPAR. In one MPAR, the signature of the medical practitioner was not included for each entry. In four MPARs, prescriptions had been altered but not rewritten.

Medication was reviewed at least six-monthly, and all medicines were administered by a registered nurse or registered medical practitioner. The expiry dates of medications were checked prior to their administration. Controlled drugs were checked by two staff members against the delivery form, and the details were appropriately entered in the controlled drug book.

At the time of inspection, no residents were self-administering medications and no residents had been prescribed crushed medication.

Good hand hygiene and cross-infection control techniques were not observed during the dispensing of medications as nursing staff were not seen to wash their hands before administering medication. Medication arriving from the pharmacist was not verified against the order to ensure that it was correct and accompanied by appropriate directions for use. Medication storage areas, which were not incorporated into the cleaning and housekeeping schedules, were not clean and tidy. In particular, the fridges on both wards were stained. During the inspection, a new rota was introduced to ensure fridges were cleaned.

Medication was stored in the appropriate environment, and a daily log of medication fridge temperatures was maintained. Medication was stored securely in a locked trolley in a secure room. There was a separate secure storage area for scheduled controlled drugs. A system of stock rotation was implemented, and an inventory of medications was completed monthly.

The approved centre was non-compliant with section 1 of this regulation for the following reasons:

a) **In three of the MPARs inspected, the MCRN of every medical practitioner prescribing medication to the residents was not included.**
b) **The discontinuation date for medication was not recorded in six MPARs inspected.**
c) **The signature of the prescriber was not included in one MPAR.**

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 two policies in relation to health and safety: a health and safety policy dated June 2017 and a Connolly Hospital infection prevention and control policy dated 2016. It also used the Connolly Hospital safety statement, which was dated November 2015. Together, the policies and safety statement addressed requirements of the *Judgement Support Framework,* with the exception of the following:

- The specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- Infection control measures, including
  - Management and reporting of an infection outbreak.
  - Support provided to staff following exposure to infectious diseases.

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

Monitoring: The health and safety policies were monitored pursuant to Regulation 29: Operational Policies and Procedures.

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of CCTV, which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The quality of CCTV images was checked regularly to ensure that the system was operating appropriately, and this was documented. Analysis had been completed to identify opportunities for improving the use of CCTV.

Evidence of Implementation: There was prominent signage indicating the locations where CCTV cameras were situated in the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The Mental Health Commission and/or the Inspector of Mental Health Services had been informed about the approved centre's use of CCTV.

Cameras were incapable of recording or storing a resident's image in any format. The CCTV cameras used to observe residents did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the residents.

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 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the recruitment, selection, and vetting of staff, which was last reviewed in March 2017. It also used the HSE's national recruitment policy. The policies addressed requirements of the *Judgement Support Framework*, with the exception of the following:

- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.

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

Monitoring: The implementation and effectiveness of the staff training plan had been reviewed annually. The numbers and skill mix of staff were assessed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability of staff in the approved centre. A planned and actual staff rota was in place. Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staff were sufficient to address resident needs and the size and layout of the approved centre.

The approved centre did not have a written staffing plan that addressed the following:

- The skill mix, competencies, number, and qualifications of staff.
- The assessed needs of the resident group profile.
- The process for reassigning staff in response to changing resident needs or staff shortages.

Annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training was completed by staff. It addressed such areas as professional, ethical, and legal practice; holistic approaches to care; interpersonal relationships; the organisation and management of care; and professional development. There was no non-consultant house doctor (NCHD), on call during the day and staff had to contact the treating team, NCHD. Only Ash ward had input from an in-house psychologist.

Training records indicated that not all health care professionals had up-to-date, mandatory training in fire safety, Basic Life Support (BLS), the Therapeutic Management of Violence and Aggression (TMVA), and the Mental Health Act 2001.

At least one staff member was trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training completed in manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults.

Staff training was documented by discipline, and staff training logs were maintained by each head of discipline. The Mental Health Act 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in the Mental Health Act administrator's office.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Ash Ward	CNM2 RPN HCA Psychologist	1 4 2 0.5 WTE	3
Ward or Unit	*Staff Grade*	*Day*	*Night*
Pine Ward	CNM2 RPN HCA	1 4 1	3
Ward or Unit	*Staff Grade*	*Day*	*Night*
High Dependency Unit	CNM2 RPN Occupational Therapists	1 2 2 WTE	2

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Whole Time Equivalent (WTE).

The approved centre was non-compliant with this regulation because not all health care professionals had up-to-date mandatory training in fire safety, BLS, TMVA, and the Mental Health Act 2001, 26(4) and 26(5).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in June 2017. It addressed requirements of the *Judgement Support Framework,* including the following:

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

The policy did not reference the following:

- The resident record content.
- Residents' access to their records. (All other access to records was outlined in the policy).

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. Clinical staff and other relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records, as set out in the policy. Clinical staff had received training in best-practice record keeping.

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

Evidence of Implementation: Residents' records were secure, up to date, and constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and national guidelines and legislative requirements. Current resident records were stored in the nurses' station on each ward. All residents' records were appropriately secured from loss or destruction, tampering, and unauthorised access or use.

A record had been initiated for every resident in the approved centre, and these were reflective of residents' current status and the care and treatment being provided. Resident records were maintained through the use of a person-specific identifier.

Resident records were not always developed and maintained in a logical sequence and in good order. Some records evidenced inconsistent filing, and all records reviewed during the inspection contained loose pages. The clinical files also indicated that records were not always maintained appropriately. One file inspected contained unsigned notes, which included inappropriate phrases among the entries. Nursing notes were not appropriately recorded in one file inspected.

Documentation relating to health and safety, food safety, and fire inspections was maintained in the approved centre.

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

a) **Records were not maintained in good order, with all clinical files inspected containing loose pages, 27(1).**
b) **Records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, as evidenced by the following, 27(1):**
   - **Some records evidenced inconsistent filing.**
   - **Not all records were maintained appropriately, as indicated by nursing care record sheets that were unsigned and included inappropriate phrases.**
   - **Nursing notes were not appropriately recorded in one file.**

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the development and review of operating policies and procedures, which was last reviewed in June 2017. It included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff had not received training on approved operational policies and procedures. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented.

All of the operating policies and procedures required by the regulations had been reviewed within three years. Obsolete versions of operating policies and procedures were archived and removed from possible access by staff. Generic policies were appropriate to the approved centre and the resident group profile. Written statements adopting generic policies were in place.

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 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of Mental Health Tribunals, which was dated April 2017. It 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 facilitating Mental Health Tribunals, as set out in the policy.

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

Evidence of Implementation: To support the tribunal process, the approved centre provided a dedicated tribunal room. Adequate resources were made available in support of the process, and staff assisted and supported residents to attend and participate in Mental Health Tribunals, where necessary.

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **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 policy in relation to making, handling, and investigating complaints, which was last reviewed in June 2017. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for documenting complaints, including the maintenance of a complaints log by the nominated person.

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

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

Evidence of Implementation: There was a nominated complaints officer in the approved centre who was responsible for dealing with all complaints. All complaints were addressed in a consistent and standardised manner. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy, the HSE's *Your Service, Your Say* leaflet, on notices in the approved centre, and in the resident information booklet.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged. The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives.

Complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. All minor complaints were logged in the complaints book on each ward and addressed locally. Where minor complaints could not be resolved locally, they were escalated to the complaints officer.

All complaints that were not minor were dealt with by the complaints officer and recorded in the complaints log. Details of the complaints, subsequent investigations, and the outcomes were recorded and kept separately from the resident's individual care plan.

The complaints log did not contain documentation in relation to complainants' satisfaction or dissatisfaction with investigation findings.

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, monitoring, and evidence of implementation pillars.

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies in relation to risk management. These included a safety statement, an additional risk management procedures policy dated April 2017, an incident reporting and management policy dated May 2017, a clinical risk assessment and management policy dated May 2017, a psychiatric emergency policy dated June 2017, and a resident absence without leave policy dated April 2017. Together, the policies addressed requirements of the *Judgement Support Framework*, including the following:

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

The policies did not specify the following:

- The responsibilities of the registered proprietor.
- The process of identification, assessment, treatment, reporting, and monitoring of
  - Organisational risks.
  - 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 process for maintaining and reviewing the risk register.
- The process for notifying the Mental Health Commission about incidents involving residents of the approved centre.

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk or in health and safety risk management. Managerial staff were trained in organisational risk management. Not all Clinical staff had received training in individual risk management processes.

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

Monitoring: The risk register was not audited at least quarterly to determine compliance with the approved centre's risk management policy, and all incidents had not been documented and risk-rated. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: The person with responsibility for risk was known by all staff in the approved centre, and responsibilities were allocated at management level to ensure the effective implementation of risk management. Risk management procedures actively sought to reduce identified risks to the lowest practical level of risk.

Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register. At the time of inspection, structural risks, including ligature points, were in the process of being removed, following a ligature audit. Where works to eliminate ligature points were ongoing, the approved centre had reduced its bed capacity to decrease risks to residents.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors. Risk assessments were completed before and during the use of seclusion and physical restraint, before a transfer or discharge, and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of risk management processes, as did residents and/or their representatives. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated using the National Incident Management System. All clinical incidents were reviewed by the MDT immediately after the incident and at the weekly MDT meeting. A record was maintained of the review and of recommended actions.

A six-monthly summary report of all incidents occurring in the approved centre was sent to the Mental Health Commission in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. The approved centre had an emergency plan that incorporated a fire evacuation plan.

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 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 insured under the auspices of 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, which was prominently displayed at the entrance area.

The approved centre was compliant with this regulation.

10.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

NOT APPLICABLE

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this rule was not applicable.

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of seclusion, which was effective as of March 2017. The policy, which had been reviewed annually, identified those who were authorised to initiate seclusion and referenced the provision of information to the resident in seclusion. It identified staff training requirements in relation to the use of seclusion. There was a policy on the use of closed circuit television (CCTV). The policy did not address ways of reducing rates of the use of seclusion.

Training and Education: Not all staff involved in the use of seclusion had signed the signature log to indicate that they had read and understood the policy. Records were maintained of staff attendance at training and were made available to the inspector.

Monitoring: An annual report on the use of seclusion had been completed and was available for inspection.

Evidence of Implementation: Residents in seclusion had access to shower facilities, however residents had to cross a corridor to use this facility. Direct observation of residents in seclusion was not possible because there was a blind spot in the room. Furnishings and fittings in the seclusion room were of a design and quality so as not to endanger patient safety. The toilet area, however was not of a design and quality so as not to endanger patient safety.

Two clinical files were inspected in relation to the use of seclusion. Both seclusion episodes were initiated by a registered medical practitioner, and the consultant psychiatrist was notified of the use of seclusion as soon as was practicable. This was recorded in the clinical files. A comprehensive assessment, including a risk assessment, was completed in advance of the use of seclusion. The use of CCTV to monitor the seclusion room was appropriate.

Seclusion was used in rare, exceptional circumstances and best interests, when the residents posed an immediate and serious threat of harm to self or others and after all other interventions to manage unsafe behaviour had been first considered.

There was no evidence that residents were informed of the reasons for, duration of, and circumstances leading to the discontinuation of seclusion. It was not possible for nursing staff to directly observe the

residents for the first hour of seclusion due to a blind spot in the room. A record of the residents was made by a nurse every 15 minutes, but in one case this did not document the resident's level of distress. Following a risk assessment, a nursing review took place every two hours. In each case, residents were informed of the ending of seclusion and the reasons for ending seclusion.

In one case inspected, the resident did not receive a medical review every four hours. In one episode, it was not possible to determine whether the resident's individual care plan (ICP) addressed assessed needs with the goal of ending seclusion because the ICP was unavailable. In one episode, the duration of the seclusion order was not recorded.

All episodes of seclusion were reviewed by the multi-disciplinary team (MDT) and recorded in the clinical files. In one case, the MDT review was not documented in the clinical file within two working days. Neither episode was fully recorded in the seclusion register because one episode was incorrectly dated and not all sections of the form were completed in the second episode.

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

a) **The policy in relation to seclusion did not address ways of reducing rates of seclusion, 10.2(a).**
b) **There was no evidence that all staff involved in the use of seclusion had read and understood the policy, 10.2(b).**
c) **Direct observation of the seclusion room was not possible because of a blind spot, 5.1(a).**
d) **In one episode, the 15-minute nursing record did not document the resident's level of distress, 5.2.**
e) **The duration of one seclusion order was not recorded, 3.4 (c).**
f) **There was no evidence that residents were informed of the reasons for, duration of, and circumstances leading to the discontinuation of seclusion, 3.6.**
g) **In one episode, a medical review of the resident did not take place every four hours, 5.4.**
h) **In one case, it was not possible to determine whether the resident's ICP addressed assessed needs with the goal of ending seclusion because the ICP was unavailable, 5.6.**
i) **Neither use of seclusion was fully recorded in the seclusion register because one episode was incorrectly dated and not all sections of the form were completed in the second episode, 9.2.**
j) **In one episode of seclusion, the MDT review was not documented in the relevant clinical file within two working days, 10.3.**

Section 69: The Use of Mechanical Restraint

NOT APPLICABLE

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

As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

11.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NON-COMPLIANT

Risk Rating **CRITICAL**

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

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

a) the patient gives his or her consent in writing to the continued administration of that medicine, or

b) where the patient is unable to give such consent –

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and in continued receipt of medication were examined. In one case, there was no documentation to verify the resident's capacity to consent to the proposed treatment. There was a pro-forma consent document, which had been partly filled in by the registrar rather than the treating consultant psychiatrist, with a note indicating that it was witnessed by a locum consultant. The clinical file did not contain a doctor's note for the day that the capacity assessment was undertaken.

In one case, the consent form did not include the name of the medications prescribed, although these were listed in the continuation notes. In one case, there was no confirmation of the patient's ability to understand the nature, purpose, and likely effects of the medication(s).

Neither consent form referenced the risks nor the benefits of medication, nor did one not include any views expressed by the patient. One form did not reference supports provided to the patient in relation to the discussion and their decision-making.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment for the following reasons:

a) **There was no documentary evidence that the treating consultant psychiatrist had assessed one patient's capacity to understand the nature, purpose, and likely effects of the proposed treatment, 56(a).**
b) **There was no evidence that the patients were informed of the risks and benefits of the medication(s) prescribed, 56(b).**
c) **Supports provided to the patient in relation to the discussion of the effects of medication and their decision-making were not documented in one case, 56(b).**

12.0 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

COMPLIANT

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, which was last reviewed in April 2017. The policy, which had been reviewed annually, addressed the following:

- The provision of information to residents regarding the use of physical restraint.
- The individuals authorised to initiate and implement physical restraint.
- The training requirements relating to physical restraint.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. A staff training plan was in place, which specified the following:

- Who should receive training.
- Areas to be addressed during training.
- The mandatory nature of training for staff involved in the use of physical restraint.
- The frequency of training.
- The identification of appropriately qualified individuals to deliver training.

A record of attendance at training was maintained. Physical restraint was never used to ameliorate staff shortages.

Monitoring: An annual report had been completed in relation to physical restraint.

Evidence of Implementation: The clinical files of three residents were examined in relation to physical restraint. These indicated that physical restraint was initiated in rare and exceptional circumstances and in best interests, where a resident posed an immediate and serious threat of harm to self or others. Physical restraint was initiated after staff had first considered other interventions and following a risk assessment, and a designated staff member was lead. The episodes of physical restraint were not prolonged beyond the period necessary.

Cultural awareness and gender sensitivity were demonstrated during the use of physical restraint. In each case, the consultant psychiatrist was notified of the use of physical restraint as soon as was practicable and a registered medical practitioner completed a medical examination within three hours of the start of physical restraint. Members of the multi-disciplinary team reviewed the episodes and documented them in the clinical files within two working days.

The residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. The consultant psychiatrist signed and dated the clinical practice forms within 24 hours, and copies of these were retained in the clinical files.

The approved centre was compliant with this code of practice.

Admission of Children

NON-COMPLIANT

Risk Rating MODERATE

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of children, which was effective as of April 2017. It addressed the requirement for each child to be individually risk-assessed and the procedures for identifying the person responsible for notifying the Mental Health Commission (MHC) of the child admission. The policy also referenced procedures in relation to family liaison, parental consent, and confidentiality.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: There had been four child admissions since the last inspection. The clinical files inspected indicated that provisions were in place to ensure the safety of the children, to ensure their rights to have their views heard, and to respond to the child's particular needs as a young person in an adult setting, including one-to-one nursing. Staff having contact with children had undergone Garda vetting, and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff.

Appropriate accommodation was available for children in the approved centre. Gender sensitivity was demonstrated in each case. The children had their rights explained and were provided with information about the available facilities in a form and language that they could understand. Advice from the Child and Adolescent Mental Health Service was available when necessary. Consent for treatment was obtained from one or both parents. Educational requirements did not apply because the admission periods were short in duration, ranging from three to eight days. The MHC was notified of the child admissions to an approved centre for adults within the required 72-hour time frame.

Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre and child residents did not have access to age-appropriate advocacy services.

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

a) **Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre, 2.5(b).**
b) **Child residents did not have access to age-appropriate advocacy services, 2.5(g).**

Notification of Deaths and Incident Reporting

NON-COMPLIANT

Risk Rating MODERATE

Please refer to the Mental Health Commission Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a risk management policy that covered the notification of deaths and incident reporting to the Mental Health Commission (MHC). It specified the roles and responsibilities of staff in relation to the following:

- The reporting of deaths and incidents.
- The completion of death notification forms.
- The completion of six-monthly incident summary reports.

The policy did not identify the risk manager or specify the roles and responsibilities in relation to the submission of death notification forms to the MHC.

Monitoring: Deaths and incidents were reviewed to identify and correct any problems as they arose and to improve quality.

Evidence of Implementation: The approved centre was compliant with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

The approved centre used the National Incident Management System for reporting incidents, and the standard incident report form was available to inspectors. A six-monthly summary of all incidents was sent to the MHC.

There had been one death of a resident of the approved centre since the last inspection. This was not notified to the MHC within the required 48-hour time frame.

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

a) **The policy did not identify the risk manager, 4.2.**
b) **The policy did not specify the roles and responsibilities in relation to the submission of death notification forms to the MHC, 4.3.**
c) **One resident's death was not notified to the MHC within the required 48-hour time frame, 2.1.**

Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

NOT APPLICABLE

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

As no resident of the approved centre had an identified intellectual disability at the time of inspection, this code of practice was not applicable.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

NOT APPLICABLE

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **LOW**

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 policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in June 2017, included a procedure for involuntary admission and a protocol for planned admission, with reference to pre-admission assessments, eligibility for admission, and referral letters. It contained protocols for urgent referrals, self-presenting individuals, and timely communication with primary care and community mental health teams. The policy addressed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. The approved centre also had a policy on confidentiality, privacy, and consent.

Transfer: The transfer policy, which was last reviewed in August 2017, included procedures for involuntary transfer and outlined the roles and responsibilities of staff in relation to the transfer of residents. It detailed how a transfer was arranged, addressed the safety of the resident and staff during a transfer, and contained provisions for emergency transfer and transfer abroad.

Discharge: The discharge policy, which was last reviewed in April 2017, included procedures for the discharge of involuntary patients and the management of discharge against medical advice. The policy referenced prescriptions and supply of medication on discharge and contained protocols for discharging homeless people, older persons, and people with intellectual disability. The follow-up policy did not reference crisis management plans or include a means of following up and managing missed appointments.

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

Monitoring: There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.

Evidence of Implementation:

The approved centre was compliant with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

Admission: Two clinical files were reviewed in relation to admission. The approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. The decision to admit was taken by the registered medical practitioner (RMP) and made on the basis of a mental illness or disorder. An admission assessment was completed in both cases and all assessments were documented in the clinical files. There was evidence of the involvement of family members/carers in the admission process. The residents were admitted to the unit most appropriate to their needs.

The approved centre's admission process was compliant under the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Residents' Personal Property and Possessions, and Regulation 20: Provision of Information to Residents. It did not comply under Regulation 15: Individual Care Plan and Regulation 27: Maintenance of Records.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical file of one resident who had been transferred to another approved centre was inspected. The decision to transfer was made by the RMP and documented, and it was agreed with the receiving facility. The resident's family/carer/advocate was involved in the transfer process. The resident was assessed prior to the transfer, and an effort was made to respect the resident's wishes and obtain consent. There was MDT involvement in the transfer. The clinical file contained copies of all relevant documentation.

Discharge: Two clinical files were inspected in relation to discharge. The decision to discharge was taken by the RMP, and a discharge plan was in place as part of the residents' individual care plans. In each case, a discharge meeting attended by the resident, key worker, relevant members of the MDT, and family members/carers/advocates took place and was documented in the progress notes. The residents received a comprehensive assessment prior to discharge. Efforts were made to inform primary care/community mental health teams of the discharges within 24 hours. In both cases, a preliminary discharge summary was issued within 3 days and a comprehensive discharge summary followed within 14 days. Timely follow-up appointments were recorded in the clinical files.

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

a) **The post-discharge follow-up policy did not reference crisis management or include a means of following up and managing missed appointments, 4.14.**
b) **There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies, 4.19.**
c) **There was no documentary evidence that all staff had read and understood the policies on admission and transfer, 9.1.**
d) **The admission process was non-compliant under two of the regulations associated with the code of practice: Regulation 15: Individual Care Plan, 17.1, and Regulation 27: Maintenance of Records, 22.6.**

Appendix 1: Corrective and Preventative Action Plan Template - 2017 Inspection Report

Regulation 5: Food and Nutrition

Report reference: Page 21

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. An identified nutritional need was not referred to the dietician for assessment, to ensure that special dietary requirements were consistent with the resident's ICP.	*New*	Corrective Action(s): Patient was referred to dietician 28th Sept 2017 Post-Holder(s) responsible: Responsible Clinician		Achieved	Completed
		Preventative Action(s): Currently reviewing ICP and Nursing assessment to include nutritional assessment and special dietary requirements. Post-Holder(s) responsible: Clinical Director, CNM III, NPDC	Formal review of the new document after 3 months from introduction	Any new change process will take time with possible improvements and updates during the process.	Use of new documents will commence in March 2018. Review July 2018

[1] Area of non-compliance reoccurring from 2016
[2] Area of non-compliance new in 2017

Regulation 15: Individual Care Plan

Report reference: Page 32-33

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
2. Four ICPs were not developed by the MDT within seven days of admission.	*New*	Corrective action(s): Memo from CD to clinical leads of MDT to ensure all residents will have a comprehensive ICP completed within seven days of admission to comply with requirements of regulation 15 and JSF. Post-holder(s): Clinical Director, Consultants	Audit ICP	Achievable & realistic	Audited on quarterly basis.
		Preventative Action(s): On-going ICP training, ICP information posters being devised for all MDT members. Post-Holder(s) responsible: All Heads of Discipline, All responsible consultants, CNM III, NPDC	Audit ICP	Achievable & realistic	Audited on quarterly basis.
3. One ICP had not been updated following MDT review on two consecutive occasions.	*New*	Corrective Action(s): Memo to be sent by CD to all consultants emphasising the importance of regular review of the ICPs to comply with requirements of regulation 15 and JSF. Post-Holder(s) responsible: Clinical Director	Audit ICPs	Achievable and realistic	Audited on quarterly basis.

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
		Preventative Action(s): On-going ICP training, ICP information posters being devised for all MDT members placed on MDT meeting room Post-Holder(s) responsible: All Heads of Discipline, All responsible consultants, Medical Clinical Tutor, CNM III, NPDC	Audit ICPs	Achievable and realistic	Audited on quarterly basis.
4. Two of the ICPs inspected did not contain specific and appropriate goals for the residents.		Corrective Action(s): Memo to be sent by CD to all consultants emphasising the importance of having a documented set of goals to comply with requirements of regulation 15 and JSF. Information posters being devised for all MDT members Post-Holder(s) responsible: Clinical Director, CNM III, NPDC	Audit ICPs	Achievable and realistic	Audited on quarterly basis.
	Reoccurring	Preventative Action(s): CD to highlight this at consultant group monthly meeting. ICP training to all staff. information posters being devised for all MDT members Audit of the ICPs Post-Holder(s) responsible: All Heads of Discipline, All responsible consultants, Clinical Director, CNM III, NPDC	Audit ICPs	Achievable and realistic	Audited on quarterly basis.

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
5. One ICP did not specify the interventions required to meet identified goals.	*Reoccurring*	Corrective Action(s Memo sent to consultant group emphasising the importance of specifying interventions required to meet such goals in the ICP of patients under their care to comply with requirements of regulation 15 and JSF. Post-Holder(s) responsible: Clinical Director	Audit	Achievable and Realistic	Quarterly
		Preventative Action(s): On-going ICP training, ICP information posters being devised for all MDT members. Post-Holder(s) responsible: All Heads of Discipline, Clinical Director, All responsible consultants, CNM III, NPDC	Audit	Achievable and Realistic	Quarterly
6. Three ICPs did not identify the resources required to provide the care and treatment identified.	*Reoccurring*	Corrective Action(s): memo sent to consultants to identify the resources by name when applicable, to address the care and treatment of individual patients to comply with requirements of regulation 15 and JSF. Post-Holder(s) responsible: Clinical Director	Audit	Achievable and Realistic	Quarterly
		Preventative Action(s): ICP poster being devised to guide staff on completing ICP	Audit	Achievable and Realistic	Quarterly

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
		Post-Holder(s) responsible: All Heads of Discipline, All responsible consultants, Clinical Director, CNM III, NPDC			

Regulation 22: Premises

Report reference: Page 40-41

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
7. Ligatures had not been minimised.	*Reoccurring*	Corrective Action(s): Maintenance work in progress to minimise ligature points and expected to be completed July 2018 Post-Holder(s) responsible: Service Manager Assistant DON	Audit	Achievable and realistic	July 2018
		Preventative Action(s): Re-audit of ligature risks post completion of work. Post-Holder(s) responsible: Assistant DON	Audit	Achievable and realistic	Sept 2018

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

Report reference: Page 42-43

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
8. In three of the MPARs inspected, the MCRN of every medical practitioner prescribing medication to the residents was not included. 9. The discontinuation date for medication was not recorded in six MPARs inspected. 10. The signature of the prescriber was not included in one MPAR.	*Reoccurring (#10)*	Corrective action(s): Checked on 15/01/2018 All MCRN recorded signatures of prescriber and discontinuation date for medication recorded on medication records. Post-holder(s): CNM III, Assistant DON	Audit	Achievable and realistic	15/01 /2018
		Preventative Action(s): Annual pharmacist lecture to NCHD Emphasis at consultant meetings and Clinical Supervision Sessions to NCHD on completing MPARs accurately and complying to reg-23 Post-Holder(s) responsible: Clinical Director, Clinical Tutor, Team Consultant	Audit	Achievable and realistic	Monthly

Regulation 26: Staffing

Report reference: Page 46-47

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
11. Not all health care professionals had up-to-date mandatory training in fire safety, BLS, TMVA, and the Mental Health Act 2001.	*Reoccurring*	Corrective action(s): On-going training is being facilitated by the service. Difficulties arise with shortages and releasing staff; however there is a schedule of training in place which is being addressed by all HOD. A memo from management team to all staff emphasising the requirements to complete mandatory trainings and MHA 2001. Re MHA 2001 All new staff will be requested to submit their certificate of Training for MHA 2001, within one month of taking up post Post-holder(s): Management Team, Heads of Discipline.	On-going monitoring by the respective Head of Discipline	This action is reliant on the availability of training and staff to either run the training or for the staff to be released	October 2018
		Preventative action(s): Each HOD will monitor training registers Post-holder(s): Heads of Discipline	On-going monitoring by the respective Head of Discipline	This action is reliant on the availability of training and staff to either run the training or for the staff to be released	Two –monthly review

Regulation 27: Maintenance of Records

Report reference: Page 48-49

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
12. Records were not maintained in good order, with all clinical files inspected containing loose pages. 13. Records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, as evidenced by the following: – Some records evidenced inconsistent filing. – Not all records were maintained appropriately, as indicated by nursing care record sheets that were unsigned and included inappropriate phrases. – Nursing notes were not appropriately recorded in one file.	*Reoccurring*	Corrective action(s): Weekly review meeting to check files with Admin staff and CNM2 to ensure files are maintained in good order. Meeting to be arranged with medical records re prospect of reviewing the quality of paper used and indexing of clinical file. Post-holder(s): Grade V administrator, Assistant DON, CNM III Re: Nursing care record sheet in one file: This was identified as Non-nursing records were made on Nursing observation sheets. To prevent this re-occurring in future, New Nursing and Non-nursing observation record sheets introduced. Post-holder(s): Assistant DON, CNM III, CNM II	audit	Achievable and realistic	Immediate
		Preventative action(s): Weekly Checks Yearly Audit Grade V Administrator CNM II Re Nursing Record Sheet. CNM II to ensure correct documentation is used. CNM II to organise education session for Nursing staff & HCA on documentation. Highlight to CNM II at meeting the importance of reviewing and observing written records of Non nursing staff carrying out Patient care. Post Holder: CNM II, Assistant DON	Weekly checks Audit of documentation	Achievable Achievable	Annually

Section 69: The Use of Seclusion

Report reference: Page 61-62

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
14. The policy in relation to seclusion did not address ways of reducing rates of seclusion.	*New*	Corrective Action(s): Policy to be Reviewed. Post-Holder(s) responsible: CNM III	Audit	Achievable and Realistic	Quarterly
		Preventative Action(s): Policy to be reviewed and all staff will be informed of the updated policy. Post-Holder(s) responsible: CNM III, Assistant DON	Audit	Achievable and Realistic	Quarterly
15. There was no evidence that all staff involved in the use of seclusion had read and understood the policy.	*New*	Corrective Action(s): Memo sent to staff requesting that they read policies and sign that they have read and understood the policies on an annual basis Post-Holder(s) responsible: All Heads of Discipline	Audit	Achievable and Realistic	Annually
		Preventative Action(s): Maintenance of Signature log on policies. Post-Holder(s) responsible: All Heads of Discipline	Audit	Achievable and Realistic	Annually
16. Direct observation of the seclusion room was not possible because of a blind spot.	*New*	Corrective Action(s): New seclusion room to be constructed during renovation of HDU In the interim to allow direct observation a mirror will be installed.	Audit on completion of works	Achievable	Immediate

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
		Post-Holder(s) responsible: Carmel Kitching Service Manager, Joan Maxwell ADON			
		Preventative Action(s): Audit on completion of works Post-Holder(s) responsible: Joan Maxwell ADON	Audit on completion of works	Achievable	Sept 2018
17. There was no evidence that residents were informed of the reasons for, duration of, and circumstances leading to the discontinuation.	*New*	Corrective Action(s): Discussed with staff working in HDU and this area highlighted. Review of Seclusion core care plan to include this. Post-Holder(s) responsible: Assistant DON, CNM III, CNM II HDU	Audit	Achievable	Quarterly
		Preventative Action(s): adherence to above Post-Holder(s) responsible: CNM II HDU	Audit of Seclusion	Achievable	Quarterly
18. In one episode, a medical review of the resident did not take place every four hours.	*New*	Corrective Action(s): Emphasis on Rules of Seclusion at consultant meetings, Clinical Supervision Sessions and induction training to NCHDs. Post-Holder(s) responsible: Clinical Tutor, Responsible Clinician	Audit of Seclusion	Achievable	Quarterly
		Preventative Action(s): Adherence to the Code of Practise Post-Holder(s) responsible: Responsible Consultant	Audit of Seclusion	Achievable	Quarterly

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
19. In one episode, the 15-minute nursing record did not document the resident's level of distress. 20. The duration of one seclusion order was not recorded. 21. Neither use of seclusion was fully recorded in the seclusion register because one episode was incorrectly dated and not all sections of the form were completed in the second episode. 22. In one episode of seclusion, the MDT review was not documented in the relevant clinical file within two working days. 23. In one case, it was not possible to determine whether the resident's ICP addressed assessed needs with the goal of ending seclusion because the ICP was unavailable.	*New*	Corrective Action(s): staff have been formally made aware of the rules of seclusion in writing and orally and have been made aware the importance of updating the ICP post seclusion Post-Holder(s) responsible: Clinical Director, Assistant DON, CNM III	Audit of Seclusion	Achievable	Quarterly
		Preventative Action(s): Training on the rules of seclusion will be delivered to nursing staff. Introduction of seclusion completion checklist after every seclusion episode. Emphasis on Rules of Seclusion at consultant meetings, Clinical Supervision Sessions and induction training to NCHDs. Post-Holder(s) responsible: CNM II HDU, Assistant DON, CNM III, Clinical Director, Clinical Tutor, Consultant Psychiatrists	Audit	Achievable	Quarterly

Part 4: Consent to Treatment

Report reference: Page 65-66

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
24. There was no documentary evidence that the treating consultant psychiatrist had assessed one patient's capacity to understand the nature, purpose, and likely effects of the proposed treatment. 25. There was no evidence that the patients were informed of the risks and benefits of the medication(s) prescribed. 26. Supports provided to the patient in relation to the discussion of the effects of medication and their decision-making were not documented in one case.	*Reoccurring*	Corrective Action(s): The relevant documentation was completed and sent to the MHC on 31 October 17. Capacity Assessment form and Consent to Treatment form reviewed and updated. Post-Holder(s) responsible: Dr Niamh Garvey Responsible Consultant		Achieved Achieved	31 October 17 Immediate
		Preventative Action(s): Accessible database with timeframes is available for all consultants on the Hospital shared folder. Treating consultant is reminded by email by MHA Administrator regarding due date. Review date reminder in the ward diary for the team. Post-Holder(s) responsible: Dr Niamh Garvey Ciaran McNamee, MHA Administrator.	audit	Achievable	Immediate and Annual audit.

Code of Practice: Admission of Children

Report reference: Page 69

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
27. Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre.	*Reoccurring*	Corrective Action(s): This is not a recognised centre for the admission of children and is not resourced to provide age appropriate services and facilities for child admissions. In a clinical emergency situation if a child is admitted to the department of psychiatry, where possible, we will provide a single bedroom with en-suite facilities attached. Ensure the right of the child to have his or her views heard. Programme of age appropriate activities will be provided by staff. Activity pack will be available in each ward. Our policy on the admission of children will be reviewed Post-holder(s): Dr. N Garvey, Clinical Director Occupational Therapist	Audit on admission of children.	Achievable	April 18
		Preventative Action(s): Audit on admission of children. Post-Holder(s) responsible: Dr Garvey, Clinical Director All Consultants.	Audit on admission of children.	Achievable	Annually

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
28. Child residents did not have access to age-appropriate advocacy services.	*New*	Corrective Action(s): The approved centre is not resourced to provide age appropriate services and facilities for child admissions. This is not a recognised centre for the admission of children. Post-Holder(s) responsible: Clinical Director, All Consultants.	N/A	N/A	N/A
		Preventative Action(s): All children should be admitted to CAMHS services. Post-Holder(s) responsible: Clinical Director All Consultants.	N/A	N/A	N/A

Code of Practice: Notification of Deaths and Incident Reporting (and Regulation 14: Care of the Dying)

Report reference: Page 70 (and page 31)

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
29. The policy did not identify the risk manager. 30. The policy did not specify the roles and responsibilities in relation to the submission of death notification forms to the MHC.	*Reoccurring (#31)*	Corrective Action(s): Policy to be reviewed and updated. In relation to submission of death Notification forms to the MHC it is specified in current policy under procedure. On review will be included under the roles and responsibilities. Post-Holder(s) responsible: Joy John CNM 3	audit	Achievable	April 2018
		Preventative Action(s): Staff will be informed of the updated policy. Yearly audit Post-Holder(s) responsible: Heads of Disciplines	audit	Achievable	April 2018
31. One resident's death was not notified to the MHC within the required 48-hour time frame.	*Reoccurring*	Corrective Action(s): Informed MHC that we were not made aware of Death within the timeframe specified. Post-Holder(s) responsible: Clinical Director, Grade V Administrator	Requested information forwarded to MHC in May 2017	Achievable	Completed
		Preventative Action(s): Daily communication with medical ward when patient is transferred from our care. Post-Holder(s) responsible Nursing staff, Team Consultant	Audit	Achievable	Annually

Code of Practice: Admission, Transfer and Discharge

Report reference: Page 73-74

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
32. The post-discharge follow-up policy did not reference crisis management or include a means of following up and managing missed appointments.	*New*	Corrective Action(s): This policy will have to be reviewed in parallel with community policy on failing to attend community services. Post-Holder(s) responsible: Joy John CNM 3	Audit	Achievable	April 2018
		Preventative Action(s): Policy reviewed as per code of practice and annual audits Post-Holder(s) responsible: Joy John CNM3	Audit	Achievable	April 2018
33. There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.	*New*	Corrective Action(s):audit will be completed within timeframe Post-Holder(s) responsible: CNM III, Assistant DON	Audit	Achievable	April 2018
		Preventative Action(s): annual audit Post-Holder(s) responsible: CNM III, Assistant DON	Audit	Achievable	Annually
34. There was no documentary evidence that all staff had read and understood the	*New*	Corrective Action(s): All staff requested to read and sign that they have read and understood policies Post-Holder(s) responsible: Heads of discipline	Audit	Achievable	Annually

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
policies on admission and transfer.		Preventative Action(s): Maintenance of Signature log on policies Post-Holder(s) responsible: Heads Of Disciplines	Audit	Achievable	Annually