Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	St John of God Hospital Limited
IDENTIFICATION NUMBER	AC0046
APPROVED CENTRE TYPE	Acute Adult Mental Health Care Psychiatry of Later Life Child and Adolescent Mental Health Care
REGISTERED PROPRIETOR	St John of God Hospital Limited
REGISTERED PROPRIETOR NOMINEE	Ms Emma Balmaine
MOST RECENT REGISTRATION DATE	17 May 2016
NUMBER OF RESIDENTS REGISTERED FOR	183
INSPECTION TYPE	Unannounced
INSPECTION DATE	24, 25, 26 May 2016
PREVIOUS INSPECTION DATE	3, 4 November 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Ms Mary Connellan
INSPECTION TEAM	Ms Marianne Griffiths Dr Susan Finnerty MCRN 009711 Dr Fionnuala O'Loughlin MCRN 08108
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCRN 009711

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1.0 Mental Health Commission 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, and
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 shall 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 shall 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 shall be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgment 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. The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART).

The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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

2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

The approved centre was located in Stillorgan in south County Dublin. It was situated on the main Stillorgan dual carriageway, set back from the road amid extensive grounds. It was a national service of the Saint John of God Hospitaller Services and was an independent not-for-profit organisation with 183 in-patient beds. It also provided a public in-patient service for the catchment area of the Cluain Mhuire Mental Health Services in South Dublin.

The approved centre provided specialist services in substance misuse, psychotic disorders, eating disorders, psychiatry of later life and adolescent disorders. The approved centre was affiliated with University College Dublin, Trinity College Dublin, Dublin City University and the University of Limerick for undergraduate and postgraduate healthcare professional programmes.

2.2 Conditions to Registration

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

2.3 Governance

There was an organisational chart and clear governance structures in place. Minutes of the Clinical Governance, Quality and Safety Executive Committee meetings were provided to the inspection team and evidenced monthly meetings with appropriate governance structures. Senior management team meetings were also held monthly and the minutes indicated a thorough and robust agenda with documented actions and outcomes. Separate senior management meetings were held at least quarterly for the Ginesa (Adolescent) service.

2.4 Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against that were applicable to this approved centre.
The inspection was undertaken onsite in the approved centre from:

24 May 2016 09:00	to: 24 May 2016 17:00
25 May 2016 08:00	to: 25 May 2016 18:00
26 May 2016 08:00	to: 26 May 2016 17:00

2.5 Non-compliant areas from 2015 inspection

The previous inspection of the approved centre on 3 and 4 November 2015 identified the following areas that were not compliant:

Regulation/Rule/Act/Code	Inspection Findings 2016
Regulation 4 Identification of Residents	Compliant
Regulation 29 Operating Policies and Procedures	Compliant
Code of Practice on the Use of Physical Restraint	Non-compliant

2.6 Corrective and Preventative Action plan

The approved centre was required to submit details of Corrective and Preventative Actions (CAPAs) to address areas of non-compliance as a result of the inspection of 2015. In all, there were three areas of non-compliance requiring CAPAs. The inspection team assessed the actions taken by the approved centre to implement the CAPAs submitted by the service following the 2015 report. All the CAPAs had been implemented by the approved centre to address areas of non-compliance identified in the 2015 inspection report.

2.7 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 15 Individual Care Plan	Low
Regulation 22 Premises	High
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines	Low
Regulation 26 Staffing	Moderate
Part 4: Consent to Treatment	Moderate
Code of Practice on the Use of Physical Restraint	Low
Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disability	Low
Code of Practice on Admission, Transfer and Discharge	Low

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.

2.8 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 4 Identification of Residents
Regulation 5 Food and Nutrition
Regulation 6 Food Safety
Regulation 7 Clothing
Regulation 8 Residents' Personal Property and Possessions
Regulation 9 Recreational Activities
Regulation 10 Religion
Regulation 11 Visits
Regulation 12 Communication
Regulation 16 Therapeutic Activities
Regulation 20 Provision of Information to Residents
Regulation 21 Privacy
Regulation 24 Health and Safety
Regulation 27 Maintenance of Records
Regulation 29 Operating Policies and Procedures
Regulation 31 Complaints Procedures

2.9 Areas not applicable

The following areas were not applicable as the rule, regulation, code of practice or Part 4 of the Mental Health Act 2001 was not relevant to this approved centre at the time of the inspection.

Regulation/Rule/Act/Code
Section 69 The use of Mechanical Restraint

2.10 Areas of good practice identified on this inspection

- A comprehensive *Orientation and Induction Booklet* had been introduced for the Nursing Department. This included all the relevant policies, procedures and protocols within the approved centre. The induction process was delivered over a ten-week period.
- *Dynamic Risk Implementation Committee* had organised training for 180 staff (at the time of inspection) in Risk Management. This training was ongoing.
- *The Manchester Patient Safety Framework* (MPSF) was to be piloted with two committees in the approved centre. It was then to be evaluated with a view to implementing it across the approved centre.
- A patient information centre, *Seomra Eolais,* had opened in the main reception area. This was staffed by volunteers and contained information on mental health and related matters. There were tablets with internet access available and applications for a range of topics such as relaxation methods and information on medication. An initiative to assist residents with skills to use a Tablet had commenced.

2.11 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.

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

There was one patient on approved leave for an afternoon at the time of inspection.

2.13 Resident Interviews

Residents were invited to speak with the inspection team. Posters indicating the presence of an inspection team in the approved centre and identifying times and dates for discussion were displayed in the approved centre during the inspection.

The inspectors met with eight residents from the Ginesa suite, three residents from St Peter's and seven from the remaining suites. Residents were complimentary of their stay in hospital to include the care and treatment, hospitality and catering department, and overall hospital environment and facilities.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	124	7	12	143
	Involuntary Patients	14	2	0	16
	Wards of Court	0	0	0	0
DAY 2	Voluntary Residents	119	7	12	138
	Involuntary Patients	15	2	0	17
	Wards of Court	0	0	0	0
DAY 3	Voluntary Residents	115	7	12	134
	Involuntary Patients	15	2	0	17
	Wards of Court	0	0	0	0

2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. Attendees from the approved centre were:

- The Registered Proprietor nominee
- The Clinical Director nominee, Consultant in Old Age Psychiatry
- The Director of Nursing
- The Occupational Therapy Manager
- The Principal Psychologist
- The Head of Social Work
- The Head of Operations and Quality
- The Human Resource and Operations Manager
- The Clinical Nurse Manager (CNM 2) from Ginesa suite
- The Clinical Nurse Manager (CNM 2) from St Peter's suite
- The Head of Pharmacy
- Nurse Practice Development Coordinator
- The Deputy Director of Nursing

The inspection team sought and was provided with further information and clarification was received on a number of issues. These are reported in the body of the report under the relevant regulation, rule or code of practice.

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

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: There was a policy entitled *Identification of Residents*. The roles and responsibilities of staff in the approved centre were identified in the policy. The policy included processes to ensure that all clinical staff used a minimum of two appropriate identifiers when prescribing care and treatment to a resident. There was a process for similar or same named residents.

Training and Education: Staff had read and understood the policy. This had been documented. Staff could articulate the process for resident identification.

Monitoring: An audit had been undertaken in March 2016 and an analysis had been completed to identify opportunities to improve the process.

Evidence of Implementation: There were a minimum of two resident identifiers appropriate to the resident profile and individual needs. This included photographic identification. Identifiers were person-specific and were appropriate to the residents' communication abilities. Two identifiers were used when administering medication and before provision of therapies and services. A red sticker alert system was used for similar or same named residents and a temporary alert was in place on the residents Mental Health Information System (MHIS) electronic record.

A Corrective and Preventative Action Plan had been completed following the inspection in 2015 to address the area of non-compliance.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.5 Regulation 5: Food and Nutrition

(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: There was a policy entitled *Food and Nutrition*. Roles and responsibilities were identified in the policy. There was a process for the management of food for each resident which included an assessment of dietary and nutritional needs when required. There was a process for the monitoring of food and water intake.

Training and Education: Staff had read and understood the policy on food and nutrition. This had been documented. Staff could articulate the processes for food and nutrition as set out in the policy.

Monitoring: Menu plans had been reviewed. Feedback from residents' satisfaction survey had been analysed and acted upon. An audit was commencing.

Evidence of Implementation: The approved centre menus had been reviewed and approved in accordance with the residents' needs. The residents were provided with a variety of wholesome and nutritious food choices at each meal. There was a vegetarian option and a salad option for both the main meal and evening tea. There was a seven-week menu cycle that changed daily and was displayed in advance. Special diets and preference requests were facilitated. Light snacks were provided in between meals with tea and coffee. There were water coolers throughout the approved centre.

Evidence-based nutritional tools were used to assess nutrition where applicable. There was access to a dietician who also worked as part of the multi-disciplinary team (MDT) for identified residents. Weight charts were implemented and monitored when indicated. Every resident was weighed on admission. Input and output charts had been maintained where appropriate.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.6 Regulation 6: Food Safety

(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: There was a policy entitled *Food Safety.* The policy identified the relevant roles and responsibilities with regard to food safety. It included procedures for food preparation, handling, storage and disposal controls. The policy referenced the relevant legislative requirements. There was a process for the management of catering equipment.

Training and Education: Staff had read and understood the policy on food safety. Staff could articulate the processes for food safety. All relevant staff had up to date training in the application of Hazard Analysis and Critical Control Points (HACCP).

Monitoring: Food and fridge temperatures had been recorded in line with food safety requirements and logs had been maintained. Actions identified by the Environmental Health Officer's (EHO) report in 2016 had been completed.

Evidence of Implementation: There were ample appropriate separate hand washing facilitates for the catering staff. There was suitable catering equipment both in the main kitchen and individual dining areas which included facilities for refrigeration, storage, preparation, cooking and serving of food. Some catering personnel wore personal protective clothing while serving food. Cleaning schedules were maintained and all catering areas and equipment observed had been appropriately cleaned. Different food stuffs had been prepared in specific identified areas that reduced the risk of contamination, food spoilage and infection. There was an ample supply of crockery and cutlery for residents.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.7 Regulation 7: Clothing

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 policy entitled *Patients' Clothing and Property.* The policy included the provision, where necessary, to provide the resident with emergency personal clothing. The policy included provision for the use of day and night clothes as specified in the individual's care plan. The policy stated that residents were encouraged to change out of night clothes during the day. There was a separate policy for laundry procedures when it was not possible for residents to send their laundry home.

Training and Education: Staff had read and understood the policies on clothing and property. This was documented. Staff could articulate the processes for residents' clothing.

Monitoring: The availability of an emergency supply of clothing had been monitored and this was documented. A record of residents wearing night clothes during the day was kept. No residents were prescribed their night clothes as part of their individual care plan during the audit cycle.

Evidence of Implementation: Residents were supported to keep and use their own personal clothing. There was an emergency supply available on each suite. All residents changed out of their night attire during the day unless specified in their individual care plan. Each resident had their own lockable wardrobe or room. Laundry facilities were available within the approved centre.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.8 Regulation 8: Residents' Personal Property and Possessions

(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 policy entitled *Patients' Clothing and Property* identified the responsibilities of staff and residents with regard to property. The policy described the communication with residents and families prior to admission regarding items permitted in the approved centre. The policy contained a list of these items. The policy described the process for the patient property list taken on admission, the record maintained and a copy of this record given to the resident.

Training and Education: Staff had read and understood the policies on clothing and property. This was documented. Staff could articulate the processes for residents' clothing and property.

Monitoring: An audit had been completed on residents' property and an analysis had been completed.

Evidence of Implementation: Each resident had a lockable wardrobe or room. Secure facilities were provided for residents' monies and there was a secure system in place through which money could be accessed. A property checklist was completed on admission and a copy was kept in the resident's file separate from their care plan. A copy was also given to the resident. Residents were supported to manage their own property while in the approved centre unless indicated in their individual care plan.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There was a policy entitled *Recreational Activities* that outlined the roles and responsibilities relating to their provision within the approved centre. It included the process to determine the residents' likes and dislikes in relation to activities and was specific to the different resident types i.e. Adult Mental Health, Psychiatry of Later Life and Child and Adolescent Mental Health. There was provision within the policy for the development of recreational activity programmes and the method of communication regarding the programmes to the individual residents. The policy specified the facilities available both within and external to the approved centre.

Training and Education: Staff had read and understood the policy on recreational activities. This was documented. Staff could articulate the processes for recreational activities.

Monitoring: A record of planned recreational activities had been maintained and individual clinical files recorded attendance for the respective resident. An audit of the process had commenced in the approved centre.

Evidence of Implementation: There was access to varying recreational activities appropriate for the resident needs. These were provided during the week and at weekends and a timetable was available in each suite. Residents had been involved in the development of the activities for their area/suite. Individual risk assessments had been completed for each resident in relation to appropriate activities while in the approved centre.
There was a wide range of recreational activities available. These included art, music, chair-based exercise and a gym. There was television, board games and a Wii in the Ginesa suite. There was also an extensive Lego Wall which residents had frequently used.
There was a gardening group and expansive grounds for walking outdoors.
Documented records had been kept both of individual and group attendance at the various recreational pursuits.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: There was a comprehensive policy with regard to religion. Roles and responsibilities were identified. There was a process for identification of the residents' religious beliefs and for the facilitation in the practice of their religion in so far as is practicable. The policy included the process on the supports available to observe religious beliefs external to the approved centre if required. There was a provision within the policy on respecting a resident's religious belief during the provision of services, care and treatment and for respecting a residents' religious beliefs within the routines of daily living. This included a resident's choice regarding their involvement in religious practice.

Training and Education: Staff had read and understood the policies and processes with regard to religion. This was documented. Staff could articulate the processes for assessment and facilitation of residents in their religion.

Monitoring: There had been audit on the assessment and facilitation of residents' religion. This included an audit on the information provided to all residents on admission.

Evidence of Implementation: Residents' rights to practice their religion were facilitated in the approved centre. Each resident was assessed regarding spiritual needs on admission by nursing/medical staff. Specific religious requirements were documented in the resident's care plan. There was a chapel and a multi-faith prayer room in the approved centre. There was daily mass in the chapel which could be transmitted to the suites if required. The chaplain visited each suite daily with communion. A Church of Ireland minister visited the approved centre and multi-faith ministers were available on request. Residents could be referred to a health care chaplain within the service for ongoing support. There were two health care chaplains in the approved centre. Any spiritual input was documented in the respective health care record.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.11 Regulation 11: Visits

(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 policy entitled *Visits/Visitors/Vetting.* The roles and responsibilities were included in the policy. There was a process for restricting visitors. The policy included provisions for separate visitor rooms and arrangements for children visiting a resident. There was provision for required visitor identification to include contractors.

Training and Education: Staff had read the policy on visits and this was documented. Staff could articulate the process for visits as set out in the policy.

Monitoring: The implementation of the policy had been reviewed. Restrictions on residents' rights to receive visitors were monitored. An analysis had been completed to identify opportunities for improvement.

Evidence of Implementation: Visiting times were publicly displayed. They were appropriate to the residents' needs and were different depending on the assessed need. Where applicable, justifications for visiting restrictions implemented were documented in the relevant clinical file. There were separate visitor rooms or a visitor area on each suite. The Darro family room on the ground floor was also available for children visiting by arrangement. Children visitors were accompanied by an adult. All visitors signed a visitors' book at the main reception or in the Ginesa suite. Professional visitors were given an identification badge to wear upon their arrival.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.12 Regulation 12: Communication

(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: There was a policy on communication that identified the roles and responsibilities of the multi-disciplinary team (MDT) and other staff in the approved centre. Communication facilities were referenced in the policy and included mail, fax, telephone, mobile phone and internet access. Assessment of the resident communication needs was not specifically mentioned in the policy. However, risk associated with external communication was documented. The policy included the protocol to be followed if staff were to examine incoming communication as required by Regulation 12 (2). The provision for access to an interpreter was included.

Training and Education: Staff had read and understood the policy. Staff could articulate the processes in relation to communication.

Monitoring: A clinical audit was being completed. There was evidence that the communication processes were being analysed.

Evidence of Implementation: Individual risk assessments were completed on admission and throughout residents' stay in the approved centre. Internal mail was only examined if deemed applicable and the protocol had been followed. Residents had access to the internet and their own mobile telephones, unless otherwise indicated, and documented in the care plan.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.13 Regulation 13: Searches

(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: There was a policy on searches in the approved centre. The policy included the management and application of searches of a resident, his or her belongs and the environment. The consent requirement was included as well as the process for carrying out a search without consent. The policy included the procedures for finding and handling illicit substances. Risk assessment was included under the section for searching an involuntary patient without consent. There was also provision for the risk assessment of other residents and patients. The requirement to record and document searches was included in the policy.

Training and Education: Staff had read and understood the policies on searches. This was documented. Staff could articulate the searching processes as set out in the policy.

Monitoring: An audit tool had been created and approved by management. A register of all searches had commenced within the approved centre in April 2016. The first audit was scheduled for September 2016.

Evidence of Implementation: Risk was assessed prior to a search being implemented. Residents' consent was sought and the resident signed the *Searching of a Patient/Room/Property* form. Two clinical staff conducted each search and this was documented. At least one staff member was the same gender as the resident and there was due regard to the resident's dignity and privacy. The search policy had been communicated to the residents. One search reviewed by the inspection team showed that the resident had agreed and signed the relevant form. The reason for the search had been documented and

the form was signed by two clinical staff. The resident had been given a copy of the search form. A record of every search made was kept on the individual suites.
When an illicit substance had been found it was removed to a locked press kept on the suite. This had been documented. The Gardaí were informed and they removed the substance for investigation, analysis and destruction.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Monitoring at the time of inspection.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.14 Regulation 14: Care of the Dying

(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: There was policy on care of the dying. The policy included the roles and responsibilities in relation to care of the dying. The policy included the identification and implementation of the resident's physical, emotional, social, psychological, spiritual and pain management needs in relation to end of life care. The involvement and accommodation of the family was included. Advance directives and Do Not Attempt Resuscitation orders (DNARs) were not included in the policy.
The processes for managing sudden death were included in the *Medical Emergency* policy. The process and responsibility for reporting a death to external bodies and notification to the Mental Health Commission (MHC) were included in the policy.

Training and Education: Staff had read and understood the policy and protocols on care of the dying. Staff could articulate the processes for end of life care.

Monitoring: Individual resident deaths were reviewed. A system analysis was undertaken for every unexpected death and there was ongoing analysis to identify opportunities to improve the processes for all deaths within the approved centre.

Evidence of Implementation: No resident was receiving imminent end of life care at the time of the inspection. The clinical file of a resident in the approved who had a DNAR order was reviewed. Associated documentation was evidenced in their clinical file.
Staff reported that when a resident was dying, the families were accommodated. Staff stated pain management, where applicable, had been prioritised and that religious beliefs and practices were respected. Staff ensured that an unexpected death was managed in accordance with the residents' religious beliefs and in a manner that accommodated the residents' family and next of kin.
All deaths had been reported within the required timeframe to the MHC.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Processes.				
	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.15 Regulation 15: Individual Care Plan

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: There was a policy on individual care plans. The policy identified the responsibility of the multi-disciplinary team (MDT) to comply with the development of the individual care plan and of the keyworker to coordinate the delivery of care. The policy specified an assessment on admission followed by a comprehensive MDT assessment. The policy specified the inclusion of needs, goals, risk management and discharge planning. The policy included the need for review of the care plan and the involvement of the resident and his or her family, if applicable, in the process. The process to provide the resident with a copy of their individual care plan was included.

Training and Education: Staff had read and understood the policy on individual care plans. Staff could articulate the processes relating to individual care planning as set out in the policy.

Monitoring: The approved centre had carried out an audit and an analysis on care plans.

Evidence of Implementation: The approved centre used a standardised template for individual care plans. There was a section for attendees at the multi-disciplinary team meeting. Needs were identified as 'Issues' and there were two separate columns for recording 'Patient Goals' and 'MDT Goals'.
Fifty-seven individual care plans were reviewed. Each resident had been assessed at admission and an initial care plan established. The individual care plans were then developed. A key worker had been allocated to all of the residents reviewed.
Two of those reviewed had consultant psychiatrist and nursing input recorded with no indication of any other members of the MDT present, despite clear evidence for psychology and social work needs. Five care plans reviewed did not have a named individual responsible for the delivery or implementation of an intervention or treatment e.g. 'nursing', 'medical' or 'MDT' was documented. Six care plans reviewed had no resident goals identified, but did have goals identified in the section 'MDT Goals' on care plan pro forma template.
The individual care plans of the residents in the Ginesa suite all had their educational requirements included. For residents in the Ginesa suite, the keyworker was the same named individual.
There was evidence of risk assessment and a risk management plan in all the care plans reviewed. There was also evidence of discharge planning.

The approved centre was non-compliant with the regulation because

(a) Not all ICPs identified necessary resources

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
X			

3.16 Regulation 16: Therapeutic Services and Programmes

(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: There was a policy on therapeutic services and programmes. The roles and responsibilities of staff had been identified in the policy along with the planning and provision requirements of the approved centre. The policy referenced the processes for external providers of services. There was provision for the recording, review and evaluation of services and programmes and the policy included resource and facility requirements. The policy included the process of assessing residents as to the appropriateness of services and programmes.

Training and Education: Staff had read and understood the policy. Staff could articulate the processes for therapeutic services and programmes.

Monitoring: There was evidence of ongoing monitoring of the range of services and programmes provided. An audit had been completed by the occupational department. Analysis had also been completed to identify opportunities to improve the processes.

Evidence of Implementation: There was a wide range of therapies and services within the approved centre appropriate to the different assessed needs of the residents. These had been delivered on an individual or group basis and were relative to the assessed needs of a resident. Programmes and services included input from occupational therapy, social work, psychology, art therapy, nursing and medical. All referrals and attendances were recorded and engagement and outcomes had been documented in individual care plans. There were separate dedicated spaces for the delivery of the programmes either on the suite or in the occupational therapy department.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.17 Regulation 17: Children's Education

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

Inspection Findings

Processes: There was a policy on the provision of children's education. It included roles and responsibilities and the planning, provision, documentation and review of the educational services to child residents. This included processes for the use of external providers. The policy referenced the *Introductory Leaflet* on education provided to the child and their representatives on admission. The resources and facilities provided were in the policy. The processes for assessment, transition and discharge planning were included in the policy. There was no provision in the policy for the legislative requirements in relation to the provision of education for child residents.

Training and Education: There was a qualified teacher and a special needs assistant employed by the approved centre. Relevant staff were appropriately trained in the applicable legislation.

Monitoring: A record was kept of all school attendances and documented in the individual clinical files.

Evidence of Implementation: There was a classroom for child and adolescent residents in the approved centre. This was in a separate area to the Ginesa suite. Children were assessed by the teacher after admission and upon referral from the MDT. The education provided reflected the required educational curriculum. There was a daily timetable which was communicated to all the residents who attended school.
When appropriate, the teacher linked with the individual's school and facilitated, when applicable, attendance at their school. At the time of the inspection, four residents were planning to complete the forthcoming *Junior Certificate* state examination.
Comprehensive records were kept of each individual's educational attainment while in the approved centre.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Processes.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.18 Regulation 18: Transfer of Residents

(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: There was a policy on transfer of residents. The policy specified the responsibility of nursing and medical staff and the role of the key worker in coordinating the transfer process. The criteria for transfer were specified in the policy and it stated that the decision to transfer should be made by a registered medical practitioner or clinical director. The policy included the requirement for the management of the resident's medication stating that medication is not routinely transferred with the resident. The policy included the need to keep records and documentation required for the resident transfer process.

Training and Education: Staff had read and understood the policy on transfers. Staff could articulate the processes for the transfer of residents as set out in the policy.

Monitoring: A log of transfers had been maintained. There was no evidence of analysis completed to identify opportunities to improve the transfer processes.

Evidence of Implementation: The clinical file of one patient who had been transferred was inspected. There was a record of a discussion between the consultant psychiatrist in the approved centre and the receiving facility. The clinical file documented ongoing assessment of the patient prior the transfer by nursing and medical staff. There was a record of the information sent to the receiving facility. All records pertaining to the transfer had been available.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.19 Regulation 19: General Health

(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: There was a policy on general health and a separate policy on responding to medical emergencies. The policy on general health identified the treating consultant psychiatrist with overall responsibility. The policy stipulated that residents had access to a medical practitioner through their own team or the non-consultant hospital doctor on call. The policy specified that there was to be a general health assessment for all residents on admission to include routine bloods and an ongoing review as required. The policy required that physical health needs were incorporated into the individual care plan (ICP). There was also the provision for the recording of the physical examination on admission. The policy included the requirement for access to screening programmes when necessary.
The policy on responding to medical emergencies identified the roles and responsibilities of the resuscitation team members. The policy described the process in the management of a cardiac arrest and anaphylaxis. The policy identified the need for a programme of training to include Basic Life Support (BLS) and the management of and access to emergency equipment.

Training and Education: Staff had read and understood the policies on the provision of general health services and for responding to medical emergencies. Staff could articulate the processes for the provision of general health services and for responding to medical emergencies.

Monitoring: Resident take-up of national screening programmes had not been recorded. There was a system in the approved centre to record those who were resident longer than six months to ensure a general health review took place. No analysis of the processes for general health was evident.
A medical emergency audit was completed quarterly. This examined staff knowledge and process in relation to medical emergency.

Evidence of Implementation: There were four emergency trolleys and two emergency bags in the approved centre. There was an Automated External Defibrillator (AED) on each trolley that had been checked daily. Weekly checks were completed on the resuscitation trolleys. Records were maintained for each emergency that included what treatment had been given. Each resident had a physical examination on admission. Any physical conditions had been recorded in the ICP. Nine residents had been in the approved centre for six months or longer and all had had a six-monthly physical examination. When required, residents had been transferred to other facilities for specialist general health care.
The approved centre grounds provided good space for walking. There was gym equipment in the Elvira room and the menu provided for lower calorie options if chosen.
The clinical files contained results of blood test, investigations and x-rays.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.20 Regulation 20: Provision of Information to Residents

(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: There was a policy on the provision of information to residents. The policy specified the responsibility of the admissions officer in ensuring residents were provided with the approved centre information pack. The policy included the provision to establish the residents' preferred means of communication on admission. The policy also included the provision of interpreter services if required. The policy identified that information was to be provided for the resident and family on admission and during their stay in the approved centre. The policy specified that information on advocacy be displayed throughout the approved centre.

Training and Education: Staff had read and understood the policy. This was documented. Staff could articulate the processes for providing information to residents as set out in the policy.

Monitoring: An audit on the provision of information to residents had commenced and involved medical, nursing and the multi-disciplinary team (MDT).

Evidence of Implementation: An *Inpatient Handbook* and information pack was given to every resident at the time of admission. This included information on housekeeping arrangements, personal property, meal times, visiting times and the complaints procedure. The resident was given documented information on their MDT members.
The hospital intranet had a site-specific section on diagnosis and on medications. These leaflets were printed off and available to all residents. This site was also available to residents in the information centre, *Seomra Eolais,* located in the main reception of the hospital. The information centre was staffed and residents could access information on a variety of mental health and related data.
There was age appropriate information on diagnosis and medication for residents in the Ginesa Suite. These residents also received an information brochure on admission and a copy of the Mental Health Commission (MHC) *Headspace Toolkit*.
One of the pharmacists had given weekly talks on medication, this was timetabled as part of occupational therapy. Information on medication included information on side-effects.

The approved centre provided an interpretation service as required. There was publicly displayed health and safety procedures.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: There was a policy on privacy that detailed the roles and responsibilities of staff with regard to the privacy and dignity of the resident. The methods for ensuring and identifying privacy were detailed and included the approved centre's layout. The process to be applied where staff did not respect residents' privacy and dignity was included, to be dealt with in accordance with the approved centre's disciplinary procedures.

Training and Education: Staff had read and understood the policy relating to privacy and dignity. Staff could articulate the processes for ensuring resident privacy and dignity.

Monitoring: Audits had been completed in relation to the premises and facilities to ensure they were conducive to privacy for residents. These had been related to bed curtains, toilet facilities and individual resident information.

Evidence of Implementation: The general demeanour of staff was noted to be considerate of residents' dignity and privacy. Staff manner and discretion when talking about or to the resident was appropriate and respectful. Staff knocked before entering a bedroom or addressed the resident before entering a bay area. Residents wore their own clothes and those who needed assistance from staff were observed to be respectfully dressed and cared for.
All bathrooms and toilet facilities had locks which could be over ridden with a staff key. Bed screens were fitted in all areas where sleeping accommodation was shared. Accommodation areas that had an observation panel on the door were suitably covered.
No identifiable resident information was evident on noticeboards or any public area. The telephone booth in St Peter's Suite had a hood for privacy.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.22 Regulation 22: Premises

(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: There was a policy for premises in the approved centre. The policy included the roles and responsibilities for the maintenance of the approved centre and related processes. The legislative requirements were referenced in the policy. The processes and procedures for maintenance, cleaning, infection control and utility controls had been identified. There was a process for the identification of hazards and ligature points.

Training and Education: Staff had read and understood the policy on premises. Staff could articulate the processes relating to the maintenance of the premises.

Monitoring: Audits had been completed in hygiene and infection control and ligatures. Analysis had been completed to identify opportunities to improve the premises. An anti-ligature project had commenced. An audit and review of the programme of maintenance and renewal of fabric and decoration had been developed and implemented.

Evidence of Implementation: The accommodation in the approved centre was furnished and equipped to a high standard. Rooms were adequately heated and well ventilated. Communal areas were suitably sized and furnished cognisant of infection control measures. The approved centre was well lit with signage and sensory aids provided to facilitate resident and visitor orientation. Locks were provided for bedrooms or wardrobes. The first phase of an anti-ligature project had been completed and extensive refurbishment was evident. The second phase was imminent at the time of the inspection but had not been commenced. There was ample space within the suites and communal areas for residents and staff. There were extensive outdoor grounds that had been very well maintained.

The technical services department maintained a log of repairs and ongoing works. There was an appropriate system for reporting faults and general maintenance issues. A cleaning schedule was maintained and records had been kept.

The approved centre was non-compliant with this regulation 22 (3) as planned works to remove identified ligature points had not been completed at the time of inspection.

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
		X	

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

(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: There was a policy on medication management. The policy specified the responsibility of medical practitioners, nurses, pharmacists and pharmacy technicians in managing medication. The legislative requirements were included in the policy. The policy specified the process for ordering, prescribing, storing and administration of medication. There was a process in the policy for the administration of controlled drugs. The policy described the process for self-administration of medication, crushing medication, omitting medication, reconciliation and refusal of medication by a resident. The policy described the process for the management of medication safety events. The process for review of medication was specified in the policy.

Training and Education: There was evidence that staff had read the medication management policy. Staff could articulate the processes for medication management. Staff had access to up-to-date information on all aspects of medication management. Staff received training on reporting medication errors on induction.

Monitoring: Audits on the medication, prescription, administration records (MPARs) had been conducted and an analysis completed.

Incident reports for medication errors were recorded via the approved centre incident reporting system *Datix.*

Evidence of Implementation: Nine MPARs were reviewed in detail. All had the appropriate resident identifiers, the generic names of medication and these had been written in full.

The frequency, dose, administration route and record of all medication administered had been completed correctly. A record of medication refused was evident. All the prescriptions had been signed and were in date.

The required Medical Council Registration Number (MCRN) had been omitted on three of the MPARs. A start date had not been entered for one prescription on a MPAR.

Inhalers were permitted for self- administration by residents following a risk assessment. Stock received from the pharmacy had not been reconciled against the order. There was no fridge in the clinical room on one of the suites and medications that required refrigeration had been kept in the adjoining ECT suite. A log of fridge temperatures had been maintained. Medication was stored in a locked trolley in a locked room and the controlled drugs in a separate locked press. The controlled drugs register showed that two nurses checked and signed the controlled drug book following administration.

Monthly stock checks had been completed by the nursing staff and medication that was out of date was returned to the pharmacy.

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

(a) The Medical Council Registration Number (MCRN) was not present on all the MPARs

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
X			

3.24 Regulation 24: Health and Safety

(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: There were policies and procedures relating to the health and safety of residents, staff and visitors updated yearly or more often when required. They identified roles and responsibilities in the *Safety Management System* and included specific reference to the registered proprietor. Safety representative roles were identified and included. Compliance with health and safety legislation and the content of the Health and Safety Statement were included. The approved centre had a policy and processes for Fire Management. The requirements for Infection Control and First Aid were included. There were two policies relating to fall prevention and initiatives. There was a policy on vehicle controls. There were policies in relation to staff training for health and safety and for the monitoring and continuous improvement requirements for the health and safety processes.

Training and Education: Staff had read and understood the health and safety policy. This had been documented. Staff could articulate the processes in relation to health and safety. *Patient Safety Workshop training* had been delivered.

Monitoring: The health and safety policy had been reviewed at least annually. It had been reviewed April 2016 and previously in September 2015.

Evidence of Implementation: The written operational policies and procedures in relation to health and safety accurately reflected the operational practices in the approved centre. Each department had its own site-specific health and safety statement as well as the overarching approved centre statement. There was an identified risk manager, health and safety representatives and an infection control nurse.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.25 Regulation 25: Use of Closed Circuit Television

(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 anytime on request.

Inspection Findings

Processes: There was a policy entitled the *Use of Closed Circuit Television* that detailed the roles and responsibilities pertaining to it. The policy outlined the function of CCTV within the approved centre and the measures used to ensure privacy and dignity for the residents. The process for the maintenance of the CCTV cameras was included in the policy.

Training and Education: Staff had read and understood the policy on CCTV and staff could articulate the processes relating to its use in the approved centre.

Monitoring: An audit had been completed in April 2016. The results and recommendations were not available at the time of inspection.

Evidence of Implementation: A newly commissioned assessment room at the main reception had a camera that was not connected. This room was not in use at the time of the inspection. The admission suite reception area also had a camera and there was no signage to this effect. The service reported that residents did not enter this area.
There was CCTV at the entry and exit area of the hospital which was clearly signed. CCTV usage was disclosed to the Mental Health Commission inspectors.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.26 Regulation 26: Staffing

(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: There was a written policy on recruitment, selection and vetting of staff dated 2015. The roles and responsibilities of staff were outlined in the policy. There was an organisational chart that included the lines of responsibility. Staff planning requirements, staff rota details and the requirement for staff training were in the policy. The required qualifications of training personnel and the evaluation of training programmes were not in the policy. There was no inclusion to the use of agency staff in the staffing policy.

Training and Education: Relevant staff had read and understood the staffing policies. Staff could articulate the processes in relation to staffing.

Monitoring: The staff training plan had been reviewed and updated on an ongoing basis. Analysis had been completed to identify areas for improvement.

Evidence of Implementation: There was an organisational chart encompassing all staff and divisions. Nursing staff rotas had been completed by the Assistant Director of Nursing (ADON). The staffing plan was cognisant of the resident profile and assessed needs. Reassignment of staff had occurred when necessary from one suite to another.

All staff had been Garda vetted to include agency staff within the approved centre.

There was a training plan in operation. Orientation and induction was provided for all new staff.

Nursing staff were in a two year rolling programme for training in Basic Life Support (BLS) and a one year rolling programme for Therapeutic Management of Violence and Aggression (TMVA). Non Consultant Hospital Doctors (NCHD's) had up to date training in BLS, Crisis Prevention Management Training and Breakaway training. There was no record of other healthcare staff having been trained in BLS or TMVA or equivalent. All staff had training in Fire Safety. There were no records of any training in the Mental Health Act (MHA).
Nursing staff had completed manual handling training and infection control. Required training for care of residents with an intellectual disability had taken place.

Completed in-service training had been facilitated by appropriately trained staff and there were adequate facilitates in the approved centre to provide the training. Copies of the Mental Health Act 2001 and associated MHC documentation were available throughout the approved centre.

The approved centre was not compliant with this regulation as not all healthcare professionals had been trained in basic life support and therapeutic management of violence and aggression or equivalent 26(4).

Clinical Staffing Table

Consultant Psychiatrist **9** Consultant Psychiatrist on call **2**	Non Consultant Hospital Doctors **9** Non Consultant Hospital Doctors on call **2**
Occupational Therapists **8.2** WTE	Pharmacy **7.30** WTE
Psychologists **6.1** WTE	Pastoral Care **1.68** WTE
Social Workers **6**	Addiction Counsellors **4**

Ward or Unit	***Staff Grade***	***Day***	***Night***
Ginesa Suite	CNM 2 CNM 1 RPN	1 1 Total number 5 3	2 RPN
Ward or Unit	***Staff Grade***	***Day***	***Night***
St Camillus Suite	CNM 2 CNM 1 RPN	1 1 Total number 5 3	2 RPN
Ward or Unit	***Staff Grade***	***Day***	***Night***
St Brigid's Suite	CNM 2 CNM 1 RPN	1 1 Total number 4 2	2 RPN
Ward or Unit	***Staff Grade***	***Day***	***Night***
St Joseph's Suite	CNM 2 CNM 1 RPN	1 1 Total number 5 3	2 RPN
Ward or Unit	***Staff Grade***	***Day***	***Night***
St Peter's Suite	CNM 2 CNM 1 RPN	1 1 Total number 5 4	3 RPN

Ward or Unit	*Staff Grade*	*Day*	*Night*
St Paul's Suite	CNM 2 CNM 1 RPN	1 1 Total number 5 3	2 RPN
Ward or Unit	***Staff Grade***	***Day***	***Night***
Carrickfergus Suite	CNM 2 CNM 1 RPN	1 1 Total number 4 2	2 RPN
Ward or Unit	***Staff Grade***	***Day***	***Night***
Carrigdubh Suite	CNM 2 CNM 1 RPN	1 1 Total number 4 2	2 RPN

	Compliant		Non-Compliant	
Compliance with Regulation			**X**	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			**X**	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.27 Regulation 27: Maintenance of Records

(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: There was a policy entitled *Maintenance of Records.* The content of records required was detailed in the SJOGH Code of Practice for Healthcare Records Management. The processes for privacy and confidentiality, authorised personnel to make entries and resident access to personal files were outlined. The destruction of record requirements and the record review requirements were part of a flow chart appendix to the policy. There was provision for retrospective entries. There was a separate policy entitled *Record Retention.* The process for retention of inspection reports such as food safety, health and safety and fire inspection was referenced in the policy.

Training and Education: Staff had read and understood the policy and staff could articulate the processes in relation to maintenance of records.

Monitoring: Resident records were audited and analysis completed to identify opportunities to improve the maintenance of records processes.

Evidence of Implementation: Records were securely stored in electronic and paper format. All paper records were stored together and all electronic records could be accessed from the one portal. There was a separate record initiated for each resident that was maintained through the use of a unique identifier. Resident records reflected the status and individual treatment provided. The records were maintained and developed in a logical sequence that could only be accessed by authorised staff from within the approved centre. The system used in the approved centre was mainly electronic and was called the Mental Health Information System (MHIS). It followed a sequential order. Paper records had also been developed and there was evidence that these had been stored appropriately.
An Environmental Health Officer's report was made available to the inspectors along with a Fire Inspection report.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.28 Regulation 28: Register of Residents

(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

An electronic register of all residents admitted to the approved centre was available to the inspection team. It contained all the required information (as per Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006).

This included resident status (voluntary or involuntary). The register was up to date.

	Compliant	Non-Compliant
Compliance with Regulation	**X**	

3.29 Regulation 29: Operating Policies and Procedures

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: There was a policy entitled *Operating Policies and Procedures.* It detailed the roles and responsibilities and processes for the development of policies and procedures in the approved centre. There was a process for the approval and dissemination of policies. The process for the review and making obsolete of records at least every three years was recorded in the policy. The requirement for a standardised template and collaboration between various disciplines was included in the policy. There was a process for the dissemination of the policies and procedures to staff. This had been recently reviewed and a new process for dissemination had been introduced. Each staff member would receive a separate copy of the policies collectively.

Training and Education: Staff had read and understood the policy and practice for managing policies and procedures within the approved centre. This was documented. Staff could articulate the processes for the development and review of operational policies.

Monitoring: An audit had been undertaken and analysis included hospital recommendations and identified actions required.

Evidence of Implementation: The policies and procedures had been developed with input from relevant staff including clinical and managerial personnel. They reflected current applicable legislation, evidence-based practice, clinical guidelines and the judgement support framework guidelines. All the policies had been appropriately approved and signed off by the members of the senior management team. All the policies required by the regulation had been reviewed within the required three year timeframe. Obsolete versions of the policies had been removed and there was a standardised format for each policy.

A Corrective and Preventative Action Plan had been completed following the inspection in 2015 to address the area of non-compliance.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.30 Regulation 30: Mental Health Tribunals

(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: There was a policy entitled *Mental Health Tribunals.* The roles and responsibilities of staff were detailed in the policy. The policy included reference to the applicable legislation in relation to Tribunals and the provision of information to the patient regarding Tribunals. There was a procedure identified regarding the communication processes between the approved centre and the external parties involved. The resource and facility requirements were included in the policy.

Training and Education: Staff had read and understood the policy on Mental Health Tribunals. This was documented. Staff could articulate the processes for the facilitation of a Tribunal in the approved centre.

Monitoring: The implementation of the procedures was monitored by the Mental Health Act administrator. There was no evidence of an annual audit or analysis to identify opportunities to improve the processes.

Evidence of Implementation: The approved centre provided private facilities and resources that supported Mental Health Tribunal process. Staff attended the Tribunal with the patient and waited outside to provide support and assistance as necessary.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Monitoring.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.31 Regulation 31: Complaints Procedures

(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: There was a policy with regard to complaints dated September 2015. The policy included the requirements to identify the roles and responsibilities of staff, including the nominated complaints person and the responsibility of the complaints committee. The policy outlined the procedure for managing complaints both in a narrative and a flow chart. Confidentiality, timeframes and documentation requirements were in the policy. The processes for escalating complaints and the appeals process were in the policy.

Training and Education: There was training in managing complaints for staff. Staff had signed that they had read and understood the policy. Staff articulated the complaints procedure.

Monitoring: An audit had been completed in November 2015 and recommendations had an action plan. Audits were to be completed bi-annually. Complaints had been analysed and actions were identified and acted upon.

Evidence of Implementation: There was a nominated person for complaints in the approved centre. This information was publicly displayed. There was a standardised approach for dealing with complaints and information on the complaints procedure was given to each resident. A record of all complaints was maintained including minor complaints that were addressed locally initially. These were escalated to the complaints officer if they could not be resolved. Timeframes were provided for all stages of the complaints processes. The complainant was informed within 20 working days and kept updated on the outcome. The outcome and satisfaction or dissatisfaction of the complainant was recorded in the complaints log. All complaints were confidential.

The approved centre was compliant and rated excellent with this regulation because it met all the elements of the Judgement Support Framework.				
	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	**X**			

3.32 Regulation 32: Risk Management Procedures

(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: Risk management: The approved centre had a comprehensive risk management policy. Roles and responsibilities in relation to risk management and implementation were in the policy. This included the person responsible for risk management, the responsibilities of the registered proprietor and the multi- disciplinary team (MDT).

The processes for identification, assessment, treatment and reporting risk were outlined in the policy as well as the processes for rating identified risks. The requirements relating to the methods for controlling specified risks to include resident absence without leave; suicide and self-harm; assault and accidental injury to residents or staff were in the policy. The policy included arrangements for the protection of children and vulnerable adults from abuse.

There was a process for maintaining and reviewing the risk register and for the record keeping requirements.

Incidents and adverse events: The process for managing incidents was included in the policy. There was also a separate policy entitled *Incident Management*. There was a policy and procedures for responding to specific emergencies.

Training and Education: Relevant staff were trained in the specific risk management practices to include health and safety risk management. Management staff were trained in organisational risk management and all healthcare staff had been trained in incident reporting and documentation. The risk manager had developed a training session on risk management which was delivered via the approved centre's information *Info Share*

sessions and was available on the intranet. A training package on *Structured Professional Judgement* had been developed and delivered to 180 staff throughout the approved centre. Training was ongoing and was to be facilitated bi-annually going forward.

Monitoring: The risk register was audited at least quarterly. All incidents were recorded in the approved centre's *Datix* information system and were risk rated. An analysis of all incident reports was completed and escalated accordingly.

Evidence of Implementation: There was an identified risk manager known by staff within the approved centre. There were risk management procedures and practices that actively reduced identified risk in so far as practicable. This included a prompt alert in the MHIS for each resident clinical note entry or review. Clinical risks were identified and documented on an ongoing basis. Health and safety risks had been identified and included in the risk register. The risk register was actively managed and reviewed monthly by the Clinical Governance, Quality & Safety Executive Committee (CGQSE) and more often if necessary by the Local Incident Management Team (LIMT).

Significant works were ongoing following an audit and analysis of identified structural risks. Phase one of this project had been completed. Phase two had not commenced and ligature anchor points remained at the time of inspection.

Individual risk assessments were completed prior to and during treatment and interventions. These were updated for each resident in the clinical file stored within the MHIS. There was a prompt alert system in the MHIS for the risk record. There was evidence of multi-disciplinary team input and clinical incidents were reviewed by the multi-disciplinary team at their weekly meeting.

Incidents were recorded in a standardised format on the *Datix* system in the approved centre. All incidents were reviewed by the risk manager and escalated appropriately according to their risk rating.

The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, in line with the Code of Practice on the Notification of Deaths and Incident Reporting.

There was an emergency plan in place that incorporated evacuation procedures.

The approved centre was not rated excellent with this regulation because it did not meet all the elements of the Judgement Support Framework for Evidence of Implementation.

	Compliant		Non-Compliant	
Compliance with Regulation	**X**			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		**X**		

3.33 Regulation 33: Insurance

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

Inspection Findings

Insurance certificates had been made available to the Mental Health Commission in advance of the inspection. These were in date and included certification of insurance for public liability; employers' liability; clinical indemnity; and property. Vehicle insurance was also covered.

	Compliant	Non-Compliant
Compliance with Regulation	**X**	

3.34 Regulation 34: Certificate of Registration

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

There was an up-to-date certificate of registration prominently displayed in the main reception of the approved centre. There were no conditions relating to the registration.

	Compliant	Non-Compliant
Compliance with Regulation	**X**	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

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

Inspection Findings

Processes: There were operational policies and procedures that complied with the rules providing for the use of electro-convulsive therapy (ECT) administered to a patient. These policies had been reviewed annually. Protocols had been developed which included obtaining consent for maintenance/continuation ECT.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff had up-to-date training in Basic Life Support (BLS).

Monitoring: An audit and an annual report had been completed in 2015. The ECT department was accredited by the Electro-Convulsive Therapy Accreditation Service (ECTAS).

Evidence of Implementation: There was a private waiting room, an adequately equipped treatment room and an adequately equipped recovery room in the ECT suite at the approved centre. Material and equipment was in line with best international practice and the ECT machines were regularly serviced and maintained.

There were up-to-date protocols for the management of cardiac arrest and anaphylaxis. There was a named consultant psychiatrist and consultant anaesthetist with overall responsibility for ECT management and ECT respectively.

There was a designated ECT nurse and two nurses were present in the ECT suite at all times when ECT was being administered.

No detained patient was receiving ECT at the time of the inspection.

	Compliant	Non-Compliant
Compliance with Rule	**X**	

4.2 Section 69: The Use of Seclusion

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: There was a policy on seclusion that consisted of a flow chart of the processes and the requirements of the rules. Included in the policy was who may carry out seclusion and the provision of information to the patient. There were processes to reduce the rates of seclusion. An annual review was evident for 2015.

There were specific policies for training for the approved centre and the Ginesa suite. These addressed the frequency of training, the identification of appropriately trained staff in the facilitation of the training and the areas to be addressed in training. There was a separate policy regarding the use of CCTV.

Training and Education: There was a written record that staff had read and understood the policies relating to seclusion. A record of training had been maintained.

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

Evidence of Implementation: There was a seclusion suite within the approved centre. There were two seclusion rooms with a separate toilet facility. At the time of the inspection both seclusion rooms were in use. These rooms had not been used as bedroom accommodation. There was CCTV in the seclusion rooms and the monitor was in the seclusion suite. This was incapable of recording or storing footage.

The seclusion register and clinical records were reviewed. The registered medical practitioner and nursing staff had adhered to the rules which included a comprehensive documentation trail. The consultant psychiatrist had been notified and had signed the seclusion register. Appropriate risk assessments had been completed and individuals had been informed of the reasons and circumstances that would lead to the discontinuation of seclusion. Next of kin had been informed. Medical reviews had been completed every four hours for each seclusion episode and these had been documented. Nursing staff maintained direct observation for the first hour of seclusion and continuous observation thereafter.

	Compliant	Non-Compliant
Compliance with Rule	**X**	

4.3 Section 69: The Use of Mechanical Restraint

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 policy stating mechanical restraint was never used.

As mechanical restraint was not used in the approved centre, this rule was not applicable.

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

5.1 Part 4: Consent to Treatment

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

Four patients were in the approved centre for longer than three months and receiving medication. These clinical files were reviewed. One patient did not consent to treatment and an assessment of capacity had been completed and documented. Form 17 had been completed within the timeframe and a copy of this was in the clinical file. There was a written record of the specific medications prescribed and a written record of the information

provided to the patient. There was a written record that detailed that treatment was in the patient's best interest.

Three patients had consented to treatment. There was no documented assessment of capacity for these patients. The written record listed the medications and the information provided to the patient. There was no written record that likely consequences of not accepting treatment or treatment alternatives had been explained to the patient. There was a record of consent that documented the patient's understanding of the information provided.

The approved centre was non-compliant with Consent to Treatment because there was no documented assessment of capacity for three patients who had consented to treatment.

	Compliant	Non-Compliant	
Compliance with Part 4		**X**	
Risk Rating			
Low	Moderate	High	Critical
	X		

6.0 Inspection Findings and Required Actions – 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.

6.1 The Use of Physical Restraint

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 physical restraint that was reviewed annually. The policy included the requirement on provision of information. The requirement on who can initiate and carry out a restraint was included in the policy. The Ginesa suite had its own policy on physical restraint that included child protection processes. The approved centre had separate policies and procedures in relation to training requirements. These included who receives that training; the areas to be addressed during the training; the frequency of the training; and the mandatory nature of the training.

Training and Education: There was a written record that staff had read and understood the policies. A record of attendances at training was maintained.

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

Evidence of Implementation: The Clinical Practice Form book was reviewed. Physical restraint had been used in rare circumstances and with the best interest of the resident. It had been used after all other interventions had been considered. Its use was based on a risk assessment.

In one case reviewed, the physical restraint had been initiated by the nursing staff and there was a designated staff member leading the restraint. The consultant psychiatrist was notified within three hours and had attended and assessed the resident.

The clinical files of residents who had been physically restrained were examined and they indicated that the residents had been informed of the reasons for the restraint, the correct documentation had been completed and signed and, with the residents' consent, their next of kin had been informed. The files showed that a same sex staff member had been present during the episodes of physical restraint.

Each episode had been reviewed by members of the multi-disciplinary team (MDT) and had been documented in the clinical files. The clinical practice forms had been completed for each episode of physical restraint. Four of these had not been placed in the clinical files of the named residents and remained in the Clinical Practice book at the time of the inspection.

A Corrective and Preventative Action Plan had been completed following the 2015 inspection where the approved centres policy on Physical Restraint had been reviewed and updated.

The approved centre was non-compliant with the Code of Practice as four clinical practice forms had not been placed in the respective clinical files.

	Compliant	Non-Compliant
Compliance with Code of Practice		**X**

Risk Rating			
Low	Moderate	High	Critical
X			

6.2 Admission of Children

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 policy on admissions that included protocols for the admission of children to the Ginesa suite. Ginesa had its own protocols and processes for admissions which included the requirement that each child be individually risk assessed. There were policies and procedures with regard to family liaison, parental consent and confidentiality. There was a process for the identification and responsibility for notification to the MHC of all child admissions when they occurred.

Training and Education: All staff in the approved centre were aware of the processes regarding the admission of children. Staff in Ginesa had specific training in the admission of children as part of their induction and orientation to the suite. A number of staff had further training in Child and Adolescent Mental Health. Staff working in Ginesa on the Child and Adolescent team all worked exclusively in this sector.

Monitoring: Ginesa Management Team meetings were held every quarter. The suite was a member of the Quality Network for Inpatient CAMHS (QNIC) which examined the quality of inpatient care through peer and self-review.

Evidence of Implementation: Ginesa was an age appropriate facility for children separate from the main hospital. No children had been admitted to the main hospital. Children admitted were aged between 14 and 17 years with provision for 12 and 13 year olds, if appropriate to their care needs and by prior arrangement. Admissions were usually pre planned.

Consent to treatment was obtained from parents or guardians and the views of the child were respected. All staff had been Garda vetted and there were copies of the Child Care Act 1991, Children Act 2001 and *Children First Guidelines* available for staff.

Accommodation comprised two single admission rooms and five twin-bedded rooms. There were four bathrooms available to the residents. There were a number of recreational spaces available to the residents and included a chill out room. A classroom facility, occupational therapy room, kitchen and the residents' dining room were all located off the suite. The residents had access to a garden by arrangement.

Each resident had an individual care plan (ICP) which included an Individual Educational Plan (IEP).

A primary nurse and keyworker system were in place for each resident.
The MHC Headspace Toolkit was used with the residents in the Ginesa suite.

	Compliant	Non-Compliant
Compliance with Code of Practice	**X**	

6.3 Notification of Deaths and Incident Reporting

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

Inspection Findings

Processes: The approved centre had a risk management policy that covered notifications of deaths and incident reporting to the MHC. The policy identified the risk manager. The roles and responsibilities of staff members in relation to reporting deaths and incidents were included in the policy.

Training and Education: Staff were aware and understood the policies and protocols for notification of deaths and incidents. Staff were able to articulate the processes.

Monitoring: All deaths and incidents had been reviewed to identify and correct problems as they arose. All adverse incidents were risk rated and reviewed at the Clinical Governance, Quality & Safety Executive Committee. All incidents rated major were also subject to a Local Incident Management Team (LIMT) review. There were also monthly Management Team meetings. Learning from the reviews was disseminated through different forums that included clinical nurse managers and academic sessions.

Evidence of Implementation: The approved centre was compliant with Regulation 32 Risk Management. There was a local incident reporting system called *Datix.* All incidents were risk rated and reviewed accordingly. A six month summary had been provided as required to the Mental Health Commission (MHC). All deaths had been reported to the MHC within the required timeframe.

	Compliant	Non-Compliant
Compliance with Code of Practice	**X**	

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

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

Inspection Findings

Processes: The approved centre had a policy and protocols for persons with an intellectual disability that reflected person centred treatment planning, least restrictive interventions and presumption of capacity. The policy identified the roles and responsibilities of staff working with persons in the mental health service with an intellectual disability. There was no provision in the policy or separate policy on the training of staff in working with people with intellectual disability. There was a protocol for communication and liaison with external agencies for people with an intellectual disability.

Training and Education: Staff had read and understood the policy and protocols for persons with an intellectual disability. Staff had trained in person-centred approaches, relevant human rights principles and in prevention and responsive strategies to problem behaviours.

Monitoring: The policies had been reviewed every three years. Restrictive practices such as physical restraint and seclusion had been reviewed annually.

Evidence of Implementation: Interagency collaboration was evident where a resident had a mental health illness and intellectual disability. A clinical file of one resident with an intellectual disability was reviewed. It showed the individual care plan included the level of support required and the assessed needs with consideration of the environment and available resources. A comprehensive assessment was completed on admission and a keyworker and a primary nurse had been identified each day to care for the resident. There had been involvement with the resident's family and a carer from their residential home had visited daily. Information provided was appropriate and the resident's understanding of information was documented.

The approved centre was non-compliant with the Code of Practice as there was no provision in the policy on the training of staff working with people with intellectual disability.

	Compliant	Non-Compliant
Compliance with Rule		**X**

Risk Rating			
Low	Moderate	High	Critical
X			

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

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

Inspection Findings

Processes: There were operational policies and procedures that complied with the Code of Practice for the Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients or residents. These policies were reviewed annually.

Training and Education: Staff working in ECT had been trained according to best international practice. This included training in Basic Life Support (BLS).

Monitoring: An audit and an annual report had been completed in 2015. The ECT department was accredited by the Electro-Convulsive Therapy Accreditation Service (ECTAS).

Evidence of Implementation: There was a dedicated ECT suite which comprised a waiting room, treatment room and recovery room that accommodated five beds. There were two registered nurses in the ECT suite at all times during treatment; one was a designated specifically trained ECT nurse. There was a named consultant psychiatrist with responsibility for the management of ECT and a named consultant anaesthetist with overall responsibility for ECT.

Appropriate information was provided both orally and in writing to residents who were being considered for ECT. There was an information leaflet which also informed the resident that he/she could have access to an advocate at any stage. A capacity to consent assessment was carried out for each resident who was considered for ECT. Written records of the assessments of capacity were in the clinical files.

Residents consented in writing for each ECT treatment session, including anaesthesia.
A cognitive assessment was completed before each programme of ECT and was monitored on an ongoing basis throughout the programme of ECT. The resident's progress was reviewed by the consultant psychiatrist and in consultation with the resident. The reasons to continue or terminate the treatment were documented in the clinical file.

An ECT register was completed on conclusion of the programme for each resident. An ECT pack was maintained in each clinical file.

	Compliant	Non-Compliant
Compliance with Code of Practice	**X**	

6.6 Admission, Transfer and Discharge

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 admission, transfer and discharge policies. The admission policy outlined roles and responsibilities relating to the admission process including referral processes, assessment, provision of information, care and treatment planning, the allocation and role of a keyworker and documentation. The policy on transfer specified the keyworker as the nominated person for coordinating a transfer. There was a procedure for involuntary transfer. The policy included emergency transfer but did not reference transfer abroad. The discharge policy included the procedure for the discharge of involuntary patients. It referenced prescriptions and the supply of medication on discharge. There was a protocol for discharging homeless people. There was a follow up policy in place but it did not include reference to relapse prevention strategies or following up and managing missed appointments. The policy included procedures for the management of discharge against medical advice. There was no reference to discharge of older persons in the policy.

Training and Education: There was evidence that staff had read the policies. Staff could articulate the processes for admission, transfer and discharge within the approved centre.

Monitoring: There was evidence of audits completed on the admission process. A log of transfers had been maintained. An audit of discharge summaries had been carried out and an analysis had been completed.

Evidence of Implementation: Admissions: The approved centre was compliant with Regulation 32 Risk Management; Regulation 20 Provision of Information to Residents; Regulation 27 Maintenance of Records; Regulation 7 Clothing; and Regulation 8 Residents' Personal Property and Possessions. The approved centre was not compliant with Regulation 15 Individual Care Plan. There was a key worker system in place and the multi-disciplinary team (MDT) records were in one clinical file. Admission was because of a mental illness or disorder and the decision to admit had been made by a registered medical practitioner. Admissions were to the most appropriate unit for assessed needs and admission assessments had been completed. All assessments and examinations were documented and in the clinical files. A key worker was assigned to each resident.

Transfer: The approved centre was compliant with Regulation 18 Transfer of Residents. Documentation from one transfer was reviewed and indicated that the patient had been transferred on Form 10: 'Notice of patient transfer to another approved centre (other than the central mental hospital)'. The decision to transfer had been made by a registered medical practitioner. This had been documented. The transfer was agreed with the receiving facility and assessment, including risk assessment, had been carried out prior to transfer.

Discharge: Decisions to discharge were made by the registered medical practitioner. Discharge plans were in place as part of the individual care plan (ICP). One file of a discharged resident reviewed showed a documented estimated date of discharge and a copy of the discharge summary with the date of an appointment for follow up. There was evidence of a comprehensive assessment prior to discharge and appropriate MDT input. The discharge had been coordinated by the key worker and a comprehensive discharge

summary had been sent to the residents General Practitioner (GP) within 14 days. A timely follow up appointment had been given.

The approved centre was not compliant with the Code of Practice on Admission, Transfer and Discharge because the approved centre was not compliant with Regulation 15 Individual Care Plan.

	Compliant	Non-Compliant
Compliance with Code of Practice		**X**

Risk Rating			
Low	Moderate	High	Critical
X			

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016

Completed by approved centre: St John of God Hospital Limited **Date submitted:** 30th September 2016

For each finding of non-compliance the registered proprietor was requested to provide a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.

Regulation 15: Individual Care Plan and Code of Practice: Admission, Transfer and Discharge (inspection report references 3.15 and 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. Not all ICPs identified necessary resources	Corrective action(s): There is a Psychologist, Occupational therapist, and Social Worker on each Multidisciplinary team. They may not all be present when a care plan is being created but their expertise is available to the patient. Multidisciplinary teams will be reminded of the importance of ensuring that the input of all disciplines is documented in the patients Individual Care Plan and of completing the patients' goals section.	Weekly audit for compliance with the relevant requirements and the bi-annual audit of the quality of Individual Care Plans	Achievable	31st October 2016
	Preventative action(s): The findings in respect of Regulation 15 alongside corrective actions required will be disseminated to all relevant clinical staff. An electronic upgrade of the care plan is currently underway; this will ensure that a responsible person is identifiable and that one set of goals is documented in every Individual Care Plan. The weekly audit for compliance with the relevant requirements and the bi-	Weekly audit for compliance with the relevant requirements and the bi-annual audit of the quality of Individual Care Plans	Achievable	31st of January 2017

	annual audit of the quality of Individual Care Plans will continue.			

Regulation 22: Premises (inspection report reference 3.22)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
2. Planned works to remove identified ligature points had not been completed at the time of inspection	Corrective action(s): The scale of the planned works to remove identified ligature points requires a budget of over €3 million. To date SJOG Hospital has expended in excess of €1.78 million in anti-ligature works on windows alone. The work is progressing as fast as possible given the demands of the service, requirement for availability of beds for patients and the budgetary implications of both closing beds to complete the works and also the cost of the works themselves in terms of materials and labour. 2.1 A prototype of the bathroom vanity unit (this unit incorporates a basin, mirror, tap mixer and cupboard combination minus the option to have a towel rail) has been designed. The Prototype deals with two aspects of the original unit, eliminates the towel rail and fits anti-ligature tap mixers.	2.1 The programme for implementation will provide for monthly updates on the design, manufacture, delivery and installation programme. The programme will be reviewed weekly by Head of Operations and monthly by CGQSE Committee, Management Team and Hospital Board.	2.1 Using Lean methodologies of manufacture and production, the key barriers to implementation will be Takt Time which is the rate at which a finished product needs to be completed in order to meet the hospital demand. The second barrier will be the availability and accessibility to the rooms, taking in to account the requirements of the patients. Thirdly the ability of the hospital to provide sufficient rooms for implementation	2.1 The vanity units in the 52 bed (St Joseph's & St Brigid's Suites) will be completed by 31 December 2016.

			taking in to account the ability to meet the going concern requirements of the hospital from a commercial perspective and from the Auditors perspective.	
	Preventative action(s): 2.2 A full re-audit of all ligature anchor points has been authorised. 2.3 A programme for implementation following the re-audit will be costed, prioritised and agreed with the Board. 2.4 The programme of works will be implemented on a phased basis throughout 2017	2.2 The completed re-audit will be presented to the CGQSE Committee, Management Team and Board 2.3 Programme to be presented to and approved by the Board via the Board Clinical Governance Sub-committee 2.4Regular reports submitted to Board Clinical Governance Sub-committee by the CEO	2.2 Achievable 2.3 Achievable 2.4 Availability and accessibility of rooms taking into account the requirements of patients while balancing this with the financial implications of closing beds to complete the works while meeting the going concern requirements from a commercial and auditor's perspective.	30th November 2016 27th January 2017 Updates to Board CGQS Sub-committee meetings in 2017

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines (inspection report reference 3.23)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
3 The Medical Council Registration Number (MCRN) was not present on all the MPARs	Corrective action(s): Doctors were reminded by email of the importance placed on this standard by the Inspectorate of Mental Health Services and the risk of non-compliance with regulation 23 if the MCRN number is not documented. The Approved Centre will fail Regulation 23 if this documentation issue is missed on even one occasion and regardless of the quality of any other aspects of prescribing practice. Responsibility of Dolores Keating, Head of Pharmacy.	Email reminder On-going audit cycle of MPAR standards	Completed	The action has been implemented.
	Preventative action(s): On-going clinical audit led by the pharmacy department and overseen by Dolores Keating, Head of Pharmacy includes monitoring of non-clinical standards such as the documentation of the MCRN number. Regular review of MPARs highlighting any discrepancies including the MCRN numbers by the pharmacy team in collaboration with medical colleagues as part of	On-going clinical audit of MPARs	In place	In place

	regular daily practice. Inclusion of the MCRN documentation requirement in training for doctors that takes place every six months and is delivered by Aoife Carolan, Senior Pharmacist. Actions will be taken to address non-compliance of any prescription writing standard in proportion to its impact on patient safety.			

Regulation 26: Staffing (inspection report reference 3.26)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
4 Not all healthcare professionals had been trained in basic life support and therapeutic management of violence and aggression or equivalent 26(4)	Corrective action(s): As noted in the Inspection report SJOG Hospital Nursing Staff were in a 2 year rolling programme for training in BLS and a 1 year rolling programme for TMV. NCHD staff have up to date BLS, CPI and Breakaway Training. Nursing staff not already trained in TMV or TCI will be given annual breakaway training which will be organised by the DDON & HR. SJOG Hospital is of the view that essential staff in this hospital receives the BLS and TMV/Breakaway training. However we note the Inspectorate's new requirement to train all healthcare professionals in BLS and Management of Violence and Aggression. We do not agree with the Inspectorate that this is either proportionate or targeted and assert that when trained there should be an expectation that the healthcare professional is being	Breakaway Training for this group of nursing staff will be recorded.	Achievable	Annually

	trained in something that they can maintain competence in. In order for this to happen they would need to be exposed to a certain frequency of incidences in order to maintain the competence. The reality is that not all healthcare professionals in the mental health inpatient setting in this hospital would be exposed to situations where they would need to use either BLS or TMV. Aligned with this we have a 24 hour provision of trained medical and nursing staff to respond in a medical emergency and/or staff alert at any location in the hospital or on the grounds. However we will work on a training programme to address the Inspectorate's current requirement to train all healthcare professionals in these two areas.	Multi-annual training plan will be developed for healthcare professionals other than nursing and NCHDs	Significant resource cost in terms of finance and wte to release all healthcare professionals for this training Risk that staff when trained will not have the opportunity to maintain competence due to the infrequency of such incidences in their daily practice	30 September 2017
	Preventative action(s): As above	As above	As above	As above

Part 4: Consent to Treatment (inspection report reference 5.1)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
5 There was no documented assessment of capacity for three patients who had consented to treatment	Corrective action(s): As per Section 56 of the Mental Health Act 2001, in all three of the cases listed, the consultant psychiatrist responsible for the care and treatment of the patient was satisfied that the patient was capable of understanding the nature, purpose and likely effects of the proposed treatment, and the consultant psychiatrist gave the patient adequate information in a form and language that the patient could understand, on the nature, purpose and likely effects of the proposed treatment. This is evidenced in each of the forms and in Section 15, page 2 of the Hospital form it is indicated by the consultant psychiatrist responsible that the patient is willing and able to give consent. The MHC issued Guidance to Approved Centres as at 13 July 2016 however **this was not in force at the date of the**			

	<u>inspection of SJOG Hospital in May 2016</u> A copy of the Part 4 of the Mental Health Act 2001 - Consent to treatment -Guidance for approved centres as issued by the MHC on 13 July 2016 has been circulated to all Consultant Psychiatrists	Guidance document issued	Completed	Completed
	Preventative action(s): MHC document: Part 4 of the Mental Health Act 2001 - Consent to treatment -Guidance for approved centres issued to all Consultant Psychiatrists	Guidance document issued	Completed	Completed

Code of Practice: The Use of Physical Restraint (inspection report reference 6.1)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
6 Four clinical practice forms had not been placed in the respective clinical files	Corrective action(s): The four restraint clinical practice forms have been placed on the respective clinical files.	Forms on clinical files	Completed	Completed
	Preventative action(s): Henceforth, restraint clinical practice forms will be removed to patients' clinical files by medical, nursing and ward administrative staff when complete	Where physical restraint has been initiated a monthly audit of the relevant clinical files will be undertaken by the Clinical Nurse Manager of the relevant suite.	Achievable	Monthly

Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities (inspection report reference 6.4)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
7 There was no provision in the policy on the training of staff working with people with intellectual disability	Corrective action(s): Policy to be amended to include reference to the training of staff	Amended policy	Achievable	31 October 2016
	Preventative action(s): Nurse Practice Development to check that policy has been amended to include reference to training	Check the policy for amendment	Achievable	31 October 2016