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Coimisiún Meabhair-Shláinte | Mental Health Commission

Department of Psychiatry, Connolly Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

DEPARTMENT OF PSYCHIATRY, CONNOLLY HOSPITAL

Department of Psychiatry, Connolly Hospital, Blanchardstown, Dublin 15

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2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
7 December 2018

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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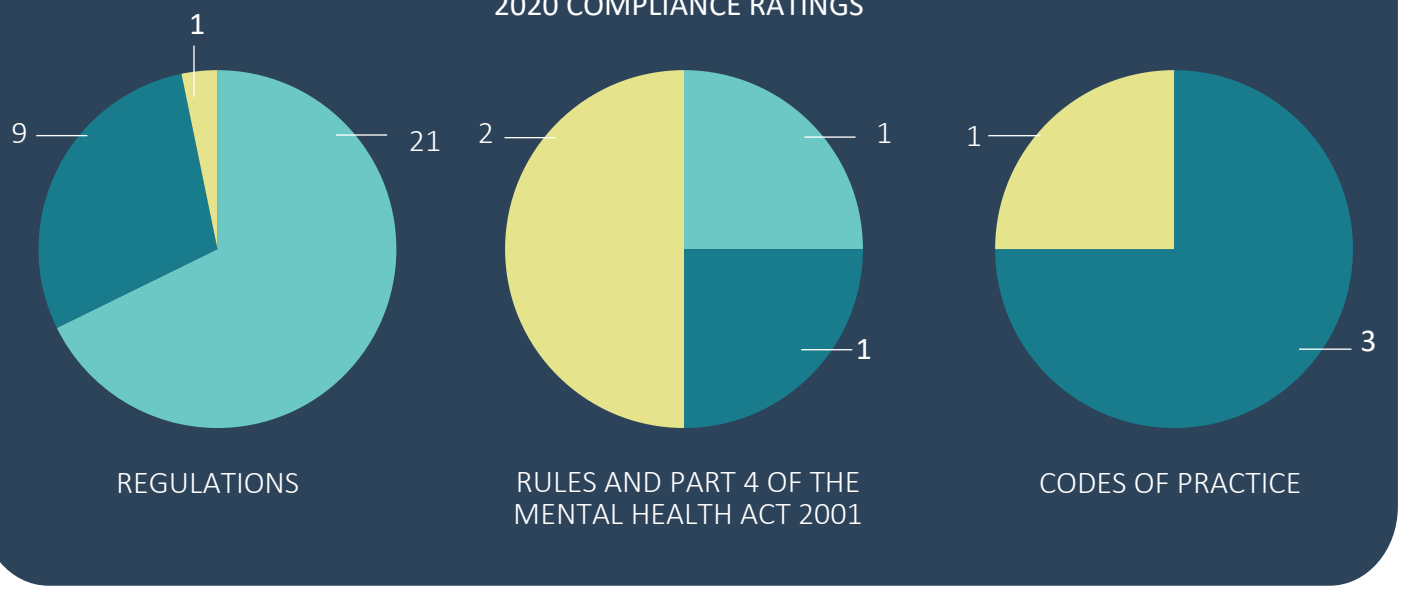
Inspection Date:
25 – 28 February 2020

Previous Inspection Date:
5 – 8 February 2019

Inspection Type:
Unannounced Annual Inspection

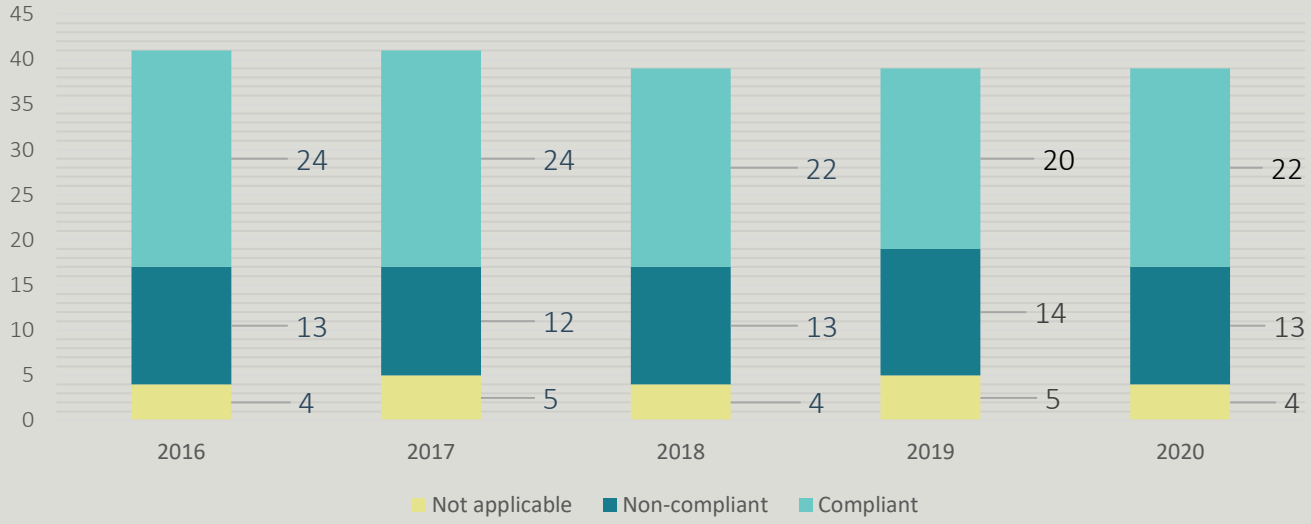
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

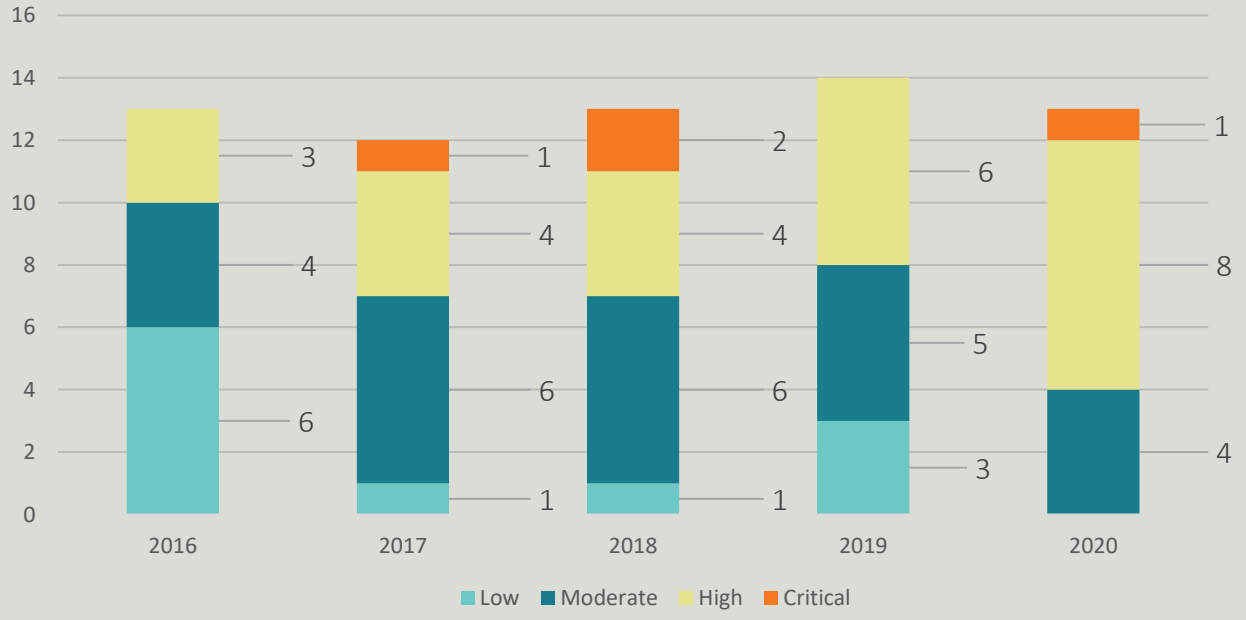
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2016 – 2020



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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) was located on the lower ground floor of Connolly Hospital in Blanchardstown. The approved centre provided acute in-patient care for the Dublin North City area from Cabra to Mulhuddart. A total of seven consultant-led teams based in four catchment areas admitted residents to the approved centre. Two rehabilitation teams and a team dealing with the homeless population also admitted to the centre.

There has been no progress in improving compliance with regulations, rules and codes of practice since 2016.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	65%	67%	63%	59%	63%
Regulations Rated Excellent	3	7	4	6	5

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 was not in breach of Condition 1 and 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 not in breach of Condition 2 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Safety in the approved centre

- The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.
- There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.
- Food safety audits had been completed periodically. Kitchen areas were clean and there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food.
- Medication was ordered, prescribed, stored and administered in a safe manner.

However:

- Fire doors had been fitted but chairs and waste bins were holding doors open. Tape obstructed the smoke detector, rendering it ineffective. The mechanism doors to the rear of the premises was broken which resulted in the fire doors remaining open. This forced opening of the doors meant that the mechanism that enabled them to close during a fire would not function correctly. A handle had been attached to a fire door. Two fire drills were not carried out in the previous year as required by the policy. Staff and management were aware of these issues, however they were not addressed.
- An effort was made to ensure that healthcare professionals working in the approved centre were up to date with mandatory training. This was successful in that some disciplines had achieved 100% with mandatory training, however, less than 50% of nurses and doctors were up to date with fire safety training.
- Structural risks, including ligature points, were not removed or effectively mitigated. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.
- There were insufficient numbers of panic alarms available.

Appropriate care and treatment of residents

- For residents on antipsychotic medication, there was an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and their prolactin levels.
- The provision of therapeutic services and programmes was excellent and met the assessed needs of the resident group.
- An Individual Care Plan (ICP) booklet was developed to inform residents of the content of their ICP and how they engage with the team to inform the care plan.

However:

- Ten ICPs were examined:
    - Two ICPs were not developed by the resident's MDT following a comprehensive assessment.

    - Two ICPs were not discussed or drawn up with the participation of the resident.
    - One ICP did not identify goals, resources, or the treatment required to meet the resident's identified goals.
    - One ICP was not reviewed by the resident's MDT weekly or updated following review.
- Not all residents' general health needs were documented to have been monitored and assessed at least every six months. Five files were examined.
    - Three clinical files did not evidence a physical examination.
    - Three did not evidence family or personal history.
    - Three files did not evidence an assessment of the resident's blood pressure.
    - Four files did not evidence the resident's nutritional status.
    - One file did not evidence an assessment of the resident's dental health.
    - Four files did not include evidence of an assessment of the resident's smoking status.
    - Four of the five files did not adequately evidence an assessment of the resident's BMI, weight, and waist circumference.
- There was no documentary evidence that a registered medical practitioner completed a physical examination of one resident no later than three hours after the start of the episode of physical restraint.
- Inspectors had difficulty retrieving information in the clinical files. Some Mental Health Commission documents, such as Form 17s: Consent to Treatment, were located in the Mental Health Administrator's office and not within the clinical files. Not all resident records were developed and maintained in a logical sequence. A number of files were not maintained in good order and had loose pages. Where an error was made, scribbled out notes were observed and there was no correction written alongside with date, time, and initials. Two appropriate resident identifiers were not recorded on all documentation across a number of clinical files.

Respect for residents' privacy, dignity and autonomy

- All bathrooms, showers, and toilets had locks on the inside of the door. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information.
- The approved centre was kept in a good state of repair internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment for which records were maintained.
- There was also a cleaning schedule implemented within the approved centre, which was observed to be very clean, hygienic, and free from offensive odours.
- Seclusion was not carried out in accordance with the Rules Governing the Use of Seclusion.
- Physical Restraint was not carried out in accordance with the Code of Practice on the Use of Physical Restraint.

However:

- A resident observation checklist containing residents' full names was left unattended on the corridor in Ash Ward.
- Residents in both Ash and Pine wards were able to keep their mobile phones following a risk assessment. However, residents in the HDU were not allowed to keep their mobiles as a result of a blanket ban for safety reasons. Individual risk assessments were not completed for these residents in HDU in relation to any risks associated with their external communication. Residents in the HDU were permitted to make three phone calls a day.
- CCTV cameras or other monitoring systems used to observe a resident were capable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form. The CCTV cameras transmitted images to a monitor that was not viewed solely by the health professionals responsible for the resident.
- The outdoor areas were littered with cigarette butts.

Responsiveness to residents' needs

- The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and weekends. Activities included board games, art supplies, books, and television. Exercise and yoga classes were arranged. There were no outdoor activities at the time of inspection as the approved centre's courtyard was closed for renovations for a period of six weeks.
- There was a choice of food at mealtimes which was attractively presented.
- The process for managing complaints was satisfactory.
- Information about the approved centre, medications and diagnoses was available.

However:

- Residents had to make a request to staff if they wanted to open or close windows, as the window mechanism did not allow residents to open windows themselves.

Governance of the approved centre

- The approved centre was overseen by two governance systems: North Dublin Mental Health Services (NDMHS) and Connolly Hospital Blanchardstown (CHB). A separate Quality and Safety Committee met monthly to consider issues relating to risk management, policy development, and incident review. Estate management was the responsibility of CHB.
- Both clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register.
- Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting.

- A committee was established to ensure the Department of Psychiatry was compliant with regulations, rules codes of practice and conditions attached by the MHC to the approved centres registration.
- Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users.

However:

- The split governance system led to uncertainty and confusion regarding completion of maintenance projects. Connolly Hospital were responsible for some projects and NDMHS accounted for some of the costs in their budget.
- In recent months, senior management had commenced a process of walking through the approved centre to note issues but these walks about were not documented.
- It was apparent that the audit process lacked detail regarding the details of issues reviewed, action plans arising, and re-audit process. The audit carried out on the maintenance of records recorded 100% compliance, which was contrary to the findings of the inspection team. The non-clinical risk advisor stated that he did not have responsibility for the approved centre and only had responsibility for Connolly Hospital.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. An Individual Care Plan (ICP) booklet was developed to inform residents of the content of their ICP and how they engage with the team to inform the care plan.

2. An illicit substance misuse policy has been developed and there was a plan to implement this policy to reduce the misuse of illicit substances.

3. Make Every Contact Count (MECC) training provided for all staff. This training provided staff members with effective tools and knowledge to carry out brief interventions with residents. Staff were provided with a foundation in behaviour change theory and techniques including the underlying principles of a patient centred approach. Modules included smoking, alcohol and drug abuse prevention, healthy eating and active living.

4. A Mental Health Commission Judgement Support Framework compliance committee has been set up to facilitate the measurement of practice against standards as set out by the Mental Health Commission (2001).

5. The contractors had started remodelling the garden.

6. Yoga classes were introduced.

7. Safewards had been implemented to reduce restrictive practice and improve the safety for everyone including mental health service staff, residents and visitors. The Safewards model offered interventions that were designed to improve communication and reduce the risk of conflict and containment events occurring.

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 Connolly Hospital in Blanchardstown. 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. 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, a tribunal room, and a 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. The HDU had since the last inspection following major renovation.

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. A large, paved outdoor space was closed for a period of six weeks for renovation and this work had commenced. The Communal areas on both Ash and Pine wards were small and inadequate to accommodate all the residents when the approved centre was at full capacity.

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**44**
Number of detained patients	17
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was overseen by two governance systems: North Dublin Mental Health Services (NDMHS) and Connolly Hospital Blanchardstown (CHB). Regular monthly NDMHS management meetings occurred, and 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. Estate management was the responsibility of CHB.

It was apparent from the walk about, undertaken by the inspection team on the first day of inspection that the split governance system led to uncertainty and confusion regarding completion of maintenance projects. Connolly Hospital were responsible for some projects and NDMHS accounted for some of the costs in their budget. A project to remove ligatures from windows was complete, however, the new mechanism to open and close the windows was not working well. Special keys to open windows required force to open and close and the keys broke often. Staff had requested several replacements. At the time of the inspection, residents had to make a request to staff if they wanted to open or close windows, as the window mechanism did not allow residents to open windows themselves. Fire doors had been fitted and the inspection team noted that chairs and waste bins were holding doors open. Tape also obstructed the smoke detector, rendering it ineffective. The mechanism doors to the rear of the premises was broken which resulted in the fire doors remaining open. This forced opening of the doors meant that the mechanism that enabled them to close during a fire would not function correctly. Staff and management were aware of these issues, however they were not addressed. It was noted that there was no responsible person designated to manage non clinical risks. In recent months senior management had commenced a process of walking through the approved centre to note issues but these this walk about was not documented.

Retrieval of some information was delayed because staff held data on computers where access passwords were not known by any other staff member. As share drives were not used, IT personnel were unable to access files and documents when staff were on sick leave or holidays. Some resident information was stored away from clinical files and not readily available to those providing care and treatment. Senior management recognised the risks attached to this practice and moved to implement corrective action immediately.

The inspection team were provided with a variety of committee minutes relating to various aspects of governance. These included minutes of the hospital Executive Management Team, the Quality and Safety Executive Committee, and the Health and Safety Committee. Issues frequently discussed include recruitment of staff, staff training and compliance. There were a number of vacant posts for nurses and doctors and details of the derogation process demonstrated every effort was made to fill these posts. A new post for psychology was recently filled. Two psychologists, two occupational therapists and an occupational therapy assistant provide therapeutic services and programmes in the approved centre. Residents were referred to their community mental health teams on discharge. Social workers provided services using the in-reach model, where nine social workers from the community mental health teams met the assessed needs of residents in the approved centre and followed up with the resident post discharge.

A committee was established to ensure the Department of Psychiatry was compliant with regulations, rules codes of practice and conditions attached by the MHC to the approved centres registration. A number of measures were implemented to improve individual care plans (ICPs). Each resident was assigned an ICP lead person who assisted them with understanding the care plan and following up with outcomes. They supported residents to attend their care plan meeting. A new leaflet to explain integrated care planning was drafted. A concerted effort was made to ensure that healthcare professionals working in the approved centre were up to date with mandatory training. This has proved somewhat, successful and some disciplines

had achieved 100% with mandatory training, however, less than 50% of nurses and doctors were up to date with fire safety training.

While members of the multidisciplinary teams produced good quality ICP audits, it was apparent that the process lacked detail regarding the details of issues reviewed, action plans arising, and re-audit process. The audit carried out on the maintenance of records recorded 100% compliance, which was contrary to the findings of the inspection team.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 12: Communication	✓		✓		✓		✓		✗	High
Regulation 15: Individual Care Plan	✗	High	✗	High	✗	High	✗	High	✗	High
Regulation 19: General Health	✓		✓		✗	High	✗	High	✗	High
Regulation 21: Privacy	✓		✓		✗	Moderate	✗	High	✗	Moderate
Regulation 22: Premises	✗	Moderate	✗	Moderate	✗	High	✗	Low	✗	High
Regulation 25: Use of Closed Circuit Television	✓		✓		✓		✗	Low	✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	High
Regulation 27: Maintenance of Records	✗	Low	✗	High	✗	High	✗	High	✗	Critical
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	High
Rules Governing the Use of Seclusion	✗	Low	✗	Moderate	✗	Critical	✗	Low	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Moderate	✓		✗	Critical	✗	High	✗	High
Code of Practice Relating to the Admission of Children	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	Low	✗	Moderate	✗	Moderate	✗	High

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

4.2 Areas of compliance rated "excellent" on this inspection

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 7: Clothing
Regulation 10: Religion
Regulation 11: Visits
Regulation 16: Therapeutic Services and Programmes

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.
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.

Fifteen residents met with the inspection team. Residents stated that the staff were nice, tried to do their best and provided good care and treatment. There were a number of areas that residents thought could be improved. These included that there was not enough to do particularly in the morning, that there was no coffee making facilities or vending machine and access to the shop in the main hospital was limited. A number of residents commented on the windows and stated that they couldn't open the window to air the room. One resident said staff had a key to open windows but they had only been opened once in a week. The garden was closed for renovations and residents said there was a strong smell of smoke in the recreation room. Two residents provided written feedback to the inspection team.

The Irish Advocacy Network (IAN) representative visited the approved centre weekly. There was a notice naming the IAN contact and details. The IAN representative provided the inspection team with a written report that summarised feedback from residents. Residents reported positively on the care received, that physical care needs were met and that there was a good range of activities in the occupational therapy department.

Areas of concern reported by service users to the advocate included that residents would like a more structured day and for some their stay was extended because there was no suitable accommodation to move to. Some residents wanted more information on recovery techniques for depression, bipolar, schizophrenia, phobia, and anxiety disorders.

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:

- Registered Proprietor
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Principal Social Worker
- Occupational Therapy Manager
- Clinical Psychologist
- Mental Health Service Manager
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 x3

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. It was agreed that outstanding documents, including bed occupancy rates, requested by the inspection team would be forwarded within one week. These documents were received within the week.

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 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.

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

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: 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.

Special dietary 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 used. Intake and output charts were maintained where appropriate.

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 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: Food was prepared in a manner that reduced the 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 pillar.

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' clothing, which was last reviewed in March 2018. The policy included all 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 specified in their individual care plan.

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 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 with them, the extent of which was agreed at admission and a detailed property checklist was complied with each resident of their personal property and possessions. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them and secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. The property checklist was updated on an ongoing basis, in line with the approved centre's policy. The checklist was kept separately from the resident's ICP.

The access to and use of resident monies was not always overseen by two members of staff and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained: where possible this was counter-signed by the resident or their representative. Residents were supported to manage their own property, unless this

posed a danger to the resident or others, as indicated in their ICP or in accordance with the approved centre's policy.

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 implementation pillar.

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

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

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

Monitoring: A record was not maintained of the occurrence of planned recreational activities. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and weekends. Activities included board games, art supplies, books, and television. Information was provided to residents in an accessible format, which was appropriate to their individual needs, though it did not include the types and frequency of appropriate recreational activities available within the approved centre. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. Exercise and yoga classes were arranged. Individual risk assessments were completed for residents, where deemed appropriate, in relation to the selection of appropriate activities.

Resident decisions on whether or not to participate in activities were respected and documented, as appropriate. The recreational activities provided by the approved centre were appropriately resourced. While opportunities were provided for indoor activities, there were no outdoor activities at the time of inspection as the approved centre's courtyard was closed for renovations for a period of six weeks, which were expected to continue for six weeks after the inspection. Additional exercise classes arranged so that resident had a choice of exercise. Communal areas were provided that were suitable for recreational activities. Documented records of attendance were not retained for recreational activities in group records or within the resident's clinical file, as appropriate.

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

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2017. The policy included all 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. Facilities were provided for religious practice and residents had access to multi-faith chaplains. Residents had access to local religious services and were supported to attend, if deemed appropriate following a risk assessment. Care and services provided within the approved centre were respectful of the residents' religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. The resident was facilitated to observe or abstain from religious practice in accordance with their wishes.

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

Regulation 11: Visits

COMPLIANT

Quality Rating **Excellent**

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were publicly displayed and were appropriate and reasonable. A separate visitors' room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety and this was communicated to relevant individuals publicly. The visiting room was suitable for visiting children.

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

Regulation 12: Communication

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

(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's policy on communication only covered Pine and Ash wards, however, operational policies and procedures for the High Dependency Unit (HDU) were not included in the policy. The following were not included for the HDU:

- The roles and responsibilities for resident communication processes.
- Communication services available to resident (including mail, fax, e-mail, Internet, phone, or any device for sending/receiving messages or goods).
- The assessment of resident communication needs.
- Circumstances in which resident communications may be examined by a senior member of staff.
- The individual risk assessment requirements in relation to limiting resident communication activities.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the incomplete policy. Relevant staff interviewed were able to articulate the processes for communication, as set out in the incomplete 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 in both Ash and Pine wards were able to keep their mobile phones following a risk assessment. However, residents in the HDU were not allowed to keep their mobiles as a result of a blanket ban for safety reasons. Individual risk assessments were not completed for these residents in HDU in relation to any risks associated with their external communication and documented in the individual care plan. Residents of the HDU had limited access to a computer in the occupational therapy department. Residents in the HDU were permitted to make three phone calls a day and signs in the ward informed them of this. The clinical director or senior staff member designated by the clinical

director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

a) **Residents in HDU were restricted in their communications under a blanket rule, and individual needs had not been assessed. The registered proprietor and the clinical director did not ensure that the resident was free to communicate at all times, having due regard to their wellbeing, safety, and health, 12(1).**
b) **The approved centre's policy did not include the operational policies and procedures of the HDU and was therefore incomplete, 12(3).**

Regulation 13: Searches

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy 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 process for dealing with illicit substances uncovered during a search.

The policy and procedures did not address the following:

- The consent requirements of a resident regarding searches.
- The considerations to be provided to residents in relation to their dignity, privacy, and gender 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 been completed to identify ways of improving search processes.

Evidence of Implementation: The clinical files relating to three searches were examined during the inspection. Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches and the request for consent and the received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents, who were informed by those implementing the search of what was happening during a search and why.

A minimum of two clinical staff were in attendance at all times when a search was being conducted and due regard was shown 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. A written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and 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 processes pillar.

Regulation 14: Care of the Dying

COMPLIANT

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

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

As there had been no deaths in the approved centre since the last inspection Regulation 14: Care for the Dying was only assessed against the processes and training and education pillars.

The approved centre was compliant with this regulation.

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 requirements of the *Judgement Support Framework*.

Training and Education: 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 received training in individual care planning.

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

Evidence of Implementation: Ten ICPs were examined during the inspection process. The ICPs were a composite set of documents and were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. The ICPs included allocated space for goals, treatment, care, resources required, and reviews. While nine of the ten ICPs examined detailed that each resident was initially assessed at admission and an ICP was completed by the admitting clinician to address the immediate needs of residents, one ICP did not evidence this.

The comprehensive assessment included: medical, psychiatric, and psychosocial history; medication history and current medications; current physical health assessments; a detailed risk assessment; social, interpersonal, and physical environment-related issues, including resilience and strengths, and; communication abilities. In one ICP examined, the assessment did not detail the resident's educational, occupational, and vocational history. Evidence-based assessments were used where possible. Two ICPs were not developed by the MDT following a comprehensive assessment, within seven days of admission.

Two ICPs were not discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, or next of kin. In all cases, the ICP identified the resident's assessed needs. However, one of the ICPs examined did not identify the resident's assessed needs, appropriate goals, or the resources required to meet the goals identified, including the frequency and responsibilities for

implementing the care and treatment. A key worker was identified to ensure continuity in the implementation of a resident's ICP.

All ICPs included an individual risk management plan and a preliminary discharge plan. One ICP was not reviewed by the full MDT in consultation with the resident weekly. One ICP was not updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. In two cases, the resident was not documented to have been offered a copy of their ICP, including any reviews. In one ICP where a resident declined or refused a copy of their ICP, this was not recorded.

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

a) **Two ICPs were not developed by the resident's MDT following a comprehensive assessment.**
b) **Two ICPs were not discussed or drawn up with the participation of the resident.**
c) **One ICP did not identify goals, resources, or the treatment required to meet the resident's identified goals.**
d) **One ICP was not reviewed by the resident's MDT weekly or updated following review.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Excellent**

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

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

INSPECTION FINDINGS

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

Training and Education: 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: The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. A list of all therapeutic services and programmes provided in the approved centre was available to residents.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. Therapeutic services and programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. A record was maintained of participation and engagement in therapeutic services in residents' individual care plans or clinical files.

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

Regulation 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*, with the exception of the criteria for transfer.

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

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred to a general ward inside Connolly Hospital was examined during the inspection process. Communication records with the receiving facility were documented and available on inspection, including agreement of resident receipt prior to transfer. Verbal communication and liaison took place between the approved centre and the receiving facility prior to the transfer. This included a discussion of the reasons for transfer, the resident's accompaniment requirements on transfer, and the resident's care and treatment plan, including needs and risk. Documented consent from resident to the transfer was available and an assessment of the resident was completed prior to transfer, including an individual risk assessment relating to the transfer and the resident's needs: this was also documented and provided to the receiving facility.

Full and complete written information for the resident accompanied them when they moved from the approved centre and was directed towards a named individual. A letter of referral, as well as a resident transfer form were part of the transfer documentation, though the required medication for the resident during the transfer process was not. A checklist was completed by approved centre to ensure comprehensive resident records were transferred to the receiving facility. 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 and evidence of implementation 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. Both the general health policy and the medical emergencies policy were last reviewed in June 2017. The policies and procedures addressed requirements of the *Judgement Support Framework*, with the following exceptions:

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

Training and Education: 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: A systematic review had not been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and staff had access at all times to an AED, both of which had weekly checks. Records were available of any medical emergency within the approved centre and the care provided. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans.

Not all residents' general health needs were documented to have been monitored and assessed as indicated by the residents' specific needs at least every six months. Five clinical files were examined in relation to six-monthly general health assessments. A number of the clinical files did not evidence certain required aspects of the six-monthly assessments: three clinical files of the five examined did not evidence a physical examination; three did not evidence family or personal history; three files did not evidence an assessment of the resident's blood pressure; four files did not evidence the resident's nutritional status; and one of two applicable files did not evidence an assessment of the resident's dental health.

Four of the clinical files did not include evidence of an assessment of the resident's smoking status, for which there was an inconsistent format of assessment: one format of assessment included a question regarding smoking status, though another assessment format produced for inspectors did not include this question. Two clinical files evidenced an assessment of the resident's weight and body-mass index (BMI), but had "normal" stated for waist circumference on one of the two files and no evidence of waist circumference on the other. However, overall, four of the five files did not adequately evidence an assessment of the resident's BMI, weight, and waist circumference.

For residents on antipsychotic medication, there was an annual assessment of their glucose regulation, blood lipids, an electrocardiogram, and their prolactin levels. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing. Residents could access national screening programmes that were available according to age and gender, such as Breast Check, cervical screening, retina check, and bowel screening. The approved centre provided information to residents regarding the national screening programmes. Residents had access to smoking-cessation programmes and supports.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all resident's general health needs were assessed regularly and no later than every six months, 19(1)(b).

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy 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 requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: 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 their 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. 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. Residents had access to interpretation and translation services as required.

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 21: Privacy

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in March 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the method for identifying and ensuring, where possible, the resident's privacy and dignity expectations and preferences.

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

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

Evidence of Implementation: Residents were called by their preferred name and the general demeanour of staff and the manner in which they communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs and sought permission before entering resident's rooms, as appropriate. All residents were wearing clothes that respect their privacy and dignity.

All bathrooms, showers, and toilets had locks on the inside of the door, unless there was an identified risk to a resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information. However, a resident observation checklist containing residents' full names was left unattended on the corridor in Ash Ward. Residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because a resident observation checklist containing residents' full names was left unattended on the corridor in Ash Ward.

Regulation 22: Premises

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

(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 March 2018. The policy included all 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 audits, however the designated scores differed for Pine and Ash Units even though the units were structurally the same. The Pine unit ligature audit did not include any action points. Documented analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: All resident bedrooms were appropriately sized to address resident needs. Residents had access to personal space, however, the sitting room on Ash was not appropriately sized. There was a capacity for 21 residents but the room could accommodate 9 residents. There was suitable and sufficient heating in the approved centre and rooms were centrally heated with pipe work and radiators guarded; however, heating could not be safely controlled in the residents' own rooms, in compliance with health and safety guidance and building regulations. Rooms were not sufficiently ventilated as some of the windows on Ash and Pine units were locked to address an identified risk: residents required staff to open the windows, though staff were observed to have difficulties opening and

closing two windows. One resident reported that the window in a five-bed dorm was opened too infrequently.

Rooms were well lit to address both staff and resident needs, and private and communal areas were suitably sized and furnished to remove excessive noise. Appropriate signage and sensory aids were provided to support resident orientation needs. There was insufficient spaces for some residents to move about due to the renovation of the outdoor space. The inspection team were assured that this was for a period of six weeks. Hazards, including steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.

The approved centre was kept in a good state of repair internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment for which records were maintained. There was also a cleaning schedule implemented within the approved centre, which was observed to be very clean, hygienic, and free from offensive odours, with the exception of outdoor areas, which were littered with cigarette butts. Where faults or problems were identified in relation to the premises, this was communicated through the appropriate maintenance reporting process. Current national infection control guidelines were followed and back-up power was available to the approved centre.

There was a sufficient number of toilets and showers for residents in the approved centre. Toilets were accessible, clearly marked and close to day and dining areas. Wheelchair accessible toilet facilities were identified for use by visitors who required such facilities. The approved centre had a designated sluice room and cleaning room, though it did not have a designated laundry room. The approved centre did not have dedicated therapy or examination rooms, as appropriate. The approved centre did not provide suitable furnishings to support resident independence and comfort as several bedrooms did not have blinds on the windows, though they did have frosted glass. The approved centre provided assisted devices and equipment to address resident needs.

Where substantial changes were required to the approved centre premises, this was appropriately assessed prior to implementation for possible impact on current residents and staff. However, the Mental Health Commission was not informed of works to the outdoor area for Pine and Ash wards that was ongoing at the time of the inspection. Remote or isolated areas of the approved centre were monitored.

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

a) **Some of the rooms, on Ash and Pine units, were not adequately ventilated as the windows within those rooms were locked, 21(1)(b).**
b) **Several of the bedrooms within the approved centre were missing blinds, 21(2).**
c) **The approved centre was observed to be very clean, hygienic, and free from offensive odours, with the exception of the outdoor areas which were littered with cigarette butts, 21(1)(a).**

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

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in June 2017. The approved centre also used two other policies: the Nursing Medication Management Policy, and; the Multi-disciplinary Medication Management – Introduction & Prescribing of Medication. The policies addressed requirements of the *Judgement Support Framework*, with the exception of the processes for medication management at admission, transfer, and discharge.

Training and Education: 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 access to comprehensive, up-to-date information on all aspects of medication management. All nursing and medical staff as well as pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses. The training was documented.

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

Evidence of Implementation: Ten MPARs were examined during the inspection process. All ten detailed two appropriate resident identifiers, the generic name of the medication or preparation (written in full), the dose given, and the administration route for the medication. Micrograms were written in full and MPARs included the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry. The MPARs had dedicated space for routine, once-off, and “as required” medication, and a record of all medications administered to and refused by the resident. The MPARs also contained a clear record of the date of initiation and discontinuation for each medication.

All entries in the MPARs were legible and written in black, indelible ink. Medication was reviewed and rewritten at least six-monthly or more frequently, where there was a significant change in the resident’s care or condition: this was documented in the clinical file. A prescription was not altered where a change

was required: where there was an alteration in the medication order, the medical practitioner rewrote the prescription.

All medicines, including scheduled controlled drugs (except those for self-administration), were administered by a registered medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber and any advice provided by the resident's pharmacist regarding the appropriate use of the product. The expiration date of the medication was checked prior to administration and expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file. Where the resident refused the medication, this was documented in the MPAR and clinical file and communicated to medical staff.

Schedule 2 controlled drugs were checked by two staff members (one of which was a registered nurse) against the delivery form and details were entered on the controlled drug book. The controlled drug balance corresponded with the balance recorded in the controlled drug book and, following administration, the details were entered in the controlled drug book and signed by both staff members.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication storage areas were incorporated in the cleaning and housekeeping schedules and were clean and free from damp, mould, litter, dust, pests, and from spillage or breakage. Food and drink was not stored in areas used for the storage of medication. The medication administration cupboard remained 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. A system of stock rotation was implemented to avoid accumulation of old stock. An inventory of medications was also conducted monthly, checking the name and dose of the medication, its quantity, and expiry date. Medications that were no longer required, which were past their expiry date or had been dispensed to a resident but were no longer required were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was 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 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. An annual Safety Statement was dated April 2018. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

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

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. Not 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 MODERATE

(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 all requirements of the *Judgement Support Framework*, including the purpose and function of using CCTV for observing residents in the approved centre. However, the policy did not include the process for the disclosure of 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 throughout the approved centre. A resident was only monitored for the purposes of ensuring the health, safety, and welfare of that resident. The usage of CCTV or other monitoring systems had been disclosed to the Mental Health Commission and/or the Inspector of Mental Health Services.

CCTV cameras or other monitoring systems used to observe a resident were capable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form. The CCTV cameras transmitted images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they began to act in a way that compromised their dignity.

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

a) **The registered proprietor did not ensure that CCTV was 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 image other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident, 25(1)(d).**
b) **The registered proprietor did not ensure that the use of CCTV was used solely for the purpose of observing a resident by a health professional who was responsible for the welfare of that resident, 25(1)(a).**

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy 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*, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including the Garda vetting requirements.

The policy and procedures did not address the following:

- 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 reviewed on an annual basis. This was documented. 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: There was no organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre's staff. A

planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. The numbers and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty and in charge at all times and this was documented. There was no written staffing plan for the approved centre. The required number of staff were on duty at night to ensure safety of residents in the event of a fire or other emergency.

Annual staff training plans were completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Both orientation and induction training was completed for staff. Not all health care professionals were trained in fire safety, Basic Life Support, the Professional Management of Aggression and Violence, the Mental Health Act 2001, or Children First.

Staff were trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan. Staff were trained in manual handling, infection control and prevention, care for residents with intellectual disabilities, resident rights, risk management, recovery-centred approaches to mental health care and treatment, as well as incident reporting and the protection of children and vulnerable adults. All staff training was documented and staff training logs were maintained. Opportunities were made available to staff by the approved centre for further education and these opportunities were effectively communicated to all relevant staff and supported through tuition support, scheduled time away from work, or recognition for achievement. In-service training was completed by appropriately trained and competent individuals. Facilities and equipment were available for staff in-service education and training.

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

Staff Training Table

Profession	Basic Life Support		Fire Safety		Mgmt. of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (54)	54	100%	25	47%	39	53%	41	76%	54	100%
Medical (28)	12	43%	12	43%	22	79%	8	29%	26	93%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (7)	6	86%	7	100%	6	86%	7	100%	7	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%

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

Staff in Approved Centre			
	Staff Grade	Day	Night
	Assistant Director of Nursing	1	
	Clinical Nurse Manager 3	1	
	Occupation Therapist	2	
	Occupational Therapist Assistant	1	
	Psychologist	1.5	

Ward or Unit Breakdown			
Ward or Unit	Staff Grade	Day	Night
Ash Ward	Clinical Nurse Manager 2	1	
	Registered Psychiatric Nurse	4	3
	Occupation Therapist		
	Social Worker		
	Psychologist		
	Health Care Assistant	1	

Ward or Unit Breakdown			
Ward or Unit	Staff Grade	Day	Night
Pine Ward	Clinical Nurse Manager 1	1	
	Registered Psychiatric Nurse	4	3
	Occupation Therapist		
	Social Worker		
	Psychologist		
	Health Care Assistant	1	

Ward or Unit Breakdown			
Ward or Unit	Staff Grade	Day	Night
High Dependency Unit	Clinical Nurse Manager 2	1	
	Registered Psychiatric Nurse	2	3
	Occupation Therapist		
	Social Worker		
	Psychologist		
	Health Care Assistant	1	

In-reach to Approved Centre*			
	Staff Grade	Day	Night
	Consultant Psychiatrist	12	
	Non Consultant Hospital Doctor	14	
	Occupation Therapist		
	Social Worker	7	
	Psychologist		

Whole time equivalent (WTE)

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

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

a) **Not all health care professionals had up-to-date training in fire safety, Basic Life Support, Professional Management of Aggression and Violence and Children's First, 26(4).**
b) **Not all health care professionals 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 CRITICAL

(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 requirements of the *Judgement Support Framework*, including the following:

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

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

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records. The audit findings did not reflect the findings of the inspection team.

Evidence of Implementation: All residents' records were, up-to-date, and were used in accordance with national guidelines and legislative requirements. However, inspectors had difficulty retrieving information in the clinical files. In one case, staff were unable to locate one resident's volume four record, despite 1-3 and 5-7 being on the ward. The file was eventually located in medical records after considerable time. Some Mental Health Commission documents, such as Form 17s: Consent to Treatment, were located in

the Mental Health Administrators office and not within the clinical files. A record was initiated for every resident assessed or provided with care and services by the approved centre. Resident records were reflective of the residents' current status and the care and treatment being provided, and were maintained using an identifier that was unique to the resident or some other effective method.

Not all resident records were developed and maintained in a logical sequence: two ICP booklets were out of logical sequence in one resident's records. A number of files were not maintained in good order and had loose pages. Resident records were accessible to authorised staff only: staff had access to the data and information needed to carry out their job responsibilities. Residents' access to their records was managed in accordance to the Data Protection Acts, and only authorised staff made entries in resident's records, or specific sections therein.

Records were written legibly in black, indelible ink and were readable when photocopied. Overall, entries were factual, consistent, and accurate and did not contain jargon or unapproved abbreviations; however, a meaningless phrase of "kept a low profile" was observed in one nursing note in a clinical file. Each entry included the date and was followed by a signature, though not all entries included the time using the 24-hour clock. The approved centre did not maintain a record of all signatures used in the resident record.

Where an error was made, this was not consistently scored out with a single line and the correction written alongside with date, time, and initials, as scribbled out notes were observed. Two appropriate resident identifiers were not recorded on all documentation across a number of clinical files. Where a member of staff made a referral to or consulted with another member of the health care team, this person was clearly identified by their full name and title. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre and records were retained or destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

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

a) **The registered proprietor did not ensure that records and reports were maintained in a manner so as to ensure ease of retrieval, 27(1).**
b) **The registered proprietor did not ensure that all records were 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 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 requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The operating policies and procedures 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. The approved centre had an up-to-date policy for all regulations that were required to have one as per this regulation. Obsolete versions of operating policies and procedures were retained but removed from access by staff.

The approved centre had an up to date policy for all regulations that specifically required one as per the Regulation.

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

Regulation 30: Mental Health Tribunals

COMPLIANT

Quality Rating **Satisfactory**

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre provided private facilities 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 satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy 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, 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: There was a nominated person responsible for dealing with all complaints who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. Residents and their representatives were facilitated to make complaints verbally, in writing, electronically by email, over the phone, and through complaint feedback,

or suggestion forms. The registered proprietor ensured access, insofar as was practicable, to advocates to facilitate the participation of the resident and their representative in the complaints process.

The approved centre's management of complaints processes was well publicised and accessible to residents and their representatives. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter in the patient information booklet, and the contact details of the nominated person was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. A method for addressing minor complaints within the approved centre was provided and all minor complaints were documented. Where minor complaints could not be addressed locally, the nominated person dealt with the complaint. All non-minor complaints were also dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's ICP. Where complaints could not be addressed by the nominated person, they were escalated in accordance with the approved centre's policy.

Time frames were provided for responding to a complainant following the initial receipt of a complaint, as well as for the investigation period of a complaint and the required resolution. Where time frames were not achieved or further investigation time was required in relation to the complaint, this was communicated to a complainant. Where applicable, a complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them: this was documented. The complainant's satisfaction, or dissatisfaction, with the investigation findings was documented.

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, including the investigation process and communication requirements with the complainant. All information obtained through the course of the management of the complaint and the associated investigation process was treated in a confidential manner and met the requirements of the Data Protection Acts 1988 and 2003 and the Freedom of Information Act 1997 and 2003.

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

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

(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 written policies in relation to risk management and incident management procedures, which had been reviewed between April and May 2017. The policies addressed requirements of the *Judgement Support Framework*, including the following:

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

The policies did not address the following:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- Organisational risks.
- Structural risks, including ligature points.
- Capacity risks relating to the number of residents in the approved centre.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk, but not all were trained in health and safety risk management. Clinical staff were

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

Monitoring: The risk register was reviewed at least quarterly to determine compliance with the approved centre's risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

Evidence of Implementation: Responsibilities were not allocated at management level and throughout the approved centre to ensure their effective implementation. The non-clinical risk advisor was identified and known to staff, however he stated that he did not have responsibility for the approved centre and only had responsibility for Connolly Hospital. The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. A handle had been attached to a fire door. Structural risks, including ligature points, were not removed or effectively mitigated. Ligature points included, blinds, a handle on a press in the recreation room. Both clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

Health and safety risks were not identified, assessed, treated, reported, monitored, and documented in the risk register by the approved centre in accordance with relevant legislation. The mental health manager and/or designate were responsible to ensure a panic alarm system was in place and operational: however, there were no panic alarms for inspectors on one day of the inspection and an insufficient number on the remaining days. There were insufficient numbers of panic alarms available. In addition, fire doors were held open with chairs and bins, which presented as hazards, and permanent stoppers were fixed to fire doors so as to keep them open. Tape also obstructed the smoke detector, rendering it ineffective. Two fire drills were not carried out in the previous year as required by the policy.

Individual risk assessments were completed prior to and during resident seclusion, physical restraint, resident transfer and discharge, as well as in conjunction with medication requirements or administration, and at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes, as were residents and their representatives. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions and the person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

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

a) **The registered proprietor did not ensure that the risk management policy was implemented in that there was no responsible person(s) overseeing the completion of safety statements and fire registers 32(1).**
b) **Fire doors were held open by chairs and waste bins, permanent stoppers had been attached to some fire doors and a smoke detector was obstructed by the use of tape, 32(1).**
c) **The registered proprietor did not ensure that a panic alarm system was operational as there were insufficient panic alarms for inspectors, 32(1).**
d) **The registered proprietor did not ensure that two fire drills per year had taken place, 32(1).**
e) **Structural risks including ligature points were not removed or effectively mitigated, and new ligatures were added to fire doors, 32(1)**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with two conditions to registration attached. The certificate was displayed prominently at the main entrance to 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 **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated January 2020. 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.

Evidence of Implementation: Three episodes of seclusion were examined on inspection. Residents in seclusion had access to adequate toilet and washing facilities and seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

In all episodes examined, seclusion was initiated by a registered medical practitioner (RMP) or a registered nurse (RN). However, in one episode, there was no documentary evidence that a consultant psychiatrist (CP) was notified as soon as was practicable of the use of seclusion. When seclusion was initiated, it only occurred after an assessment, including risk assessment, and the initiation of seclusion was recorded in the resident's clinical file and seclusion register by the person initiating seclusion. Seclusion orders were recorded in the clinical file and seclusion register by a RMP, who indicated the duration of the seclusion order as no more than eight hours. In one episode, the seclusion register was not signed by the responsible CP or duty CP within 24 hours.

Seclusion was only used in rare and exceptional circumstances and in the 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. Residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of seclusion. In one episode, the resident's next of kin or representative was not informed of the use of seclusion and no reason was recorded in the clinical file.

There was direct observation of the resident by a registered nurse for the first hour of each episode of seclusion examined, with continuous observation evidenced thereafter. There was no four-hourly review by the RMP in one of the episodes examined: a review took place after five hours. Residents were informed of the ending of an episode of seclusion and the reason was recorded in the clinical file along with all uses of seclusion. All uses of seclusion were also recorded on the seclusion register. In one episode, a copy of the seclusion register was not placed in the clinical file.

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

a) **There was no documentary evidence that a consultant psychiatrist was notified as soon as was practicable of the use of seclusion in two episodes, 3.2.**
b) **The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours in one episode of seclusion, 3.5.**
c) **A copy of the seclusion register was not placed in the clinical file in one episode of seclusion, 9.3.**
d) **A reason was not recorded in the clinical file as to why one resident's next of kin or representative was not informed of the use of seclusion, 3.7(a).**
e) **A medical review by a registered medical practitioner was not completed every four hours in one episode of seclusion examined, 5.4.**
f) **There was no written record that staff had read and understood the policy relating to the use of seclusion, 10.2.**

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In each case, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment. In both cases, the patient was unable to consent to continued treatment and a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed.

The forms contained the name of the medications prescribed and a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications. In both cases, the form also contained details of a discussion with the patient, including: the nature and purpose of the medications; the effects of the medications, including any risks and benefits; any views expressed by the patient, and; any supports provided to the patient in relation to the discussion and their decision-making.

The forms also documented the approval by a consultant psychiatrist and the authorisation by a second consultant psychiatrist in each case.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

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 January 2020. 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 been completed.

Evidence of Implementation: Three episodes of physical restraint were examined during the inspection process. Physical restraint (PR) was used in rare, exceptional circumstances and in the best interests of the resident, where the resident posed an immediate threat of serious harm to themselves or others. Physical Restraint was only used after all alternative interventions to manage a resident's unsafe behaviour was considered and was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint.

In all episodes, physical restraint was initiated by a registered medical practitioner (RMP), a registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint and a designated staff member was responsible for leading in the physical restraint and for monitoring the head and airway of the resident. In two episodes, there was no documentary evidence that a consultant psychiatrist (CP) or the duty consultant psychiatrist was notified as soon as was practicable. In one episode, there was no documentary evidence that an RMP completed a physical examination of the resident no later than three hours after the start of an episode of physical restraint. In all episodes, the order for physical restraint lasted a maximum of 30 minutes.

Each episode of physical restraint was recorded in the resident's clinical file and a clinical practice form (CPF) was completed by the person who initiated and ordered the use of PR no later than three hours after the episode. However, the CPF was not signed within 24 hours by a consultant psychiatrist in one of the episodes examined. In all episodes, the resident was informed of the reasons for, likely duration of,

and circumstances leading to the discontinuation of physical restraint unless the information was prejudicial to the resident's mental health, well-being or emotional condition.

The resident's next of kin or representative was informed of the use of PR as soon as was practicable and with the resident's consent. A record of the communication was placed in the clinical file. However, in one episode, the resident's next of kin was not informed of the use of physical restraint and no justification was provided as to why. Where practicable, a same sex staff member was present at all times during the episodes of physical restraint. The resident was afforded the opportunity to discuss the episode with members of the MDT involved in their care as soon as was practicable. In one episode, the completed clinical practice form was not placed in the resident's clinical practice form. Where applicable, each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

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

a) **There was no documentary evidence that a registered medical practitioner completed a physical examination of one resident no later than three hours after the start of the episode of physical restraint, 5.4.**
b) **In one episode, there was no justification recorded in the clinical file as to why the resident's next of kin or representative was not informed of the use of physical restraint, 5.9(a).**
c) **In two episodes, there was no documentary evidence that the consultant psychiatrist or the duty consultant psychiatrist were notified of the use of physical restraint as soon as was practicable, 5.3.**
d) **In one episode, the clinical practice form was not signed by a consultant psychiatrist within 24 hours, 5.7(c).**
e) **In one episode, the completed clinical practice form was not placed in the resident's clinical file, 8.3.**
f) **There was no written record indicating staff had read and understood the policy relating to the use of physical restraint, 9.2(b).**

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 May 2018. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures 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: Documents relating to the admission of a child to the approved centre was examined during the inspection process. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided by the approved centre, as it was an adult unit. Provisions were in place to ensure the safety of the child, to respond to a child's special needs as a young person in an adult setting, and to ensure the right of the child to have their views heard. Staff that had contact with the child had undergone Garda vetting and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff.

Appropriate accommodation was designated to the child, including age and gender-segregated sleeping and bathroom areas. Staff observation acknowledged gender sensitivity. Observation arrangements, including assignment of a designated staff member, was provided as considered clinically appropriate. Children did not have access to age-appropriate advocacy services.

Children had their rights explained to them and information was provided about the ward and the facilities available in a form and language they could understand. Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre. Appropriate visiting arrangements for families were available, including for children visiting. The Commission was notified of all children admitted to the approved centre for adults within 72 hours of admission using the associated notification form. Consent for treatment was obtained from one or both parents.

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

a) **Children did not have access to age-appropriate advocacy services, 2.5(g).**
b) **Age-appropriate facilities and a programme of activities appropriate to age and ability of children admitted to the approved centre were not provided, 2.5(b).**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

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 and transfer policies, but not the discharge policy.

Evidence of Implementation:

Admission: One clinical file was examined in relation to the admission process. The admission was on the basis of mental illness or mental disorder. The resident 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. A key worker system was in place in the approved centre.

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

Discharge: The clinical file of one resident who had been discharged was examined. The resident's discharge plan included the estimated date of discharge, a follow-up plan, and documented communication with the relevant general practitioner, primary care team, or community mental health team. However, the discharge plan did not include a reference to early warning signs of relapse and risks. The discharge meeting was not attended by residents, key worker and family, carer, or advocate, where appropriate: only the consultant psychiatrist attended the meeting.

The resident's discharge assessment addressed their psychiatric and psychosocial needs, current mental state examination, a comprehensive risk assessment and risk management plan, and informational needs. The discharge was coordinated by a key worker and a preliminary discharge summary was sent to the general practitioner, primary care team, or community mental health team within three days. However, a comprehensive discharge summary was not evidenced to have been issued within 14 days. The

comprehensive discharge summary included details of the resident's diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse. The comprehensive discharge summary did not include details of outstanding health or social issues. There was a timely follow-up appointment.

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

a) **The discharge plan for one resident did not include a reference to early warning signs of relapse and risks, 34.2.**
b) **One discharge did not include a documented discharge meeting attended by the resident, key worker and a family member, carer, or advocate, 34.4.**
c) **One discharge did not include a comprehensive discharge summary issued within 14 days, 38.3(b).**
d) **There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies, 9.1.**
e) **There was no audit of the implementation of and adherence to the discharge policy, 4.19.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 12: Communication					
Reason ID : 10001371		**Residents in HDU were restricted in their communications under a blanket rule, and individual needs had not been assessed. The registered proprietor and the clinical director did not ensure that the resident was free to communicate at all times, having due regard to their wellbeing, safety, and health, 12(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All residents are free to communicate at all times, having due regard to their wellbring,safety and health. The wirtten operational Communication Policy to be amended with removal of the "Blanket Rule" and access to communication for patients in HDU to be based on risk/clinical assessment as deemed necessary and documented in the Individual Care Plan.	Annual review of Policies by Compliance and Policy Committee.	Achievable & Realistic	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Communication Policy to be amended with removal of "Blanket Rule" and access to communication for	Annual review of Policies by Compliance and Policy Committee.	Achievable & Realistic	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	patients in HDU to be based on risk/clinical assessment.				
Reason ID : 10001372		**The approved centre's policy did not include the operational policies and procedures of the HDU and was therefore incomplete, 12(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	HDU to be added and explicitly specified in the Approved Centre's Communication Policy.	Annual review of Policies by Compliance & Policy Committee.	Achievable	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	HDU to be explicitly and specifally added to the Communication Policy and all other applicable policies where also necessary	Policy reviews by Compliance & Policy Committee.	Achievable & Realistic	31/12/2020	Clinical Director; Nursing Management (DONA/CMN3), Compliance & Policy Committee.

Regulation 19: General Health					
Reason ID : 10001409		**The registered proprietor did not ensure that all resident's general health needs were assessed regularly and no later than every six months, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All patients with pending General Health Assessments had assessments completed. New system to be introduced where patients are clearly identified to the team that the patient has been admitted for 6 months. This has been discussed with Compliance and Policy Committee and will be rolled out (Dependent on COVID19 restrictions)	To be reviewed by Compliance and Policy Committee.	Achievable and Realistic	30/09/2020	Clinical Director; Responsible Consultant Psychiatrists; Compliance and Policy Committee.
Preventative Action	New system to be introduced where patients are clearly identified to the team that the patient has been admitted for 6 months. This has been discussed with Compliance and Policy Committee and will be rolled out	To be reviewed by Compliance and Policy Committee.	Achievable and Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Responsible Consultant Psychiatrists; Compliance and Policy Committee.

	(Dependent on COVID19 restrictions)				

Regulation 21: Privacy					
Reason ID : 10001402		**A resident observation checklist containing residents' full names was left unattended on the corridor in Ash Ward.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Checklist was removed at time of inspection and staff aware of GDPR obligations.	Checklist removed.	Achievable.	18/09/2020	Clinical Director; Head of Security; Nursing Management.
Preventative Action	Security moved to own room away from main corrdior. Checklist is contained within folder obsecuring names from view.	Reviewed by Compliance and Policy Committee	Achievable and Realistic.	31/10/2020	Clinical Director; Head of Security; Nursing Management.

Regulation 22: Premises					
Reason ID : 10001395		**Some of the rooms, on Ash and Pine units, were not adequately ventilated as the windows within those rooms were locked, 21(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Service Manager Dublin North City has liaised with estates/maintenance in order to acquire suitable windows that allow security and ventilation. Members of the Managment team have conducted site visits to review windows. Funding bid will be developed and works will require tender and will be added to the Programme of Works. This process has potential to be affected by COVID19 restrictions.	Process to be reviewed by Compliance and Policy Committee with feedback to Local Area Management Committee.	Achievable & Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Local Area Management in Dublin North City Mental Health Services and HSE Estates.
Preventative Action	DNC Service Manager has liaised with estates/maintenance in order to acquire suitable windows that allow security and ventilation. This	Process to be reviewed by Compliance and Policy Committee with feedback to Local Area	Achievable & Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Local Area Management in Dublin North City Mental Health Services and HSE estates.

	process has potential to be affected by COVID19 restrictions.	Management Committee.			
Reason ID : 10001396		**Several of the bedrooms within the approved centre were missing blinds, 21(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	I wish to confirm that since the date of the Inspection the Company who repair blinds have repaired the broken/missing blinds.	Process to be reviewed by Compliance and Policy Committee with feedback to Local Area Management Committee.	Achieved	30/11/2020	Clinical Director; Service Manager, Local Area Management of Dublin North City Mental Health Services.
Preventative Action	Blind manintenance is an ongoing issue in the approved centre. Blinds are often damaged or missing leading to probelms. Approved centre to engage regular review of blinds on windows on a bimonthly basis. The DNC Service Manager has progressed work to secure a Programme of Maintenance and this should be in place by 2021.	All staff encouraged to report deficits with physical infrastructure to Compliance and Policy Committee. Programme of Maintenance/Estates items progressed by the Service Manager/nominee and will be standing item on Compliance committee agenda.	Achievable & Realistic	31/12/2020	Clinical Director; Service Manager, Local Area Management of Dublin North City Mental Health Services.
Reason ID : 10001397		**The approved centre was observed to be very clean, hygienic, and free from offensive odours, with the exception of the outdoor areas which were littered with cigarette butts, 21(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Out door areas were cleaned and renovated after the MHC inspection.	Reviewed by Compliance and Policy Committee.	Achievable and Realistic.	25/09/2020	Clinical Director; Nursing Management Service Manager.
Preventative Action	Ongoing programme of cleaning of outdoor areas established. A Smoke Free Campus Committee is proposed to be established to explore options of Department of Psychiatry moving to smoke free campus.	Reviewed by Compliance and Policy Committee.	Achievable & Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Nursing Management.

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10001373		**The registered proprietor did not ensure that CCTV was 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 image other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident, 25(1)(d).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The CCTV cameras in the Seclusion have potential abilty to record but this function is disabled in software thus satff do not have access to recording function.	CCTV camera in Seclusion Room unable to record patient activity this functionality is disabled.	Achievable & Realistic	30/09/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Ensure rcording functionality cannot be engaged in softward for CCTV system for Seclusion Facility.	To be reveiwed on annual walk around of premises by senior management.	Achievable & Realistic (Pending COVID19 restrictions)	30/09/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10001374		**The registered proprietor did not ensure that the use of CCTV was used solely for the purpose of observing a resident by a health professional who was responsible for the welfare of that resident, 25(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The CCTV camera which are located on the main corridor of the approved centre which are located outside the doors to Ash Ward and Pine Ward will be disabled and removed (ie	Measurable upon removal of the CCTV camera system.	Achievable & Realistic	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	those within the Approved Cntre). The CCTV camera system used to monitor the seclusion room will remain as this is only used for observing a resident by a health care professional who is responsible for the welfare of the resident.				
Preventative Action	The only CCTV camera system remaining within the approved cetnre will the system in the Seclusion Room and this is compliant with clear business purpose for its use in accordance with GDPR.	CCTV camera system in Seclusion Facility is only used by Health Care Professionals for the sole purpose of observation of Residents. The other CCTV system within approved centre will be removed at earliest opportunity. Maintenace and Estates will be tabled as standing item on the agenda of the complance committee in future.	Achievable & Realistic funding approved	31/12/2020	Clinical Director; Nursing Management, Service Manager, Compliance & Policy Committee.

Regulation 27: Maintenance of Records					
Reason ID : 10001412		**The registered proprietor did not ensure that records and reports were maintained in a manner so as to ensure ease of retrieval, 27(1). The registered proprietor did not ensure that all records were in good order, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A) The registered proprietor did not ensure that records and reports were maintained in a manner so as to ensure ease of retrieval, 27(1). B) The registered proprietor did not ensure that all records were in good order, 27(1). Corrective Action: All files are to be maintained in a manner so as to ensure ease of retrieval and that all records were in good order.	A) Audits are performed on a regular basis by both administration and nursing. Results monitored by the Compliance and policy committee B) Audits are performed on a regular basis by both administration and nursing. Results monitored by the Compliance and policy committee	A) Immediate - subject to Covid contingencies B) Immediate - subject to Covid contingencies	31/12/2020	A) Clinical Director; MDT Staff, Service Manager (admin staff); Compliance and Policy Committee. B) Clinical Director; MDT Staff, Service Manager (admin staff); Compliance and Policy Committee.
Preventative Action	A) Monthly audit of files B) HSEland online training on Maintenance of records Module to be completed by all staff	A) Monthly audits and results monitored by Compliance and Policy Committee. B) Monthly audits and results monitored by	A) Immediate - COVID dependent B) Immediate - COVID dependent	31/12/2020	A) Clinical Director, Service Manager (admin staff); Compliance and Policy Committee. B) Clinical Director, Service Manager (admin staff); Compliance and Policy Committee.

		Compliance and Policy Committee.			

Regulation 32: Risk Management Procedures					
Reason ID : 10001390		**The registered proprietor did not ensure that the risk management policy was implemented in that there was no responsible person(s) overseeing the completion of safety statements and fire registers 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	As per the JSF, 2015, 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. The DNC Health & Safety Committee is chaired by the DNC Service Manager, this Committee reviews Risk Assessments to inform Service/Site Specific Safety	Policy when complete to be submitted to Quality and Patient Safety and Health & Safety Committee of Dublin North City Mental Health Services.	Achievable & Realistic	31/10/2020	Clinical Director; Nursing Management, Compliance & Policy Committee, DNC Health & Safety Committee

	Statesments and Fire Registers. management policy is in process of being issued to address the deficits highlighted above. The CHODNCC Fire Officer visited the Approved Centre immediately after the inspection to introduce updated measures for this agenda.				
Preventative Action	Risk management policy to be monitored regularly as per date on policy. To be reviewed by the Compliance and Policy Committee.	For review by Compliance and Policy Committee and overseen by the Quality and Patient Safety and H&S Committees of Dublin North CIty Mental Health Services.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10001391		**Fire doors were held open by chairs and waste bins, permanent stoppers had been attached to some fire doors and a smoke detector was obstructed by the use of tape, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Isuses identified during inspection were reported to Connolly Hospital Maintenance/Estates Department and	Connolly Hospital and DNC Management Team are developing an Estates/ Maintenance SOP	Achievable & Realistic	23/09/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	repaired during time of inspection. To progress this requirement Connolly Hospital/CHODNCC Estates to identify works and service responsible for works that are required. It is imperative that we have a consensus in respect of maintenance requirements going forward for the Department of Psychiatry and Sycamore. CHODNCC Estates developed draft Maintenance Programme for consideration. The Service Manager, DNC is meeting with the Estates Manager, Connolly Hospital to review.				
Preventative Action	Annual Fire Safety check to be carried out as part of annual health and safety inspection. All deficits detected to	Reviewed by Health and Safety Committee of Dublin North City Mental Health Services.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	be reported to Connolly Hospital Estates and Maintenance Immediately.				
Reason ID : 10001392		**The registered proprietor did not ensure that a panic alarm system was operational as there were insufficient panic alarms for inspectors, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Panic alarm systems are operational and pologies for the insufficient numbers of panic alarms available for inspection at time of inpsection.	Under consideration by Compliance and Policy Committee.	Yes funding approved	18/09/2020	DNC Service Manager has approved funding for the purchase of Panic alarms. New system for ensuring distribution; charging and return of panic alarms to be inplemented.
Preventative Action	New Panic alarms to be purchased and request submitted in regards to this. New system for ensuring distribution; charging and return of panic alarms to be inplemented. Under consideration by Compliance and Policy Committee.	To be reviewed by Compliance and Policy Committee.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Management Dublin North City Mental Health Services; Compliance & Policy Committee.
Reason ID : 10001393		**The registered proprietor did not ensure that two fire drills per year had taken place, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	DNC Service Manager has linked with the CHODNCC Fire Officer. Fire Drill to	Frequency of Fire Drillsl to be monitored by the	Achievable & Realistic (COVID19 dependent)	31/10/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	be organised with Fire Safety Officer at the soonest opportunity (COVID19 restrictions dependent).	Compliance and Policy Committee.			
Preventative Action	DNC Service Manager to ensure two annual fire drills to be arranged with Fire Offiicer	Reviewed by Compliance and Policy Committee.	Achievable & Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10001394		**Structural risks including ligature points were not removed or effectively mitigated, and new ligatures were added to fire doors, 32(1)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature Audit to be conducted to review ligature risks as identified.	Reviewed by Compliance and Policy Committee and overseen by Quality and Patient Safety Committee as well as Health and Safety Committee of Dublin North City Mental Health Services.	Achievable & Realistic (COVID19 restrictions dependent)	31/10/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Annual ligature audit to be conducted.	Reviewed by Compliance and Policy Committee and overseen by Quality and Patient Safety Committee as well as Health and Safety Committee of Dublin North City	Achievable & Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

		Mental Health Services.			

Rules Governing the Use of Seclusion					
Reason ID : 10001403		**There was no documentary evidence that a consultant psychiatrist was notified as soon as was practicable of the use of seclusion in two episodes, 3.2.The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours in one episode of seclusion, 3.5. A copy of the seclusion register was not placed in the clinical file in one episode of seclusion, 9.3. A reason was not recorded in the clinical file as to why one resident's next of kin or representative was not informed of the use of seclusion, A medical review by a registered medical practitioner was not completed every four hours in one episode of seclusion examined, 5.4.3.7(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	WIll retrospecitively file the copy of the seculsion register in relevant patient's medical notes. All staff in High Dependence Unit to receive training on the policy relating to the use of Seclusion and confirm the correct processes to be followed before; during and after.	Completion of filing and training is measurable.	Achievable	30/11/2020	Clinical Director; Nursing Management and Compliance and Policy Committee.
Preventative Action	All new staff to the Department are to recieve training on the policy on Seclusion and will sign that training has been completed as part of induction. Training on	Audit of Seclusions to be performed on six monthly basis.	Achievable and Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Nursing Management; Complinace and Policy Committee.

	Seclusion rules to be organised on rolling basis by managment and available to attend by all staff in Approved Centre. New paper work to be introuced (Care Bundle) which is a sticker based checklist that ocvers all procedures of seclusion rules. This will be introduced by management to the Approved Centre in January 2021 and encourage better compliance with rules as outlined by MHC.				
Reason ID : 10001408		**There was no written record that staff had read and understood the policy relating to the use of seclusion, 10.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to recieve policy with method of recording that they have read policy. This may need to be an on-line method due to COVID19 restrictions.	To be monitored by Compliance and Policy Committee	Achievable and Realistic (COVID 19 Restrictions Dependent)	31/10/2020	Clinical Director; Head of Disciplines; Compliance Committee.

Preventative Action	All staff to recieve policy with method of recording that they have read policy. This may need to be an on-line method due to COVID19 restrictions. Policy to be included in induction process for all new staff in unit.	To be monitored by Compliance and Policy Committee	Achievable and Realistic (COVID 19 Restrictions Dependent)	31/12/2020	Clinical Director; Head of Disciplines; Compliance Committee.

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10001382		**There was no documentary evidence that a registered medical practitioner completed a physical examination of one resident no later than three hours after the start of the episode of physical restraint, 5.4. In one episode, there was no justification recorded in the clinical file as to why the resident's next of kin or representative was not informed of the use of physical restraint, 5.9(a).n two episodes, there was no documentary evidence that the consultant psychiatrist or the duty consultant psychiatrist were notified of the use of physical restraint as soon as was practicable, 5.3. n one episode, the clinical practice form was not signed by a consultant psychiatrist within 24 hours, 5.7(c). In one episode, the completed clinical practice form was not placed in the resident's clinical file, 8.3.**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Use of Physical Restraint Training to be provided to all staff working in High Dependence area in the correct procedure to follow in relation to Physical Restraint. The Mental Health Act Administrator will continue management of statutory forms and file into charts.	Six Monthly audit	Yes	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	To ensure that education on Physical Restraint Policy is embedded and inculcated will be included in all induction programmes for new staff (Medical; Nursing and Health and Social Care Profesisonals) from dated of next staff intake. Staff to sign policy document to show that they have received training and read and understood the	To be reviewed by six monthly audit and will be reported to Compliance & Policy Committee	Achievable as care bundle will be in operation with effect from December 2020. New Medical staff due to start in January 2020; Nusing and HSCP commence work on a rolling basis and explicit instruction to be provded when they commence work.	31/12/2020	Clinical Director; Nursing Management, Service Manager, Compliance & Policy Committee.

	policy relating to the use of physical restraint. A new form to be introduced to medical records (care bundle) which is a checklist in sticker form that will be inserted into patient's chart subsequent to an episode of Physical Restraint. This will ensure staff awareness of the correct procedure following epsiode of restraint including the necessity for Physical Examination; Contact of NoK or Family Member; ensure requirement for correct signing of statutory paperwork. Plan to ensure adequate cover for Mental Health Act Administrator when on leave to ensure that filing function is completed.				
Reason ID : 10001387		**There was no written record indicating staff had read and understood the policy relating to the use of physical restraint, 9.2(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to be circulated Policy and sign in log will be kept to confirm that they have read and understood the policy mechanism (likely to be on-line remote process for some staff groups due to COVID19 restrictions)	Audit of compliance with policy sign-in monitored by Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Due to need to reduce handling of documents by more than one person process will likely have to move to on-line)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

Preventative Action	All existing staff to be circulated policies and asked to give evidence of having read them at the start of each year. All new staff to have policies included in induction process.	Audit of policy sign-in to be monitored by Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Due to need to reduce handling of documents by more than one person process will likely have to move to on-line)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10001388		**Children did not have access to age-appropriate advocacy services, 2.5(g)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Issue previously discussed at Compliance and Policy Committee and was unable to identify approrpiate agencies. Compliance Committee will again explre options available. Policy of unit is that children are admitted for a brief time when unavoidable and awaiting transfer to apprpriate unit. Services are only able to be identified when there is aprolonged admission and this is tailored to the needs to the particular circumstances.	Reviewed by Compliance and Policy Committee.	Unrealistic and unachieveable. Likely that appropriate advocacy services will only be identied at the time of a prolonged admission of a child.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Compliance and Policy Committee will attempt to identify agency that will provide advocacy services.	To be reviewed by Compliance & Policy Committee	Unrealistic. As admission of a child has been an unusual event it is unlikely any advocacy service will provide input on regular basis. Likely that advocacy services will only be engaged at time of prolonged admission.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10001389		**Age-appropriate facilities and a programme of activities appropriate to age and ability of children admitted to the approved centre were not provided, 2.5(b)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Age apropriate facilites are to be provided to children on an individual basis as admission of a child is an unusual event. Policy of unit is that admission of a child is only when no other option is necessary and the admission is only pending transfer to appropriate unit.	To be reveiwed by Compliance & Policy Committee.	Achievable & Realistic (Pending COVID19 restrictions) to have policy on sorcing appropriate facilites at time of prolonged admission of child.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Age apropriate facilites are to be provided to children on an individual basis as admission of a child is an unusual event. Policy of unit is that admission of a child is only when no other option is necessary and the admission is only pending transfer to appropriate unit.	To be reveiwed by Compliance & Policy Committee.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10001377		**One discharge did not include a documented discharge meeting attended by the resident, key worker and a family member, carer, or advocate, 34.4. The discharge plan for one resident did not include a reference to early warning signs of relapse and risks, 34.2. One discharge did not include a comprehensive discharge summary issued within 14 days, 38.3(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Once file identifier recieved the Service will to retrieve patient file the subject of the breach of discharge policy and inform treating team of same. Will urgently assess and ensure the team has retrospectively corrected deficit and if not, completed to date, will advise on way to remedy deficit and ensure learning. Would be grateful for File Identifier to inform this process.	QPS Committee	Once File identified will be implemented in full asap	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee; Responsible Consultant Psychiatrist.
Preventative Action	Audit on the implementation of and adherence to the dicharge Policy to be conducted on a six monthly basis. Audit results will be relayed to the teams on areas of non-compliance.	Six monthly Audit of policy.	Achievable & Realistic	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10001380		**There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies, 9.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to be circulated Admission, Transfer and Discharge policy document	Audit of Policy signing logs to be done annually.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Heads of

	with sign-in sheet to indicate that they understand same.				Disciplines; Compliance & Policy Committee.
Preventative Action	All staff to be circulated Admission, Transfer and Discharge olicy document with sign-in sheet. All new staff at induction to be circulated wtih all policies and sign-in sheet.	Audit of Policy signing sheets and logs to be done annually.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Heads of Disciplines; Compliance & Policy Committee.
Reason ID : 10001381		**There was no audit of the implementation of and adherence to the discharge policy, 4.19.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Audits of the implementaiton of and adherence to the Discharge Policy to completed on next Audit cycle (end of month) subject to COVID19 restrictions.	Audits reviewed by Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Updated note: Audits were suspended subsequent to Infection Prevention Control risk assessnent due to requirement to reduce footfall and mimismise numbers of staff handling charts at the Approved Centre.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Audit on Admission/Discharge/Transfer Policy to be included in six Monthly Audit cycle.	Audits reported to Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Note: Audits were suspended as an infection risk during maximum retriction level due to attempts to reduce number of people ahndling charts and reduced footfall into Approved Centre)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

Appendix 2: Background to the inspection process

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

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

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

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

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

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

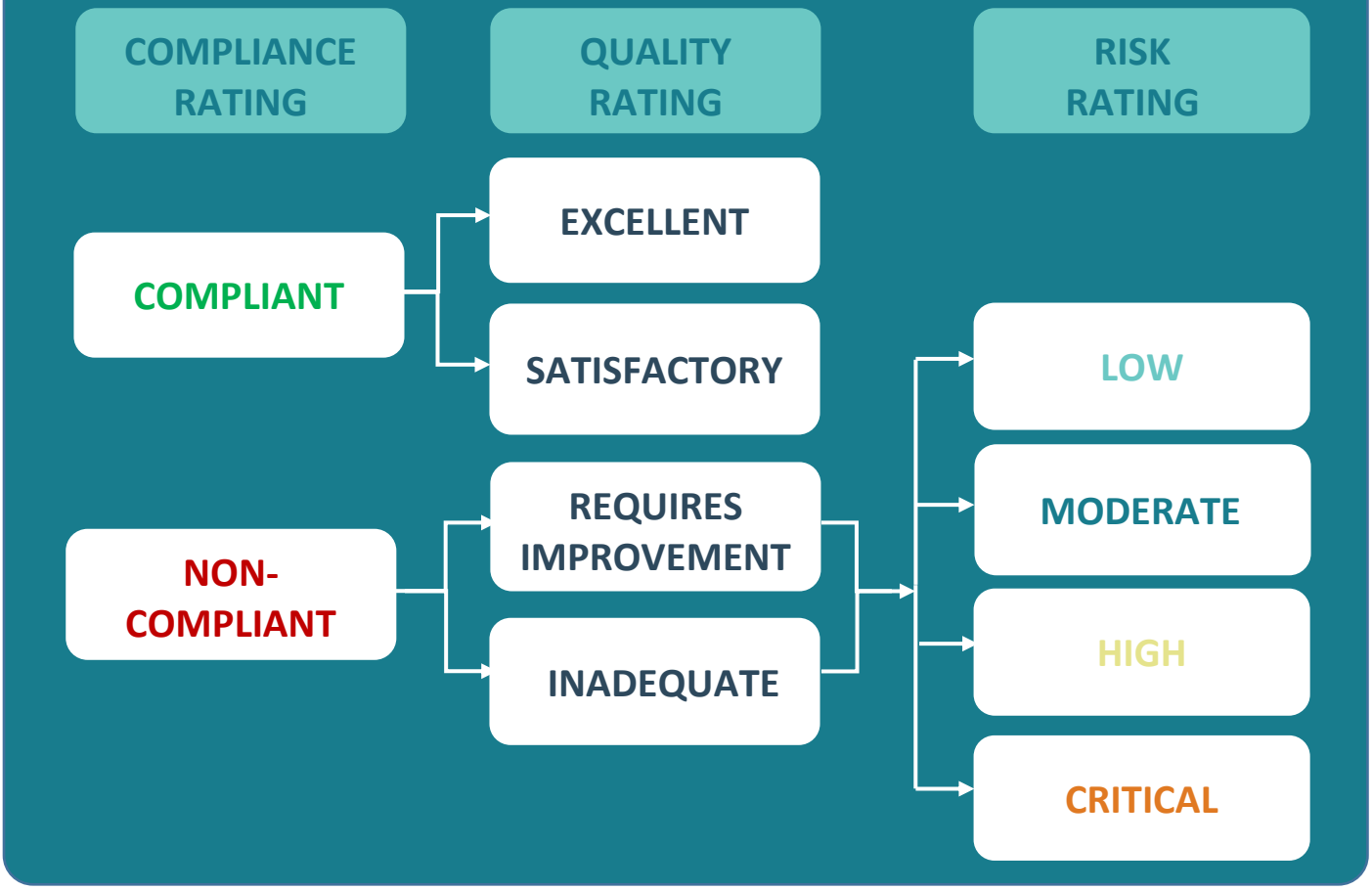
The Inspector will also assess the quality of services provided against the criteria of the *Judgement Support Framework*. As the requirements for the rules, codes of practice and Part 4 of the 2001 Act are set out exhaustively, the Inspector will not undertake a separate quality assessment. Similarly,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

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

COMPLIANCE, QUALITY AND RISK RATINGS

The following ratings are assigned to areas inspected:

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



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

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

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

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