Department of Psychiatry, Connolly Hospital

ID Number: AC0020

2019 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 2018

Conditions Attached:
Yes

Registered Proprietor:
HSE

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

Inspection Team:
Dr Enda Dooley, MCRN 004155, Lead Inspector
Karen McCrohan
Emma Harrington
Susan O'Neill

Inspection Date:
5 – 8 February 2019

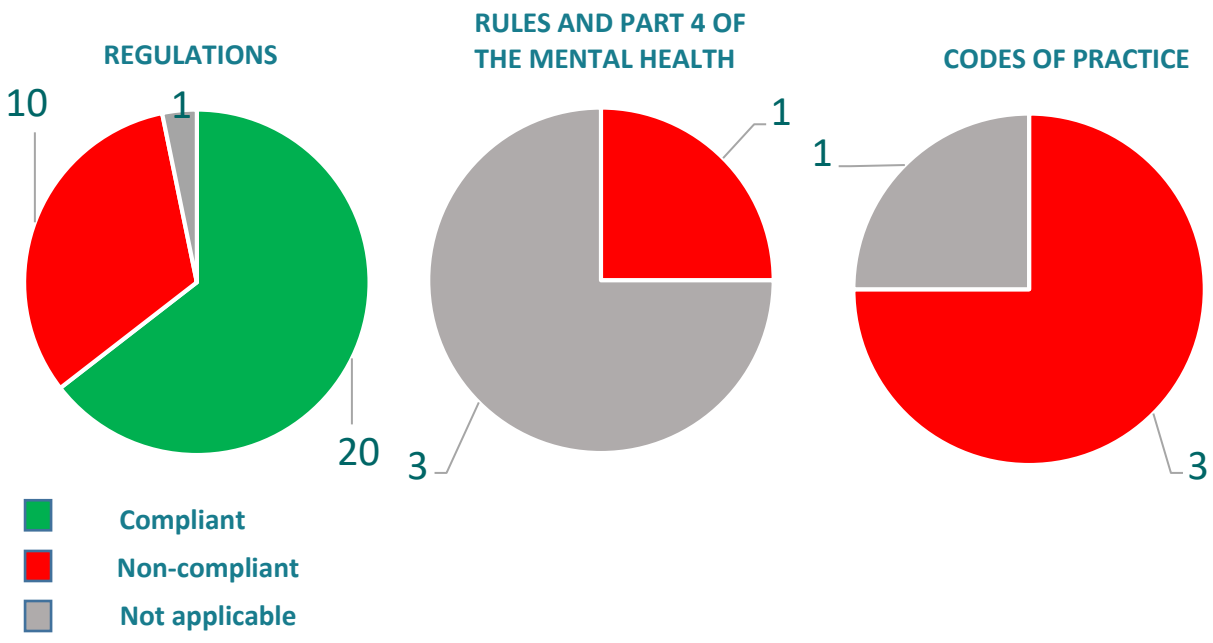
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
7 – 10 August 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
Thursday 1 August 2019

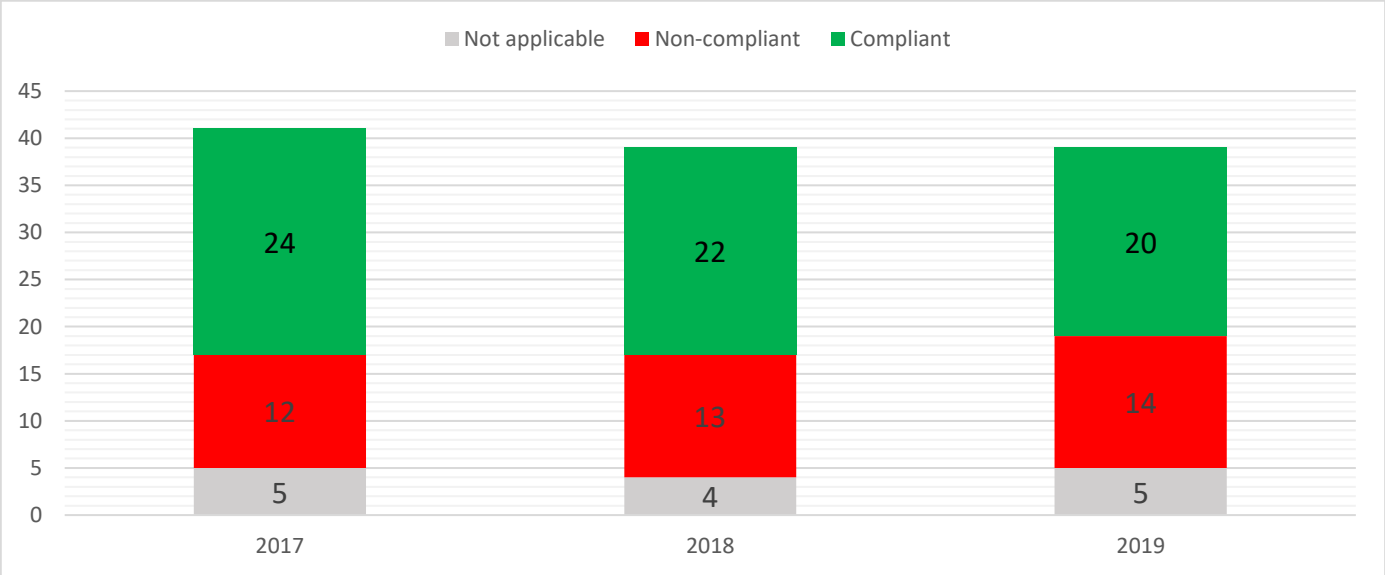
2019 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2019

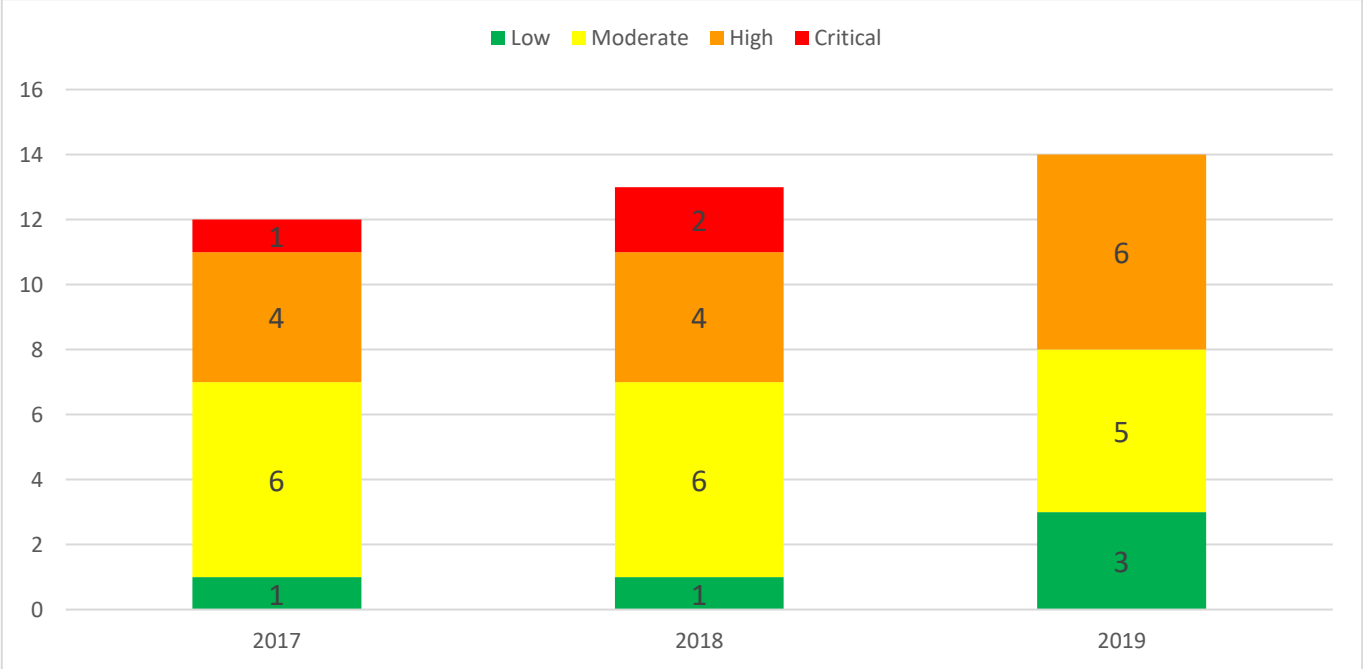
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2017 – 2019



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 2017 – 2019



Contents

1.0 Inspector of Mental Health Services – Review of Findings 4
2.0 Quality Initiatives 10
3.0 Overview of the Approved Centre 11
3.1 Description of approved centre 11
3.2 Governance 11
3.3 Reporting on the National Clinical Guidelines 12
4.0 Compliance 13
4.1 Non-compliant areas on this inspection 13
4.2 Areas of compliance rated “excellent” on this inspection 13
4.3 Areas that were not applicable on this inspection 14
5.0 Service-user Experience 15
6.0 Feedback Meeting 15
7.0 Inspection Findings – Regulations 17
8.0 Inspection Findings – Rules 62
9.0 Inspection Findings – Mental Health Act 2001 65
10.0 Inspection Findings – Codes of Practice 65
Appendix 1: Corrective and Preventative Action Plan 71
Appendix 2: Background to the inspection process 97

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

The Department of Psychiatry (DOP) had 47 beds and was located on the lower ground floor of Connolly Hospital building. The approved centre provided acute in-patient accommodation for the Dublin North City area from Cabra to Mulhuddart. The approved centre was part of the Dublin North City and County Healthcare Organisation (previously CHO 9). Seven consultant led teams admitted residents to the approved centre as well as two rehabilitation teams and a team providing mental health services for the homeless population.

Compliance with regulations, rules and codes of practice had steadily decreased over the past three years from 66% in 2017 to 63% in 2018 and in this 2019 inspection, to 56%. The DOP has been non-compliant with eight regulations, rules and codes of practice for three consecutive years. Six compliances with regulations were rated as excellent.

Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection.

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

Finding on this inspection: The approved centre complied with Condition 1. The approved centre was non-compliant with Regulation 15: Individual Care Plan at the time of inspection.

Condition 2*: To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission*.

Finding on this inspection: The approved centre was due to submit their training plan in April 2019. The approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Safety in the approved centre

There was evidence that there were safe practices in the approved centre:

- At the time of this inspection, the High Dependency Unit was closed for major renovation. Arrangements were in place for residents requiring treatment in conditions of high support to be transferred to another approved centre.
- Residents interviewed stated that they felt safe within the facility.
- Work had been completed to minimise ligature points. A ligature audit had been completed with an action plan to minimise identified risks.
- A plan was implemented to reduce risks to residents while works to the premises were ongoing.
- Individual risk assessments were completed prior to and during resident transfer, discharge, and in conjunction with medication requirements or administration.
- The requirements for the protection of children and vulnerable adults were appropriate and implemented.
- There was an emergency plan that specified responses by staff to possible emergencies, including evacuation procedures.
- Recruitment and retention of staff posed on-going problems. This applied particularly to the medical, nursing, and psychology disciplines.

However:

- Not all staff handling food had up-to-date training in food safety commensurate with their role.
- One medication prescription and administration record (MPAR) did not record the resident's allergies, which had the potential to lead to a serious medication error.
- Medication requiring refrigeration was stored in a dedicated fridge. It was noted, however, that fridge temperature was not logged on a daily basis.
- Within the garden area, there was broken furniture with sharp edges exposed. These were removed during the inspection.
- Not all staff were trained in the mandatory training in fire safety, Basic Life Support, the prevention and management of violence and aggression and the Mental Health Act 2001.

Appropriate care and treatment of residents

- The approved centre had a comprehensive therapeutic occupational therapy programme facilitated by two occupational therapists and one occupational therapist assistant (all three staff members were full-time and based solely in the approved centre). All residents had access to an occupational therapy group and individual sessions.
- All residents had access to a social worker on a one-to-one basis. All residents in Ash ward had access to psychology, with individual and group sessions.
- Residents could access general health services and be referred to other health services. Residents had information on, and could access, appropriate national screening programmes. There was a localised policy on tobacco use and residents were supported to stop smoking.

However:

- The development of individual care plans (ICPs) with the resident was inadequate, despite a condition to their registration in regard to care plans.
    - One ICP was not a composite set of documents.
    - In four cases, ICPs were not developed by the multi-disciplinary team.
    - In one case reviewed, there was a failure to document assessment of medical, psychiatric, or medication history, or assess current medications.
    - In a number of cases, there was no documentary evidence that the resident had been involved in the development of the ICP or in a weekly review of the ICP.
    - In four ICPs reviewed, there was a failure to document appropriate goals for the resident.
    - The resources required to achieve the goals specified were not indicated in three ICPs reviewed.
    - ICPs were not consistently updated.
    - In a number of cases, there was no evidence that the resident had been offered a copy of their ICP.
    - A key worker was identified to ensure continuity in the implementation of each ICP; however, this was not evidenced within the ICP.
- Residents within Pine ward did not have access to psychology, despite an assessed need within individual care plans. The Ash ward psychologist facilitated a 'living well' group once per week. However, this group was not open to residents in Pine ward.
- In three files, there was no evidence that registered medical practitioners assessed residents' general health needs at admission.
- In one episode of seclusion, a medical review of the patient was not undertaken within four hours after the commencement of the episode of seclusion.

Respect for residents' privacy, dignity and autonomy

In some areas there was respect shown for residents' privacy, dignity and autonomy:

- Visiting times were appropriate and reasonable, and were publicly displayed. A separate visitors' area was provided where residents met visitors in private.
- There were no restrictions on communication.
- Resident consent was sought prior to all searches, which was documented. Searches were implemented with due regard to the resident's dignity, privacy, and gender.
- Where residents shared a room, bed screening ensured that their privacy was not compromised and rooms that were overlooked by public areas had opaque glass.
- Seclusion was used in the approved centre but only in rare and exceptional circumstances and in residents' best interests when the resident posed immediate threat of serious harm to self or others. It was only initiated after risk assessment, and after all other interventions to manage resident's unsafe behaviour were considered. The resident was informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion.

However, there were serious breaches of Regulation 21 Privacy:

- Noticeboards in the nurse's station in both units displayed resident names and other information. These boards were visible through glass panelling from outside the nurse's station.
- During the course of the inspection, a list of resident names was observed in the reception area of the unit which was accessible to visitors and non-clinical staff.
- CCTV cameras, which were located within corridor areas of the centre which were accessed by residents, were capable of recording or storing a resident's image. Monitors in the nursing office were viewable by residents and/or members of the public.

Human Rights

There were two breaches of human rights evident in the approved centre at the time of inspection:

1. The staff did not adhere to the Code of Practice when a resident was physically restrained:
    - There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy.
    - In one case, a staff member was not designated to be responsible for leading the physical restraint and monitoring the head and airway of the resident.
    - In no case did a registered medical professional complete a medical examination within three hours of the end of the episode.
    - In two cases, residents were not informed of reasons for, likely duration of, or circumstances leading to discontinuation.
    - In no case was there evidence that each episode was reviewed by members of the multi-disciplinary team and documented within two working days.

2. The right to privacy was not upheld in the approved centre:
    - CCTV cameras, which were located within corridor areas of the centre which were accessed by residents, were capable of recording or storing a resident's image. Monitors in the nursing office were viewable by residents and/or members of the public.
    - Noticeboards in the nurse's station in both units displayed resident names and other information. These boards were visible through glass panelling from outside the nurse's station.
    - During the course of the inspection, a list of resident names was observed in the reception area of the unit which was accessible to visitors and non-clinical staff.

Responsiveness to residents' needs

- The dietitian approved menus to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, which was presented in an attractive and appealing manner. Residents had at least two meal choices.

- Rooms were well heated and ventilated. There was a cleaning schedule and the approved centre was clean.
- Information about the approved centre and residents' diagnosis and medications were available for each resident and there was a good responsive complaints process in place.
- The approved centre provided excellent access to recreational activities throughout the week appropriate to the resident group profile, with recreational rooms with board games, books and art supplies freely accessible. There was access to a pool table, a garden, and an art room. A fitness instructor ran a fitness group once a week.

However:

- There was only one TV room on Ash Unit with 11 seats. As the only TV room on the unit, this room was not appropriately sized for the number of residents on the unit.
- Communal areas on both Ash and Pine wards were small and inadequate to accommodate all the residents.
- The courtyard garden had a lot of cigarette butts and broken furniture.
- Residents felt that there was a lack of constructive activities available on the ward, particularly for those residents who were unable to go to the Occupational Therapy department.

Governance of the approved centre

- The approved centre was part of Dublin North City and County Community Healthcare Organisation. Governance and Management processes were incorporated within the overall governance procedures for the organisation.
- A separate Quality and Safety Committee met monthly to consider issues relating to risk management, policy development, and incident review.
- The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy.
- Incidents were recorded and risk-rated in a standardised format. The designated risk manager reviewed incidents for any trends or patterns occurring in the services, and clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of that review and recommended actions.
- The approved centre's policies were reviewed and updated with input from both clinical and managerial staff in consultation with other stakeholders. All operating policies required by the regulations had been reviewed within the last three years.

However:

- There were failures in clinical governance in that compliance with regulatory requirements showed disimprovement. There was no evidence that this was considered a serious risk or that actions were in place to address this.

2.0 Quality Initiatives

The following quality initiatives, which were introduced since the previous inspection, were identified on this inspection:

1. Electrocardiogram training for nursing staff.

2. Phlebotomy training for nursing staff.

3. An Exploring Lifestyle Changes group had been developed and initiated by the Occupational Therapy Department.

4. New bedside chairs had been provided.

5. A Physical Restraint bundle had been developed and was in the process of being introduced.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry (DOP) was located on the lower ground floor of the main hospital building. The approved centre provided acute in-patient accommodation for the Dublin North City area from Cabra to Mulhuddart. The approved centre was part of the Dublin North City and County Healthcare Organisation (previously CHO 9). A total of seven consultant led teams based in four catchment areas admitted residents to the approved centre. In addition, two rehabilitation teams and a team dealing with the homeless population also admitted to the centre.

The DOP consisted of a long reception corridor with adjacent offices, tribunal room, and family visiting room. Resident accommodation was on two wards, Ash and Pine, located off the reception corridor. The unit Occupational Therapy Department was located on a separate corridor off the main reception area. Both Ash and Pine Wards had accommodation for 21 residents. A High Dependency Unit (HDU) with accommodation for up to five residents, incorporating a seclusion room, was attached to Ash ward. At the time of this inspection, the HDU was closed for major renovation. Arrangements were in place for residents requiring treatment in conditions of high support to be transferred to another approved centre.

Resident accommodation on both Ash and Pine wards consisted of a mix of single rooms (two), double rooms (three), four-bedded rooms (two), and a five-bedded room. All bedrooms were en suite and all bathrooms had been renovated over the last two years. Both wards shared a large, paved outdoor space which lacked any greenery. Communal areas on both Ash and Pine wards were small and inadequate to accommodate the whole population.

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

Resident Profile	
Number of registered beds	***42 (5 temporarily closed)***
Total number of residents	**36**
Number of detained patients	10
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Dublin North City and County Community Healthcare Organisation. Governance and Management processes were incorporated within the overall governance procedures for the organisation. Regular monthly Management Meetings occurred at which a variety of issues pertinent to the approved centre such as finance, recruitment and retention of staff, staff training, and service development were discussed. A separate Quality and Safety Committee met monthly to consider issues

relating to risk management, policy development, and incident review. Copies of the minutes of both these committees were provided to the inspectors and these indicated an active governance process relating to the approved centre.

Meetings with heads of clinical disciplines outlined both specific and more general risks together with support and supervision processes. In particular, recruitment and retention of staff posed on-going problems. This applied particularly to the medical, nursing, and psychology disciplines. There is currently no approved psychology position to service the needs of patients on Pine ward requiring such supports. Particular concerns were expressed at the effect of increasing levels of homelessness within the catchment area, and particularly affecting those with mental health difficulties, on protracting length of stay for social rather than specifically mental health issues.

The approved centre's policies were reviewed and updated with input from both clinical and managerial staff in consultation, as appropriate, with other stakeholders. All operating policies required by the regulations had been reviewed within the last three years.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2018 and 2017 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2017		Compliance/Risk Rating 2018		Compliance/Risk Rating 2019	
Regulation 13: Searches	✓		X	Moderate	X	Moderate
Regulation 15: Individual Care Plan	X	High	X	High	X	High
Regulation 16: Therapeutic Services and Programmes	✓		✓		X	Moderate
Regulation 19: General Health	✓		X	High	X	High
Regulation 21: Privacy	✓		X	Moderate	X	High
Regulation 22: Premises	X	Moderate	X	High	X	Low
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	X	High	X	Moderate	X	High
Regulation 25: Use of Closed Circuit Television	✓		✓		X	Low
Regulation 26: Staffing	X	Moderate	X	Moderate	X	Moderate
Regulation 27: Maintenance of Records	X	High	X	High	X	High
Rules Governing the Use of Seclusion	X	Moderate	X	Critical	X	Low
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		X	Critical	X	High
Code of Practice Relating to the Admission of Children	X	Moderate	X	Moderate	X	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	X	Low	X	Moderate	X	Moderate

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

4.2 Areas of compliance rated "excellent" on this inspection

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 30: Mental Health Tribunals

4.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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

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

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

Six residents met with the inspectors and provided background on their experience since admission to the approved centre. Most residents expressed satisfaction regarding the quality of care and support they received from staff. In general, residents were satisfied with the food. Residents felt that there was a lack of constructive activities available on the ward, particularly for those residents who were unable to go to the Occupational Therapy department. Residents felt safe within the facility. One resident expressed concern regarding the suitability of the disabled bathroom facilities, which had been recently installed.

6.0 Feedback Meeting

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

- Head of Service, Mental Health
- General Manager, Mental Health
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Service Manager, Mental Health
- Occupational Therapy Manager
- Senior Psychologist
- Principal Social Worker
- Acting Assistant Director Of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The service acknowledged the conditions currently applying and indicated a priority in addressing the various deficits identified as quickly as possible.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre used a minimum of two resident identifiers, which were appropriate to the resident group profile and individual needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Identifiers were appropriate to the residents' communication abilities and were person specific. A system alerted staff to residents with the same, or similar, names.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The dietitian approved menus to ensure nutritional adequacy in accordance with residents' needs. Residents were provided with a variety of wholesome and nutritious food, which was presented in an attractive and appealing manner. Residents had at least two meal choices, including daily hot meals. Residents had access to safe, fresh drinking water and hot and cold drinks were provided.

For residents with special dietary needs, their needs were assessed and addressed in residents' individual care plans, if needed. These needs were regularly reviewed by a dietitian. Residents and their representatives were educated about resident diets and their interaction with medication. An evidence-based nutrition assessment tool was not used. Intake and output charts were maintained where appropriate.

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

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. Not all staff handling food had up-to-date training in food safety commensurate with their role. For those who had been trained this was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

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

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

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

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

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 **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents were entitled to bring personal possessions to the approved centre. Resident property checklists were compiled on admission. Checklists for valuables were updated on an ongoing basis. Checklists were kept separate from residents' individual care plans (ICP) and were available to residents. Where the approved centre assumed responsibility for a resident's personal property and possessions, they were safeguarded appropriately. Secure facilities were provided for the safekeeping of the residents' personal property. However, the resident safe was only accessible for three periods during the day.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Residents were allowed their mobile phone; however, they were only allowed their phone chargers for allocated periods during the day. Access to, and use of, resident monies was overseen by one staff member and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained and where possible counter-signed by the resident or their representative.

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

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

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. Both units had a recreational room with board games, books, art supplies freely accessible, and space for residents to sit. There was one TV room within Ash Unit and two TV rooms within Pine Unit. There was a large open courtyard accessible from the recreation rooms in both units. Residents could also attend the occupational therapy area where they had access to a pool table, a garden, and an art room. Activities were provided throughout the week, with indoor and outdoor exercise opportunities provided. A fitness instructor ran a fitness group once a week within the occupational therapy area. The occupational therapist reported that this was developed after feedback from residents. An information sheet was available to residents with outside leave of the local activities such as the local park for walks. The recreational activities were appropriately resourced. Communal areas were provided that were suitable for recreational activities.

Information was provided to residents on the types and frequency of activities in an accessible format on the notice board in both units and within the occupational therapy area. Individual risk assessments were completed to help select activities. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. A meeting was held with residents every six weeks to gather feedback on programs and get suggestions for improvements. Action plans were drawn up based on the feedback received. Residents were free to choose whether to participate and their decisions were respected and documented. Logs of participation were maintained for recreational activities. The occupational therapist attended the multi-disciplinary meetings on the units to provide input on residents' uptake of recreational activities.

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. The policy included all/did not include any of the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation of the policy to support residents' religious practices was reviewed to ensure that it reflected the identified needs of residents. This was documented.

Evidence of Implementation: Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. Religious beliefs were assessed on admission. Facilities were provided within the approved centre for residents' religious practices and residents were supported to attend local religious services, if appropriate. Residents could use the oratory in the main hospital. Residents also had access to multi-faith chaplains. Care and services were respectful of the residents' religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate and reasonable, and were publicly displayed. A separate visitors' area was provided where residents met visitors in private, if appropriate. The visiting area was suitable for visiting children, with children's toys available in the visiting room. Children visiting were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents had access to mail, fax, internet, and telephone. A ward telephone was present on both units and was free to use. Nursing staff could dial and receive calls at the nurse's station and channel through to this phone. A computer was available in the occupational therapy department. Residents could use this under supervision only.

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches, which was last reviewed in June 2017. The policy and procedures addressed requirements of the *Judgement Support Framework*, including the following:

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

The policy did not outline the consent requirements of a resident regarding searches. The policy did not reference the considerations to be provided to residents in relation to their dignity and privacy during searches.

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

Monitoring: A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had not been completed to identify ways of improving search processes.

Evidence of Implementation: Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. Risk was assessed prior to a search of a resident or their property. Resident consent was sought prior to all searches, which was documented. Where consent was not received, the process relating to searches without consent was implemented. The

resident search policy and procedure was communicated to all residents. Staff informed residents of what was happening during a search and why.

At least two clinical staff were in attendance at all times when searches were conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched.

Documentation and recording of searches undertaken was inconsistent. While a record of every search of a resident or property was available in the search log, this failed to provide a traceable identification of the resident being searched (contrary to the requirements specified in the log). Documentation in the contemporary clinical record of searches undertaken was inconsistent.

The approved centre was non-compliant with this regulation because the written record of searches undertaken did not clearly identify the resident involved, 13 (9).

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying, which was last reviewed in May 2018. The policy and protocols included the requirements of the *Judgement Support Framework* with the exception of the process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred somewhere else (e.g. for general health care services).

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

Monitoring: Documented analysis had not been completed to identify opportunities for improving the processes relating to care of the dying.

There had been one death since the last inspection. As it was not an expected death and the death of the resident did not occur in the approved centre, this regulation was only assessed against the processes, training and education, and monitoring pillars.

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

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

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

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

Evidence of Implementation: Ten ICPs were reviewed on inspection. Most residents were initially assessed at admission and an ICP was completed to address his or her immediate needs. However, one resident's file did not contain an initial ICP, and two residents had an initial ICP, but it did not contain any documented goals. One ICP was not a composite set of documents, as it contained two ICP booklets and did not contain any dates.

In four cases, ICPs were not developed by an MDT following a comprehensive assessment within seven days of admission. In one case reviewed, there was a failure to document assessment of medical, psychiatric, or medication history, or assess current medications.

In a number of cases, there was no documentary evidence that the resident had been involved in the development of the ICP or had been involved in a weekly review of the ICP. In four ICPs reviewed, there was a failure to document appropriate goals for the resident. The resources required to achieve the goals specified were not indicated in three ICPs reviewed. ICPs were not consistently updated by the MDT in consultation with eh resident, and in a number of cases, there was no evidence that the resident had been offered a copy of their ICP.

Each ICP was stored in the clinical file and was identifiable and uninterrupted. ICPs included a risk management plan. A key worker was identified to ensure continuity in the implementation of each ICP; however, this was not evidenced within the ICP. Evidence-based assessments were used where possible.

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

a) **Four ICPs were not in place within seven days.**
b) **One resident's ICP was not a composite set of documents.**
c) **ICPs did not consistently document appropriate goals and resources.**
d) **ICPs were not consistently reviewed and updated by the resident's MDT.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Therapeutic programmes and services were appropriate and met the assessed needs of residents, as documented in their individual care plans (ICP). Programmes and services were aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Programmes and services were evidence-based.

The approved centre had a comprehensive therapeutic occupational therapy programme facilitated by two occupational therapists and one occupational therapist assistant (all three staff members were fulltime and based solely in the approved centre). The occupational therapy department was resourced with a weekly petty cash fund. Therapeutic groups included basic cooking group, craft group, animal assisted therapy, smoothie making group, meal planning, gardening group, exploring lifestyle changes group, exercise group, cookery group, and a leisure group. The exercise group was co-facilitated by a fitness instructor. All residents had access to an occupational therapy group and individual sessions.

All residents had access to a social worker on a one-to-one basis. All residents in Ash ward had access to psychology, with individual and group sessions. However, residents within Pine ward did not have access to psychology, despite an assessed need within individual care plans. The Ash ward psychologist facilitated a 'living well' group once per week. However, this group was not open to residents within the Pine ward.

Services were provided in a separate dedicated room containing facilities and space for individual and group therapies. Where no internal service existed, an appropriate external service with an approved, qualified health professional was found.

A list of services and programmes provided in the approved centre was available to residents. A record was maintained of participation, engagement, and outcomes achieved through the therapeutic programme in residents' ICPs or clinical files.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16 (1).

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents. The policy was last reviewed in March 2018. The policy addressed requirements of the *Judgement Support Framework*, but did not outline the criteria for transfer.

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

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

Evidence of Implementation: An assessment of the resident was completed and documented prior to transfers, including an individual risk assessment. Verbal communication and liaison took place between the approved centre and the receiving facility prior to transfers, and included a discussion of the reasons for transfer, care and treatment plans, and the resident's accompaniment requirements. Complete written information was sent to a named individual in the receiving centre in advance of the transfer. The information accompanied the resident upon transfer. Information included a letter of referral, medication requirements, and a transfer form. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred.

Communications between the approved centre and receiving facility were documented and followed up with a written referral where there were emergency transfers. Documented consent from the resident was available, or justification as to why consent was not received. Communication records with the receiving facility were documented and available on inspection. Copies of all records relevant to the resident transfer were retained in the resident's clinical file.

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

Regulation 19: General Health

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in June 2017. The medical emergencies policy was last reviewed in June 2017. The policies and procedures included the requirements of the *Judgement Support Framework,* with the following exceptions:

- The resource requirements for general health services, including equipment needs.
- Access to national screening programmes available for residents 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. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

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

Evidence of Implementation: Nine clinical files were reviewed on inspection. Residents received appropriate general health care interventions in line with their individual care plans. In three files, there was no evidence that registered medical practitioners assessed residents' general health needs at admission as part of the approved centre's provision of care. The reason for this was not documented. There was one resident who had been admitted for over six months. A six monthly general health assessment had not been completed on this resident due to refusal by the patient. It was, however, documented by the medical practitioner why it had not been completed. The patient had had various incremental assessments undertaken, including assessment of weight, blood pressure, smoking and nutritional status, glucose regulation, blood lipids, an electro-cardiogram exam, and a medication and dental review.

Residents could access general health services and be referred to other health services. Residents had information on, and could access, appropriate national screening programmes, including breast check, cervical screening, retinal checks (if appropriate), and bowel screening. There was a localised policy on tobacco use and residents were supported to stop smoking. Residents' completed general health checks

and associated results were recorded. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator. Both were checked weekly.

The approved centre was non-compliant with this regulation because not all residents' general health needs were assessed regularly and, particularly, on admission, 1(b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents. The policy was last reviewed in June 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: An information booklet was provided to residents and their representatives at admission in the required format. The booklet was clearly and simply written, and outlined the required information on care, services, and housekeeping practices, including arrangements for personal property, mealtimes, visiting times, and visiting arrangements, the complaints procedure, relevant advocacy and voluntary agencies, residents' rights, and details of the multi-disciplinary team.

A variety of diagnosis and medication-related information, including risks and potential side effects, was available and provided to residents as appropriate. Information included evidence-based information about diagnosis, unless the provision of such information would be detrimental to a resident's health and well-being. The justification for restricting information was documented. Information was accessible and residents had access to interpretation and translation services as required. Information documents provided by or within the approved centre were not appropriately reviewed or approved prior to use. The *Your Choice Your Medication* website was used for medication information, but diagnosis information was not reviewed and was not approved prior to use.

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

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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 March 2018. The policy addressed requirements of the *Judgement Support Framework*, but did not outline the method for identifying and ensuring, where possible, the resident's privacy and dignity expectations and preferences.

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

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

Evidence of Implementation: Staff had an appropriate demeanour and dressed appropriately. Staff communicated with residents appropriately, used discretion when discussing medical conditions or treatment, and used residents' preferred names. Staff sought the resident's permission before entering their room. All bathrooms, showers, toilets, and single bedrooms had locks with an override function on the inside of the door, unless there was an identified risk to a resident. All residents were wearing clothes that respected their privacy and dignity. Residents were facilitated to make private phone calls.

Where residents shared a room, bed screening ensured that their privacy was not compromised. Shared rooms did not have blinds on door observation panels; however, each bed had a curtain to maintain privacy. Rooms that were overlooked by public areas had opaque glass. Noticeboards in the nurse's station in both units displayed resident names and other information. These boards were visible through glass panelling from outside the nurse's station.

During the course of the inspection a list of resident names was observed in the reception area of the unit which was accessible to visitors and non-clinical staff.

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

a) **Residents' privacy and dignity was not appropriately respected, as notice boards in Ash and Pine Units displayed identifiable resident information, (21).**
b) **Residents' privacy was not appropriately respected, as documents displaying identifiable resident information were observed outside private clinical areas, (21).**

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Residents had access to personal space and room to move about. There were suitable furnishings to assist resident independence and comfort. A hoist was available and there was an assisted bathroom; however, the new equipment was difficult to use. There were enough toilets and showers, which were appropriately placed and identified. There was a sluice room, cleaning room, and dedicated therapy room. There was no laundry room, and laundry was completed offsite. However, there was only one TV room on Ash Unit with 11 seats. As the only TV room on the unit, this room was not appropriately sized for the number of residents on the unit. Pine Unit had two TV rooms. The courtyard was appropriately sized.

Rooms were well heated and ventilated. Heating could be changed in individual resident rooms. The approved centre had adequate lighting, appropriate signage and sensory aids, and no excessive noise was noted. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Within the garden area, there was broken furniture with sharp edges exposed. These were removed during the inspection. There was a cleaning

schedule and the approved centre was clean and hygienic. Current national infection control guidelines were followed.

The approved centre was not kept in a good state of repair, as the courtyard garden had a lot of cigarette butts and broken furniture. There was a regular programme of general maintenance. Maintenance and faults were recorded and communicated appropriately. The approved centre had access to back-up power.

It was clear work had been completed to minimise ligature points. A ligature audit had been completed with an action plan to minimise identified risks; however, there was no evidence of how this action plan was being monitored and who was responsible to ensure it was completed. Where substantial changes were required to the premises, this was appropriately assessed for possible impact on current residents and staff. The Mental Health Commission was informed prior to the commencement of works. Remote or isolated areas were monitored.

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

a) **The approved centre did not have an appropriately sized communal television room having regard to the number and mix of residents, 22 (2).**
b) **Hazards were present; this signified that the overall approved centre environment was not maintained with due regard to the specific needs of residents and their safety and well-being, 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 series of written policies in relation to the ordering, storing, prescribing, and administration of medication:

- Ordering, prescribing, storing, and administration of medicines policy, which was last reviewed in June 2017.
- Nursing Medication Management policy, which was last reviewed in January 2015.
- Multidisciplinary Medication Management Policy, which was last reviewed in January 2009.
- Multidisciplinary Medication Management Policy, which was last reviewed in November 2009.

The policies included the requirements of the *Judgement Support Framework* with the exception of the processes for medication management at admission, transfer, and discharge.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Ten MPARs were reviewed on inspection. All entries were legible, written in black, indelible ink, and used two appropriate identifiers. MPARs had dedicated space for routine, once-off, and "as-required" medications. A record of the dose, frequency, administration route, date of initiation, and generic and full name. MPARs included the Medical Council Registration Number of every medical practitioner prescribing medication, and MPARs were signed by the medical practitioner after each entry. It was noted, however, that one MPAR did not record the resident's allergies. In two cases, the MPARs did not have a record of all medications administered to the resident. In three MPARs, the discontinuation dates of all medications were not documented.

All medicines were administered by a registered nurse or medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber and pharmacist's advice. The expiration date of medication was checked prior to administration; expired medications were not administered. Good hand-hygiene techniques were implemented during the administering of medications. Schedule 2

controlled drugs were checked by two staff members, including one registered nurse, against the delivery form. Details were entered on the controlled drug book and signed by both staff members. The controlled drug balance corresponded with the balance recorded in the controlled drug book.

When a resident's medication was withheld, the justification was noted in the MPAR and documented in a clinical file. Where residents refused medication, this was documented in the MPAR and clinical file, and communicated to medical staff.

Medication was stored in an appropriate environment. Medication storage areas were clean, and free from damp, mould, litter, dust, pests, spillage or breakage. Food and drink was not stored in areas used for medication storage. Medication storage areas were incorporated in the cleaning and housekeeping schedules.

Medication dispensed or supplied to residents was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication trolley and medication administration cupboard were locked at all times and secured in a locked room. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security. Medication requiring refrigeration was stored in a dedicated fridge. It was noted, however, that fridge temperature was not logged on a daily basis.

Medication was reviewed and rewritten at least six-monthly, or more frequently as appropriate; this was documented in clinical files. Medical practitioners rewrote prescriptions where alteration was required. The pharmacist implemented a system of stock rotation and completed a weekly inventory of medications. Medications that were no longer required or were past their expiry date were appropriately and returned to the pharmacy for disposal.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to prescribing and storing of medicines to residents.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety of residents, staff, and visitors, which was last reviewed in June 2017. The policy and safety statement addressed requirements of the *Judgement Support Framework*, but did not outline specific roles to be allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.

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

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

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and protocols in relation to the use of CCTV. The policy was last reviewed in March 2018. The policy addressed requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre. The policy did not outline requirement to disclose the existence and usage of CCTV or other monitoring devices 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.

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

Monitoring: The quality of the CCTV images was checked regularly to ensure that the equipment was operating appropriately. This was documented. Analysis had been completed to identify opportunities for improving the processes relating to the use of CCTV.

Evidence of Implementation: There were clear signs in prominent positions where CCTV cameras (or other monitoring systems) were located. Residents were not only monitored for the purposes of ensuring their health, safety, and welfare. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. CCTV cameras, which were located within corridor areas of the centre which were accessed by residents, were capable of recording or storing a resident's image. CCTV cameras transmitted images other than to a monitor that was viewed solely by the health professional responsible for the resident. Monitors in the nursing office were viewable by residents and/or members of the public. The usage of CCTV was disclosed to the Mental Health Commission.

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

a) **The use of closed circuit television was not solely for the purpose of observing a resident by a health professional, 25 (1)(a).**
b) **The closed circuit television used was capable of recording or storing a resident's image, 25 (1)(d).**

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

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

- The organisational structure of the approved centre, including lines of responsibility.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

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

Evidence of Implementation: The numbers and skill mix of staffing were sufficient to meet resident needs. Staff were recruited and vetted in accordance with the approved centre's policy and procedure. Staff had the appropriate qualifications to do their job. The required number of staff were on duty at night to ensure safety of residents in the event of a fire or other emergency. A planned and actual staff rota was maintained and an appropriately qualified staff member was on duty and in charge at all times; this was documented. There was no organisational chart to identify the leadership, management structure, and lines of authority and accountability. Where agency staff were used, there was a comprehensive contract between the approved centre and registered/licensed staffing agency, which set out the vetting requirements for potential staff.

There was not a written staffing plan. Annual staff training plans had been completed to identify required training and skills development. New staff completed orientation and induction training. All staff were trained in Children First. However, not all health care professionals were trained in fire safety, Basic Life Support, management of violence and aggression, and the Mental Health Act 2001. Relevant staff had

received other training, including manual handling, infection control and prevention, and risk management.

Opportunities were made available and communicated to staff, and staff were supported to undertake further education. In-service training was completed by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training.

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

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (55)	31	56%	41	75%	37	67%	21	38%	55	100%
Medical (35)	16	54%	5	14%	11	31%	10	29%	31	89%
Occupational Therapist (3)	n/a	0%	3	100%	3	100%	3	100%	3	100%
Social Worker (6)	5	83%	2	33%	1	17%	6	100%	6	100%
Psychologist (1)	0	0%	1	100%	1	100%	1	100%	1	100%

There was a CNM3 overseeing the management of the approved centre during the day and an A/CNM3 by night. The following is a table of clinical staff assigned to the approved centre:

Ward or Unit	Staff Grade	Day	Night
	CNM2	1	-
	RPN	4	3
	HCA	1	-
Ash Ward	Occupational Therapist	2 (shared)	-
	OT Assistant	1 (shared)	-
	Social Worker	By arrangement	-
	Psychologist	By arrangement	-

Ward or Unit	Staff Grade	Day	Night
	CNM2	1	-
	RPN	4	3
	HCA	1	-
Pine Ward	Occupational Therapist	2 (shared)	-
	OT Assistant	1 (shared)	-
	Social Worker	By arrangement	-
	Psychologist	By arrangement	-

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

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

a) Not all staff had up-to-date training in Fire Safety, Basic Life Support, Professional Management of Aggression and Violence, 26 (4).
b) Not all staff had up-to-date training in the Mental Health Act 2001, 26 (5).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: The approved centre maintained a record for every resident who was assessed or provided with care. Records were held securely and were up to date. Only authorised staff could access data and make new entries, and residents' could access records in line with relevant legislation. Staff had access to the information needed to carry out their job.

Records were factual and consistent, written legibly in indelible black ink, reflecting the residents' current status, and signed appropriately. File entries did not document the time of entry. It was noted that none of the files used two appropriate identifiers on each page, with pages either having no or one identifier. Two files were observed to have loose pages. Where errors were made, they were not properly corrected. This was seen across all files inspected.

The approved centre also maintained a record of signatures used in resident record. Where a member of staff made a referral, or consulted with a colleague, this person was clearly identified by their full name and title. Information or advice was given over the phone was documented.

Documentation of food safety, health and safety, and fire inspections was maintained. Records were retained or destroyed in accordance with legislative requirements.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness and accuracy. Records were not kept in good order, 27(1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in April 2018. 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 had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

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

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately formatted, approved, and communicated to all relevant staff. Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained but removed from access by staff.

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 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in April 2017. The policy and procedures included all of the requirements of the *Judgement Support Framework*.

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

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

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

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

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in May 2018. The policy and procedures addressed requirements of the *Judgement Support Framework*, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre. The policy and procedures did not address the communication of the complaints policy and procedure with residents, their representatives, family and next of kin, and visitors.

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

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

Evidence of Implementation: Residents and their representatives were provided with information on the complaints process, with information being well publicised and accessible. Residents and their representatives were assisted to make complaints using appropriate methods and were facilitated to access an advocate. There was a nominated complaints officer who was responsible for dealing with complaints, who was clearly identified. There was also a method for addressing minor complaints. Where services, care, or treatment were provided on behalf of the approved centre by an external party, the nominated person was responsible for the full implementation of the approved centre's complaints management process.

All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and informed promptly of the outcome and details of the appeals process. The complaints officer maintained a log for complaints they dealt with, including complete details of the complaint, investigation, and outcomes. This was kept distinct from the resident's individual care plan.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected because of the complaint being made. All information obtained in the complaints process was treated confidentially, consistent with relevant legislation.

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 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 written policy in relation to risk management and incident management procedures:

- Clinical Risk Assessment and Management Policy, which was last reviewed in May 2017.
- Additional Risk Management Procedures Policy, which was last reviewed in April 2017.
- Incident Reporting and Management Policy, which was last reviewed in May 2017.
- Leave Policy, which was last reviewed in April 2017.
- Psychiatric Emergency Policy, which was last reviewed in June 2017.

The policy addressed requirements of the *Judgement Support Framework*, including the following:

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

The policy did not address the following:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

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

Evidence of Implementation: The risk management procedures did not actively reduced identified risks to the lowest practicable level of risk. Review and implementation of the risk register and ligature audits had assisted in reducing risks to the lowest practicable level. Nevertheless, ligature risks have not yet been excluded, for example window blind fittings throughout the approved centre. Clinical, corporate, and health and safety risks were identified, assessed, monitored, and documented in risk registers. Structural risks, including ligature points, were removed or effectively mitigated. A plan was implemented to reduce risks to residents while works to the premises were ongoing. The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management processes.

Individual risk assessments were completed prior to and during resident transfer, discharge, and in conjunction with medication requirements or administration. Multi-disciplinary teams, residents, and their representatives were involved in the development, implementation, and review of individual risk management processes.

Incidents were recorded and risk-rated in a standardised format. The designated risk manager reviewed incidents for any trends or patterns occurring in the services, and clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of that review and recommended actions. The Mental Health Commission was provided with a six-monthly summary report of all incidents, with information anonymised at a resident level.

The requirements for the protection of children and vulnerable adults were appropriate and implemented. There was an emergency plan that specified responses by staff to possible emergencies, including evacuation procedures.

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

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with no conditions to registration attached. The certificate was displayed prominently at the entrance of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating **LOW**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated April 2018. The approved centre had separate written policies in relation to the use of seclusion, the training of staff in relation to the use of seclusion, and the use of CCTV for observing residents in seclusion.

The policy addressed the following:

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

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

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Three episodes of seclusion (which had occurred prior to the closure of the seclusion room in November 2018) were reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests, when the resident posed immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage resident's unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner or nurse. A consultant psychiatrist was notified as soon as practicable of the use of seclusion. Seclusion orders did not last longer than eight hours. The resident was informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion. Residents were informed of the ending of an episode of seclusion; this was recorded. Cultural awareness and gender sensitivity was demonstrated. Residents' clothing and searches respected their right to dignity, bodily integrity, and privacy.

A registered nurse undertook direct observation for the first hour following the initiation of a seclusion episode, with continuous observation thereafter. A written record of the seclusion episode was made by a nurse every 15 minutes, including level of distress and behaviour. During this review, at least two staff entered the seclusion room. In one case, a medical review of the patient was not undertaken within four hours after the commencement of the episode of seclusion.

The seclusion initiation was recorded in a clinical file and seclusion register by the person who initiated seclusion. The seclusion register was signed by responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. The reason for ending seclusion was recorded in clinical files. A copy of the seclusion register placed in clinical file. In two episodes of seclusion, the episode was not reviewed and documented by members of the multi-disciplinary team and documented in the clinical file within two working days.

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

a) **In one episode of seclusion, a medical review of the patient was not undertaken within four hours after the commencement of the episode of seclusion, 3.3(c).**
b) **In two episodes of seclusion, the episode was not reviewed and documented by members of the multi-disciplinary team and documented in the clinical file within two working days, (10.3).**
c) **Not all staff had signed the written record to indicate that they had read and understood the policy, 10.2(b).**

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of The Mental Health Act 2001 Consent to Treatment was not applicable to this approved centre. Please see *Section 4.3 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

Use of Physical Restraint

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated April 2018. It addressed the following:

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

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

Monitoring: An annual report on the use of physical restraint in the approved centre had/had not been completed.

Evidence of Implementation: Three episodes of physical restraint were reviewed on inspection. In all cases, physical restraint was used in rare, exceptional circumstances, and in the best interests of the resident. Physical restraint was only exercised where a resident posed immediate threat of serious harm to self or others, after all alternative interventions had been considered, and based on a risk assessment. Orders for physical restraint did not last for longer than 30 minutes.

Physical restraint was initiated by an appropriate health professional in line with the physical restraint policy. In one case, there was no evidence that a staff member was designated to be responsible for leading the physical restraint and monitoring the head and airway of the resident.

In none of the cases reviewed was there documentary evidence that a registered medical professional complete a medical examination within three hours of the end of the episode. Similarly, in the three cases reviewed there was no documented evidence that each episode was reviewed by members of the multi-disciplinary team (MDT) within two working days. In one case, the resident did not have the opportunity to speak with the MDT about the episode.

The consultant psychiatrist or duty consultant psychiatrist was notified as soon as was practicable. This was documented. Cultural awareness and gender sensitivity was demonstrated. A same sex staff member was present at all times during physical restraint where practicable. In two cases, there was no evidence that residents were informed of reasons for, likely duration of, or circumstances leading to discontinuation.

Each episode of physical restraint was documented in a clinical file. A clinical practice form was completed by the initiator of physical restraint within three hours. That form was signed by a clinical psychiatrist within 24 hours and placed into the resident's clinical file.

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

a) **There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy 9.2(b).**
b) **In one case, there was no evidence that a staff member was designated to be responsible for leading the physical restraint and monitoring the head and airway of the resident.**
c) **In no case did a registered medical professional completed a medical examination within three hours of the end of the episode, 5.4.**
d) **In two cases, there was no evidence that residents were informed of reasons for, likely duration of, or circumstances leading to discontinuation, 5.8.**
e) **In no case was there evidence that each episode was reviewed by members of the multi-disciplinary team and documented within two working days, 7.2.**
f) **In one case, the resident did not have the opportunity to speak with the MDT about the episode, 9.3.**

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 a child, which was last reviewed in April 2017. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

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

Evidence of Implementation: Age-appropriate facilities and a programme of activities were not provided by the approved centre. Provisions were in in place to ensure the safety of the child, respond to child's special needs as a young person in an adult setting, and to ensure the right of the child to have his/her views heard. Children were nursed in a separate area to adults.

Children had their rights explained and information about the ward and facilities provided in an understandable way; this was recorded. Children did not have access to child advocacy services. Consent for treatment was obtained from one or both parents.

Appropriate visiting arrangements and accommodation was provided, including age- and gender-segregated sleeping and bathroom areas. The resident was nurse alone within the HDU area of the unit. Observation arrangements, including assignment of designated staff member, was provided as considered clinically appropriate and respected gender sensitivity.

Advice from the Child and Adolescent Mental Health Service was available. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. The Commission was notified of children admitted to approved centres for adults within 72 hours of admission using the associated notification form. Staff having contact with the child had undergone Garda vetting.

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 of child admission were not provided, 2.5 (b).**
b) **Child admissions did not have access to age-appropriate advocacy services, 2.5 (g).**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge. They were last reviewed in June 2017, April 2017, and May 2018 respectively. They included all of the policy-related criteria for the codes of practice.

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

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

Evidence of Implementation:

Admission: All admissions were on the basis of mental illness or mental disorder. Residents received an admission assessment, which included presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information such as work situation, education, and dietary requirements. The resident received a full physical examination. Resident's representatives were involved in the admission process, with the resident's consent. A key worker system was in place.

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

Discharge: The clinical file of one recently discharged resident was reviewed. The file did not document the involvement of the resident in the discharge process. The approved centre maintained discharge plans, which included references to early warning signs of relapse and risks and a follow-up plan. They did not include documented communication with relevant health professionals or an estimated date of discharge.

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

a) **One discharge did not include an estimated date of discharge or documented communication with the relevant general practitioner/primary care team and/or Community Mental Health Team, 34.2**
b) **One discharge did not include a documented discharge meeting attended by the resident, key worker, relevant members of the MDT, and family/carer/advocate, where appropriate (i.e. with the consent of the resident), 34.4.**
c) **There was no documentary evidence that relevant staff had read and understood the policies, 9.1.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 13: Searches					
Reason ID : 10000041		**The written record of searches undertaken did not clearly identify the resident involved, 13 (9).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All written documentation in relation to searches will clearly identify the resident involved. Head of Discipline to email all staff that updated search log is available and policy to be updated accordingly.	Annual audit monitored by QPS sub-committee of area management committee	Achievable and Realistic.	30/09/2019	Assistant Director of Nursing; Nursing Staff.
Preventative Action	All written documentation in relation to searches will clearly identify the resident involved. Head of Discipline to ensure that all staff are educationed in regard to this policy.	Annual audit monitored by QPS sub-committee of area management committee	Achievable and Realistic.	30/09/2019	Assistant Director of Nursing; Nursing Staff.

Regulation 15: Individual Care Plan

Reason ID : 10000043		Four ICPs were not in place within seven days.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All ICPs to be completed and in-situ within specific time-frame.	Monthly Audits of ICPs monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic	30/09/2019	Lead Clinician for resident.
Preventative Action	ICP committee formed to oversee and provide education on same. MDT education session on ICPs delieved.	Monthly Audits of ICPs monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic	30/09/2019	Heads of Discipline; Lead Clinician for resident.
Reason ID : 10000044		**One resident's ICP was not a composite set of documents.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All ICPs to be a composite set of documents and all Lead Clinicians to be informed by email regarding this.	Monthly Audits monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic.	30/09/2019	Lead Clinician for Residents; Heads of Discipline.
Preventative Action	ICPs comittee formed to oversee all aspects of compliance with ICPs.	Monthly Audits monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic.	30/09/2019	Lead Clinician for Residents; Heads of Discipline.
Reason ID : 10000045		**ICPs did not consistently document appropriate goals and resources.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All ICPs to document all areas identified within Mental Health	Monthly Audits monitored by QPS sub-committee of	Achievable and Realistic	30/09/2019	Lead Clinician for resident; Heads of Discipline.

	Commission Guidelines.	Area Management Committee.			
Preventative Action	ICP committee formed to ensure compliance with all aspects of ICPs. Specific education session on ICPs delievered to Lead Clinican for residents.	Monthly Audits monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic	30/09/2019	Lead Clinician for resident; Heads of Discipline.
Reason ID : 10000046		**ICPs were not consistently reviewed and updated by the resident's MDT.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	ICPs are to be consistently reviewed and updated by resident's MDT, Clinical Director to email Lead Clinicans for residents in regards to ICP requirement.	Monthly Audits monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic	30/09/2019	Lead Clinician for resident; Heads of Discipline.
Preventative Action	ICP committee formed to oversee all aspects of compliance with ICPs.	Monthly Audits monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic	30/09/2019	Lead Clinician for resident; Heads of Discipline.

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10000042		**The registered proprietor did not ensure that residents had access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Support for inpatient unit to be provided for from Community Mental Health team psychology.	MDT team review of care plan	Achievable. Main barrier is staff shortages	30/09/2019	Heads of Discipline
Preventative Action	Application for a Clinical Psychology post with dedicated time to approved centre which has been approved by Chief Officer and is awaiting funding from National Division.	Presence of Clinical Psychologist with dedicated in-patient committment.	Main barrer to achieving implementation are difficulties with recruitment.	30/09/2019	Heads of Discipline

Regulation 19 General Health					
Reason ID : 10000047		**Not all residents' general health needs were assessed regularly and, particularly, on admission, 1(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All residents to have their general health needs documented regularly (as part of ICP) and on admission. Medical Staff informed regarding policy via email.	Biannual Audit performed and monitored by QPS sub-committee of Area Management committee.	Achievable and Realistic.	30/09/2019	Clinical Director; Medical Staff
Preventative Action	All residents to have their general health needs documented regularly (as part of ICP) and on admission. Policy included in Induction for new medical staff (July and January)	Biannual Audit performed and monitored by QPS sub-committee of Area Management committee.	Achievable and Realistic.	30/09/2019	Clinical Director; Medical Staff

Regulation 21: Privacy

Reason ID : 10000086		Residents' privacy and dignity was not appropriately respected, as notice boards in Ash and Pine Units displayed identifiable resident information, (21). Residents' privacy was not appropriately respected, as documents displaying identifiable resident information were observed outside private clinical areas, (21).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Notice boards have all been replaced with "fold over notice boards" which conceal resident information from members of public. Existing staff to read and sign policy on privacy and policy on privacy to be included in induction programme.	Yearly inspection	Achievable and Realistic	30/09/2019	Heads of Discipline
Preventative Action	Notice boards have all been replaced with "fold over notice boards" which conceal resident information from members of public. Existing staff to read and sign policy on privacy and policy on privacy to be included in induction programme.	Yearly inspection	Achievable and Realistic	30/09/2019	Heads of Discipline

Regulation 22: Premises

Reason ID : 10000048		The approved centre did not have an appropriately sized communal television room having regard to the number and mix of residents, 22 (2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Increased diversity of activities provided on ward so that Television room does not have full patient occupation at any time.	Yearly review.	Achievable.	30/09/2019	Heads of Discipline
Preventative Action	Increased diversity of activities provided on ward so that Television room does not have full patient occupation at any time. Ongoing maintenance of environment to minimise hazards.	Yearly review	Achievable.	30/09/2019	Heads of Discipline

Reason ID : 10000049		Hazards were present; this signified that the overall approved centre environment was not maintained with due regard to the specific needs of residents and their safety and well-being, 22 (3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ongoing maintenance of environment to mimimise hazards following review of premises in annual inspection.	Yearly review	Achievable	30/09/2019	Heads of Dsicipline
Preventative Action	Staff to report hazards encountered	Yearly review	Achievable	30/09/2019	Heads of Dsicipline

	and to report to line management, annual inspection of unit to identify hazards and manage same.				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10000052		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to prescribing and storing of medicines to residents.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ensure that suitable and appropriate practices relating to the prescribing of medicines are followed. Education session from Pharmacy department delivered on 11th of Febraury 2019. Email to medical staff reminding of appropriate prescribing practices.	Quartery Audits of MPARs monitored by the QPS of the Area Management Committee.	Achievable and realistic	30/09/2019	Clinical Director; Lead Clinician for residents.
Preventative Action	Ensure that suitable and appropriate practices relating to the prescribing of medicines are followed. Prescribing practice to be included as part of NCHD induction each July and January.	Quartery Audits of MPARs monitored by the QPS of the Area Management Committee.	Achievable and realistic	30/09/2019	Clinical Director; Lead Clinician for residents.

Regulation 25: Use of Closed Circuit Television

Reason ID : 10000055		The use of closed circuit television was not solely for the purpose of observing a resident by a health professional, 25 (1)(a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CCTV screen in Nursing Office to be obscured by "frosting" of the window preventing screens from being observed by non-health professionals. Awaiting works to be completed by estates.	Yearly inspection	Achievable and Realistic	30/09/2019	Heads of Discipline
Preventative Action	CCTV screen in Nursing Office to be obscured by "frosting" of the window preventing screens from being observed by non-health professionals. Awaiting works to be completed by estates.	Yearly inspection.	Achievable and Realistic	31/12/2019	Heads of Discipline
Reason ID : 10000056		**The closed circuit television used was capable of recording or storing a resident's image, 25 (1)(d).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	No CCTV camera used for observation of a resident by a health professional are used for the	Yearly inspection	Achievable and Realistic	30/09/2019	Heads of Discipline

	purpose of recording or storing a patient's image. To ensure that CCTV system installed is incapable of storing or recording information.				
Preventative Action	No CCTV camera used for observation of a resident by a health professional are used for the purpose of recording or storing a patient's image. To ensure that current or future CCTV systems are incapable of recording or storing information.	Yearly inspection	Achievable and Realistic	31/12/2019	Heads of Discipline

Regulation 26: Staffing

Reason ID : 10000087		Not all staff had up-to-date training in Fire Safety, Basic Life Support, Professional Management of Aggression and Violence, 26 (4). Not all staff had up-to-date training in the Mental Health Act 2001, 26 (5)			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All existing staff to be reminded to have achieved up to date training in Fire Safety, Basic Life Support, Professional Management of Aggressiona and Violence. All existing staff to be reminded to have up to date training in the Mental Health Act 2001. Required courses to be organised to fill deficit in training.	To maintain and update internal database. To complete 3 monthly reviews.	Achievable, however difficulties arise with shortages and releasing staff. There will be a schedule of training in place which is being addressed by all HOD	30/09/2019	Heads Of Disciplines/ Mental Health Administratior.
Preventative Action	All existing staff to be reminded to have achieved up to date training in Fire Safety, Basic Life Support, Professional Management of Aggressiona and Violence. All existing staff to be reminded to have up to date training in the Mental Health Act 2001.	3 Monthly Review.	Achievable.	31/12/2019	Heads of Disciplin

	Required courses to be organised to fill deficit in training. All new staff to have mandatory training requirements as part of induction and courses provided on regular basis.				

Regulation 27:Maintenance of Records					
Reason ID : 10000057		**The registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness and accuracy. Records were not kept in good order, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure that records are maintained in a manner that ensures completeness and accuracy.	Fortnightly Chart Review Meetings.	Achievable.	17/06/2019	Administrative Staff/ Clinical Nurse Manager 2
Preventative Action	To observe charts for Completeness and accuracy and to address and to complete corrective action post fortnightly review meetings where applicable.	Audit measuring Tool.	Achievable.	17/06/2019	Adminstrative Staff and Clincial Nurse Manager 2

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10000030		**Age-appropriate facilities and a programme of activities appropriate to age and ability of child admission were not provided, 2.5 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Admission of Children to the approved centre is not entertained at all times. In the exceptional circumstances that a child is admitted ot the unit (while awaiting transfer) age appropriate activites will be assigned at that time.	Review of admissions of children at end of year	Limited availability and limited access out of hours of appropriate child in-patient beds.	10/06/2019	Heads of Discipline
Preventative Action	Admission of Children to the approved centre is not entertained at all times. In the exceptional circumstances that a child is admitted ot the unit (while awaiting transfer) age appropriate activites will be assigned at that time.	Review of admissions of children at end of year	Limited availability and limited access out of hours of appropriate child in-patient beds.	10/06/2019	Heads of Discipline
Reason ID : 10000031		**Child admissions did not have access to age-appropriate advocacy services, 2.5 (g).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Admission of children is an exceptional event and is only done temporarily while awaiting transfer to age appropriate unit. In these cases the patient is referred to the nearest Child and Adolescent Mental Health Services. There is no permanent age apropriate advocacy service in the unit however the provision of advocacy services is requested from the CAHMS service at that time on a case by case basis.	Review admissions of children at the end of the year.	Barrier is the limitation of and access to age appropriate in-patient beds especially out of hours.	30/09/2019	Heads of Discipline
Preventative Action	Admission of children is an exceptional event and is only done temporarily while awaiting transfer to age appropriate unit. In these cases the patient is referred to the nearest Child and Adolescent Mental Health Services.	Review admissions of children at the end of the year.	Barrier is the limitation of and access to age appropriate in-patient beds especially out of hours.	30/09/2019	Heads of Discipline

	There is no permanent age apropriate advocacy service in the unit however the provision of advocacy services is requested from the CAHMS service at that time on a case by case basis.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10000034		**In two cases, there was no evidence that residents were informed of reasons for, likely duration of, or circumstances leading to discontinuation, 5.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Medical and Nursing Staff to ensure that all residents are informed of the reasons for; likely duration of and circumstances leading to the discontinuation of each epsidoe of Physical Restraint.	Audited Quarterly and monitored by the QPS sub-committee of area management committe.	Realistic and Achievable.	30/09/2019	All Nursing and Medical Staff. Clincal Director Assistant Director of Nursing
Preventative Action	Medical and Nursing Staff to be given education on full compliance with with Physical Restraint policy based on Code of Practice. Physical Restraint Policy to be included in induction for new Medical and Nursing staff.	Audited Quarterly and monitored by the QPS sub-committee of area management committe.	Realistic and Achievable.	30/09/2019	All Nursing and Medical Staff. Clincal Director Assistant Director of Nursing
Reason ID : 10000035		**In no case did a registered medical professional completed a medical examination within three hours of the end of the episode, 5.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Medical Staff to be informed and educationed in Physical Restraint COP and Policy. All	Included in Quarterly Audits monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic.	30/09/2019	Medical Staff, Clinical Director.

	medical staff to ensure that they have examined and documented same within the required time line. All medical staff will be informed by email that it is there responsibility to complete documentation within the required time lines.				
Preventative Action	Medical Staff to be informed and educationed in Physical Restraint COP and Policy. This will be included as part of induction for new NCHDs starting in July & January.	Included in Quarterly Audits monitored by QPS committee of Area Management Committee.	Achievable and realistic.	30/09/2019	Clinical Director
Reason ID : 10000036		**In one case, there was no evidence that a staff member was designated to be responsible for leading the physical restraint and monitoring the head and airway of the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Nursing Staff to be educated on the policy in regards to Physical Restraint based on Code of Practice and to enusre that one staff member has been identified to monitor	Quarterly Audit monitored by QPS sub-committee of Area Mangement Committee.	Achievable and Realistic.	30/09/2019	Nursing Staff; Assistant Director of Nursing.

	the head and airway of a resident during each episode of physical restraint. All staff to ensure that same is documented.				
Preventative Action	All Nursing Staff to be educated on the policy in regards to Physical Restraint based on Code of Practice.	Quarterly Audit monitored by QPS sub-committee of Area Mangement Committee.	Achievable and Realistic.	30/09/2019	Nursing Staff; Assistant Director of Nursing.
Reason ID : 10000037		**There was no written record to indicate that staff involved in the use of physical restraint had read and understood the policy 9.2(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Medical and Nursing Staff to be educated in relation to policy on Physycal Restraint based on Code of Practice. Policy signing sheets to be issued for both Medical and Nursing Staff.	Quarterly Audit to be monitored by the QPS sub-committee of the Area Management Committee.	Achievable and Realistic	30/09/2019	Clincal Director; Assistant Director of Nursing.
Preventative Action	All Medical and Nursing Staff to be educated in relation to policy based on Code of Practice. Policy signing sheets to be issued for both Medical and Nursing Staff.	Quarterly Audit to be monitored by the QPS sub-committee of the Area Management Committee.	Achievable and Realistic for all permanent staff.	30/09/2019	Clincal Director; Assistant Director of Nursing.

Reason ID : 10000088		**In one case, the resident did not have the opportunity to speak with the MDT about the episode, 9.3. In no case was there evidence that each episode was reviewed by members of the multi-disciplinary team and documented within two working days, 7.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Medical, Nursing and MDT team members (who attend MDT meetings in DOP Connolly) to be educated on the Policy on Physical Restraint based on COP to enusre all residents are afforded the opportunity to be reviewed by their MDT with the required time-line.	Quarterly Audit monitored by QPS sub-committee of the area management committee	Achievable and Realistic	30/09/2019	Heads of Discipline.
Preventative Action	All Medical, Nursing and MDT team members (who attend MDT meetings in DOP Connolly) to be educated on the Policy on Physical Restraint based on COP to enusre all residents are afforded the opportunity to be reviewed by their MDT with the required time-line.	Quarterly Audit monitored by QPS sub-committee of the area management committee	Achievable and Realistic	30/09/2019	Heads of Discipline.

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10000040		**There was no documentary evidence that relevant staff had read and understood the policies, 9.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to receive education on the Policy on Admission, Transfer and Discharge based on COP. All staff to sign that they have read and understood the Policy.	Quarterly Audit to be monitored by the QPS sub-committee of the Area Management Committee	Achievable and Realistic.	30/09/2019	Clinical Director; Assistant Director of Nursing.
Preventative Action	All staff to receive education on the Policy on Admission, Transfer and Discharge based on COP. All staff to sign that they have read and understood the Policy.	Quarterly Audit to be monitored by the QPS sub-committee of the Area Management Committee	Achievable and Realistic.	30/09/2019	Clinical Director; Assistant Director of Nursing.
Reason ID : 10000089		**One discharge did not include a documented discharge meeting attended by the resident, key worker, relevant members of the MDT, and family/carer/advocate, where appropriate (i.e. with the consent of the resident), 34.4. One discharge did not include an estimated date of discharge or documented communication with the relevant general practitioner/primary care team and/or Community Mental Health Team, 34.2**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All members of team to be educated in regards to policy on Admission, Transfer and Dischrage based on COP to ensure	Quarterly Audits of ICPs to be monitored by the QPS sub-committee of the Area management committee.	Achievable and Realistic.	30/09/2019	Members of MDT teams; Clinical Director; Assistant Director of Nursing.

	that all residents are afforded a discharge meeting and estimated discharge date.				
Preventative Action	All members of team to be educated in regards to policy on Admission, Transfer and Dischrage based on COP to ensure that all residents are afforded a discharge meeting and estimated discharge date.	Quarterly Audits of ICPs to be monitored by the QPS sub-committee of the Area management committee.	Achievable and Realistic.	30/09/2019	Members of MDT teams; Clinical Director; Assistant Director of Nursing.

Rules Governing the Use of Seclusion

Reason ID : 10000060		Not all staff had signed the written record to indicate that they had read and understood the policy, 10.2(b).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Medical and Nursing staff to be reminded by email to read and sign policy signature log.	Yearly Audit of signature log monitored by QPS sub-committee of area management committee.	Achievable and realistic for existing staff	30/09/2019	All Medical and Nursing Staff; Assistant Director of Nursing; Clinical Director.
Preventative Action	All existing Medical and Nursing Staff reminded to read and sign policy signature log annually, need to read and sign policies to be included in induction for all new staff.	Yearly Audit of signature log monitored by QPS sub-committee of area management committee.	Achievable and realistic for existing staff	30/09/2019	All Medical and Nursing Staff; Assistant Director of Nursing; Clinical Director.
Reason ID : 10000090		**In one episode of seclusion, a medical review of the patient was not undertaken within four hours after the commencement of the episode of seclusion, 3.3(c). In two episodes of seclusion, the episode was not reviewed and documented by members of the multi-disciplinary team and documented in the clinical file within two working days, (10.3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure that all documentation and patient reviews are conducted within required time-line as specified by COP. Medical and Nursing Staff reminded by email regarding this.	Quartly Audit monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic for all existing staff	30/09/2019	All medical and nursing staff; Clinical Director and Assistant Director of Nursing; Lead Clinician for Resident.

Preventative Action	To ensure that all documentation and patient reviews are conducted within required time-line as specified by COP. Policies in regards to Mental Health Act to be included in induction for all new staff.	Quartly Audit monitored by QPS sub-committee of Area Management Committee.	Achievable and Realistic for all existing staff	31/12/2019	All medical and nursing staff; Clinical Director and Assistant Director of Nursing; Lead Clinician for Resident.

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

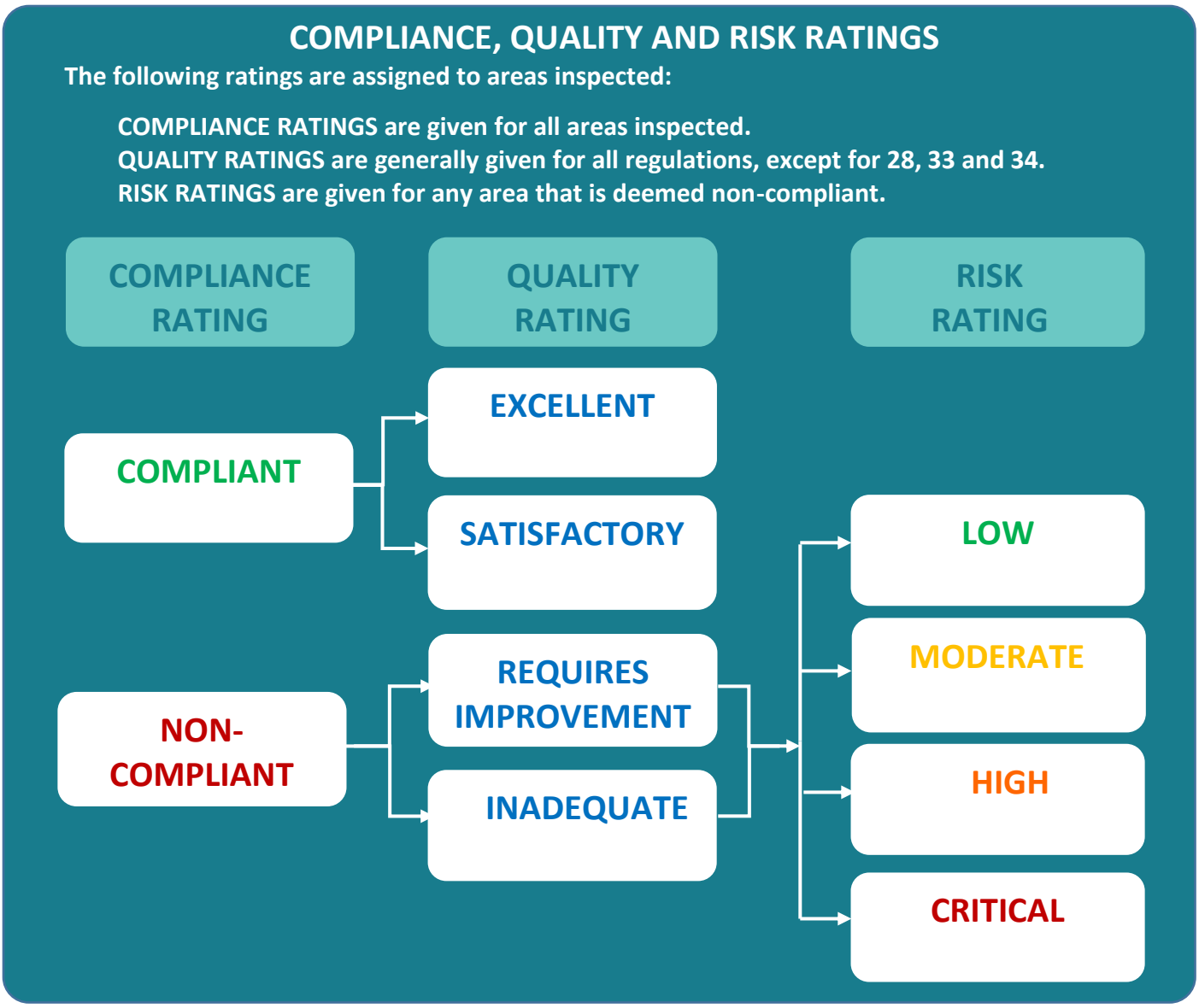
Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly, due to the nature of Regulations 28, 33 and 34 a quality assessment is not required.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.