Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	St Aloysius Ward, Mater Misericordiae University Hospital
IDENTIFICATION NUMBER	AC0028
APPROVED CENTRE TYPE	Acute Adult Mental Health Services
REGISTERED PROPRIETOR	Mr Gordon Dunne
REGISTERED PROPRIETOR NOMINEE	Not Applicable
MOST RECENT REGISTRATION DATE	25 September 2015
NUMBER OF RESIDENTS REGISTERED FOR	15
INSPECTION TYPE	Unannounced
INSPECTION DATE	18, 19, 20 April 2016
PREVIOUS INSPECTION DATE	21, 22, 23 September 2015
CONDITIONS ATTACHED	No
LEAD INSPECTOR	Dr Susan Finnerty MCRN 009711
INSPECTION TEAM	Dr Enda Dooley MCRN 004155
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 the original building of the Mater Misericordiae University Hospital, necessitating a walk through another ward to gain access. The approved centre consisted of a long corridor, with rooms on either side. There was a large sitting/dining room with an internal smoking room, an activation room and a relaxation room. There was one single bedroom, a double bedroom and six-bed and four-bed dormitories. At the time of inspection, there was no access to an outdoor space.
There were extensive renovations ongoing at the time of inspection. Ceilings and lighting had been replaced. Floor coverings were in the process of being replaced and two showers and two toilets were being constructed. Work had commenced on the garden and it was reported that there would be access to it through the dining area by end of May 2016. A new pantry was planned but this had not yet been funded. The smoking room was due to be removed as part of the renovations.
On the first day of inspection there were nine residents, including one detained patient. This decreased to five residents on the second and third day of inspection. There were no residents who had a delayed discharge. There had been no children admitted since the previous inspection.

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

The CEO of the Mater Misericordiae University Hospital (MMUH) was the registered proprietor of the approved centre. The Health Service Executive (HSE) provided funding for some resources: the sector consultant psychiatrist; seven of the 17 nurses employed in the approved sector; and the clinical psychologist. The MMUH funded ten nurses and the two consultant psychiatrists in liaison psychiatry and provided the structure of the approved centre and maintenance of the approved centre. The Clinical Director was based in St Vincent's Hospital, Fairview. Nursing staff reported to three directors of Nursing: Mater Hospital, St Vincent's Fairview and the area director of nursing.
There were senior management team meetings with the registered proprietor every two months and minutes were provided to the inspection team. There were regular consultant psychiatrist meetings and nurse management meetings.

2.4 Inspection scope

This was an unannounced annual inspection. All aspects of the regulations, rules and codes of practice were inspected against as applicable.

The inspection was undertaken onsite in the approved centre on:

18 April 2016 from 09:30 to: 18 April 2016 17:00
19 April 2016 from 09:00 to: 19 April 2016 17:00
20 April 2016 from 09:00 to: 20 April 2016 16:30

2.5 Non-compliant areas from 2015 inspection

The previous inspection of the approved centre on 21, 22 and 23 of September 2015 identified the following areas that were not compliant:

Regulation/Rule/Act/Code	Inspection Findings 2016
Regulation 9 Recreational Activities	Non-compliant
Regulation 16 Therapeutic Services and Programmes	Non-compliant
Regulation 23 Ordering, Prescribing, Storage and Administration of Medicines	Non-compliant
Regulation 26 Staffing	Non-compliant
Regulation 27 Maintenance of Records	Non-compliant
Rules Governing the Use of Seclusion	Non-compliant

2.6 Corrective and Preventative Action plan

Corrective and Preventative Action Plans (CAPAs) had been provided to the Mental Health Commission for non-compliance with regulations identified in the 2015 inspection report. The Commission monitors the implementation of CAPAs on an ongoing basis. The latest CAPA review was completed on 6 January 2016. Twelve updates were required from the registered proprietor by 12 April 2016, but had not been provided by the due date. These updates and supporting documentation were provided during the inspection and are included in the findings under relevant regulations in this report.

2.7 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 6 Food Safety	Moderate
Regulation 9 Recreational Activities	High
Regulation 13 Searches	Moderate
Regulation 11 Visits	Moderate
Regulation 15 Individual Care Plan	High
Regulation 16 Therapeutic Services and Programmes	Critical
Regulation 20 Provision of Information to Residents	Moderate
Regulation 21 Privacy	Moderate
Regulation 22 Premises	Moderate
Regulation 23 Ordering, Prescribing, Storing and Administration	High
Regulation 26 Staffing	High
Regulation 27 Maintenance of Records	Moderate

Regulation 29 Operating Policies and Procedures	Low
Regulation 32 Risk Management Procedures	Moderate
Rules Governing the Use of Seclusion	Low
Code of Practice on Notification of Deaths and Incident Reporting	Low
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	High

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

2.8 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 7 Clothing
Regulation 24 Health & Safety

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 inspection.

Regulation/Rule/Act/Code
Regulation 14 Care of the Dying
Regulation 17 Children's Education
Rules Governing the Use of ECT
Rules Governing the Use of Mechanical Restraint
Part 4 of the Mental Health Act 2001 Consent to Treatment
Code of Practice on the Admission of Children
Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities
Code of Practice on the Use of ECT

2.10 Areas of good practice identified on this inspection

- A Smoking Cessation Programme had commenced. This will be included in individual care plans (ICPs) for participating residents.
- A working group was reviewing the format of the ICP to improve the information sought and provided about individual residents.
- Audits had taken place in medication management, admissions, transfers and seclusion.
- Training in Prevention and Management of Aggression and Violence (PMAV) was being rolled out to Emergency Department (ED) staff and security personnel, as well as mental health nurses.

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 were no patients on leave from the approved centre pursuant to section 26 of the Mental Health Act 2001.

2.13 Resident Interviews

Residents were invited to speak with the inspection team directly and through the use of a poster. Three residents availed of the opportunity. The inspection team also sat and chatted with residents during their tea-break. The Irish Advocacy Network representative was also invited to speak with the inspection team, and did so. All residents highly praised the care they were receiving and said that the nursing staff were kind and listened to them. They also praised the quality of the food and particularly mentioned the catering staff as being approachable and friendly.

Three residents complained of lack of recreational activities, therapies and outdoor space and also of ongoing boredom. One resident said that activities were often cancelled or did not take place and felt that two scheduled activities a day was not sufficient, especially if they did not always happen.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	8	0	0	8
	Involuntary Patients	1	0	0	1
	Wards of Court	0	0	0	0
DAY 2	Voluntary Residents	4	0	0	4
	Involuntary Patients	1	0	0	1
	Wards of Court	0	0	0	0
DAY 3	Voluntary Residents	4	0	0	4
	Involuntary Patients	1	0	0	1
	Wards of Court	0	0	0	0

2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. The following people attended: registered proprietor; area director of nursing; clinical director; director of nursing, St Vincent's Hospital Fairview; assistant director of nursing (ADON); CNM (clinical nurse manager) 2; estates manager; CNM1; clinical psychologist; and consultant psychiatrist in liaison psychiatry. 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, code of practice and section 2.3 on governance.

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 written policy on the identification of residents. Roles and responsibilities in the policy included the responsibility of the registered proprietor and consultant psychiatrists to inform residents of the policy. The use of two identifiers for treatment was not specified in the policy; the policy only specified the use of an identification bracelet. There was no process in the policy for the identification of same name residents.

Training and Education: Staff had signed the policy to say they had read and understood it. Staff were able to articulate the process for identifying residents.

Monitoring: No annual audit had taken place to ensure appropriate identifiers on clinical files. No analysis was carried out to improve the process of identification.

Evidence of Implementation: Two resident identifiers were in place for each resident: their medical registration number and identity bracelets. Both identifiers were used when giving medication and carrying out investigations. There were no residents of the same name in the approved centre.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet 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.

Processes: There was a written policy in place in the approved centre. The policy stated that it was the responsibility of the registered proprietor "to ensure that food is wholesome and nutritious with element of choice that takes into account any special dietary needs." No other roles or responsibilities were outlined in the policy. The policy stated that food management should be in accordance with Hazard Analysis and Critical Control Points (HACCP) to ensure food is properly prepared, wholesome and nutritious, with cognisance of special dietary needs and residents' requests.
There were no processes outlined in the policy to assess residents' dietary and nutritional needs or to monitor food and water intake and as such, the policy did not meet all the elements of the Judgement Support Framework

Training and Education: Staff had signed to say they read and understood policy and were able to articulate the processes for food and nutrition.

Monitoring: Menus were reviewed every three weeks in the main kitchen by the dietician. The dietician analysed allergen and special dietary requirements to improve menus.

Evidence of Implementation: There was a dietician in the main kitchen who reviewed menus on a three week basis and also reviewed special diets. Wholesome and nutritious food was served at dinner. There was fried food two to three times a week for tea, but there was a salad option. Yoghurt and fruit were available at all times. Food was attractively presented. Tea and coffee were served with meals at mid-morning, mid-afternoon and at 20:00. A water dispenser was in the dining room. Hot meals were served at lunchtime and tea-time. There was no resident in the approved centre who had a special dietary requirement.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet 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 written policy in place in relation to food safety. It stated that it was the responsibility of staff to ensure that food was safe to eat and that strict hygiene practices were observed in accordance with food regulations. Food safety legislation was referenced in the policy. The management of catering and food safety processes was outlined in the policy.

Training and Education: Staff had signed the policy to say that they had read and understood it. Catering staff were also able to articulate the process of ensuring food safety. Staff had up-to-date training in HACCP.

Monitoring: The catering staff carried out regular food safety audits, including food temperatures, fridge temperatures, dishwasher temperatures and hygiene audits.

Evidence of Implementation: There were hand washing facilities in the kitchen. The kitchen was clean but the cupboards were broken and doors were hanging off their hinges. The floor required replacing. There was very little space for preparing food for serving and the kitchen itself was very small. There was sufficient equipment, cutlery and crockery.

The approved centre was not compliant with this regulation because

(a) there was insufficient space for the preparation of food for serving (Regulation 6(1)(b)) and
(b) the cupboards were broken and therefore unsuitable for storage (Regulation 6(1)(b)).

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

Risk Rating			
Low	Moderate	High	Critical
	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: There was a written policy in place with regard to clothing. The policy outlined the processes and procedures in relation to clothing. This included the procedure in relation to residents wearing their own clothes and the wearing of night clothes during the day.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of the management of clothing.

Monitoring: Monitoring of wearing of night clothes by residents during the day was recorded.

Evidence of Implementation: Residents were dressed in their day clothes and all clothing worn by residents was clean and appropriate. There was a supply of emergency clothing. Each resident had a facility to store their clothes.

	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: There was a written policy on personal property and possessions. The policy outlined the roles and responsibilities of staff in relation to managing residents' personal property and possessions. The policy contained processes for recording residents' personal property and possessions, including money. It also included the provision that residents were facilitated in retaining control over their own possessions as far as was practicable.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of managing residents' personal property and possessions.

Monitoring: Each resident's property and possessions were documented. No analysis was completed to identify opportunities to improve the processes for residents' personal property and possessions.

Evidence of Implementation: There was a safe for the storage of residents' valuables and money. Residents were facilitated to manage their own possessions. An individual property list was in place, separate from the ICP. Access to residents' money was overseen by two staff, both of whom signed the record with the resident.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet 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 written policy in place on recreational activities. The policy stated that it was the responsibility of the registered proprietor to provide recreational activities. The process for developing recreational activities, including involvement of the residents in the process, was in the policy. There was no process for assessing risk in relation to recreational activities. Facilities for the provision of activities were not specified in the policy, nor were methods of communicating recreational activities to residents.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of providing recreational activities.

Monitoring: A record of recreational activities was maintained in the approved centre.

Evidence of Implementation: There were books, games, DVDs and a TV in the activity room and sitting area. There was a music session once a week which consisted of playing CDs. There was an activity room for arts and crafts. A record of attendance at recreational activities was maintained and reports were included in individual residents' nursing files. Residents spoke of being bored and having nothing to do.

There was no access to an outside space, any exercise or table games such as table-tennis or pool. Work on the garden had commenced. There was an activities timetable, but this consisted of two activities or therapies a day and residents reported that these did not always happen. There was no activities nurse or occupational therapist.

Both Corrective and Preventative Action Plans were completed.

The approved centre was not compliant with this regulation as there was insufficient access to recreational activities for residents.

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

Risk Rating			
Low	Moderate	High	Critical
		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 written policy in place on religion. The policy outlined the processes for facilitating practice of religion.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of facilitating the practice of religion.

Monitoring: There was no evidence that there was a review of the implementation of the policy to support residents' religious practices to ensure they reflected the identified needs of the residents.

Evidence of Implementation: There was evidence that the staff in the approved centre facilitated the practice of religion. There was access to a chaplain of choice. There was no suitable facilities for practicing religion in the approved centre. Depending on risk assessment, residents could attend religious services away from the approved centre.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet 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: There was a written policy in place in relation to visits. The policy included the roles and responsibilities of staff in relation to visits, the process for restricting visits, visiting times and the process of identifying visitors.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of managing arrangements for visiting.

Monitoring: There was no documented evidence of review or analysis of visiting arrangements or restrictions to visitors.

Evidence of Implementation: Visiting times were clearly displayed at the entrance to the approved centre. While there was no visitors' room in operation at the time of inspection, one had almost been completed, which would meet the requirements as a visitors' room and for children visiting. At the time of the inspection, there was no private space for visiting. Children were accompanied by an adult at all times when visiting residents.

The approved centre was not compliant with this regulation because there was no private space for visits.

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

Risk Rating			
Low	Moderate	High	Critical
	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 written policy in place in relation to communication. The policy included the process for the facilitation of communication, restrictions on communication and methods of external communication.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of facilitating and managing communication.

Monitoring: There was no evidence of monitoring of the processes in relation to communication.

Evidence of Implementation: No resident had restrictions in relation to communication. Residents had access to mobile phones, cordless phone and mail.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet 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: The approved centre had a written policy in place in relation to searches. The policy included the roles and responsibilities of staff; risk assessment prior to a search; procedures for searching; the considerations for privacy and dignity; the process for obtaining consent from the resident for a search; and documentation of searches. There was a separate policy in relation to the finding of illicit substances.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of conducting searches.

Monitoring: There was no evidence of review of search processes. No analysis was carried out to lead to improvement of the search processes.

Evidence of Implementation: Residents' property was searched routinely on admission and on return from leave. Risk assessments were carried out on admission. Two nurses conducted searches. Residents were informed as to why the search was taking place and dignity and privacy of the resident was maintained.

No explicit consent was obtained for these searches. Searches were not documented, nor was the reason for conducting the search documented.

The approved centre was not compliant with this regulation because:

(a) no explicit consent was obtained for these searches (Regulation 13(4));

(b) searches were not documented (Regulation 13(9)) and
(c) the reason for conducting the search was not documented (Regulation 13(9)).

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

Risk Rating			
Low	Moderate	High	Critical
	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 a written policy in relation to care of the dying and unexpected death.

No deaths had occurred in the approved centre since the previous inspection.

	Compliant	Non-Compliant
Compliance with Regulation	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 written policy in place on individual care plans (ICPs). The policy stated that it is the responsibility of the registered proprietor and multi-disciplinary team (MDT) to ensure that each resident has an ICP which reflects assessed need. The process for initial and ongoing assessment of needs was not in the policy. The policy stated that ICPs should be in accordance with this regulation. It stated that residents should be involved in developing their ICPs and should receive a copy. It did not specify timelines in relation to ICPs or the process for reviewing and updating ICPs.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of developing and reviewing ICPs.

Monitoring: No audits of ICPs had taken place. However, analysis of the current ICP had highlighted deficiencies and a new ICP was being developed to address this.

Evidence of Implementation: There were nine residents in the approved centre on the first day of inspection and all nine clinical files were inspected. Six residents had an ICP; three residents had been in the approved centre for less than seven days and did not have an ICP. No resident had an initial care plan, developed by the admitting team and resident, at the time of their admission.

The ICP template included needs, goals, interventions and resources required. However, in two cases goals were incorrectly stated as interventions. In other cases, the goals were sparse and generic (for example "stabilise mental state") and goals did not address the needs of the residents as documented in the progress notes. In one case, the goal was inappropriate, citing "homeless" as a goal. MDT input was limited due to the lack of an MDT, and consisted of medical and nursing and, on some occasions, psychology. Therefore, there were unmet needs for multi-disciplinary involvement in both assessments and interventions. Risk assessment did not form part of the ICP; risk assessments were kept separately in the nursing file.

Each resident had a primary nurse who functioned as a key worker but there was no evidence of their involvement in the ICP. Only two residents were offered a copy of their care plan and there was no documentation that residents had been offered an opportunity to input into their ICP. In three ICPs, there was evidence that the resident had been asked if they would like their family involved in their ICP.

The ICPs were located separately in the body of the progress notes and not in one composite set of documentation.

The approved centre was not compliant with this regulation because:

(a) the ICPs did not contain appropriate goals;
(b) there was a lack of MDT involvement;
(c) there was lack of involvement by residents in their ICPs;
(d) the ICP was not contained in one composite set of documentation.

	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 written policy in place in the approved centre. The policy included the responsibility of the registered proprietor to ensure there was an appropriate range of therapeutic activities and responsibility of staff to provide therapeutic services and programmes. Planning and provision of therapeutic services and programmes were outlined in the policy. Resources and facilities for provision of therapeutic services and programmes were not in the policy. Recording requirements were outlined in the policy. The policy stated that the Therapeutic Programme Group would update programmes according to the needs of residents and availability of resources and that physical and psychosocial needs will be identified. There was no reference to risk assessment.

Training and Education: Staff had signed to say they had read and understood the policy. Staff were able to articulate the process of providing therapeutic services and programmes.

Monitoring: Staff were in the process of completing an audit of therapeutic services and programmes and attendances. Analysis has been completed and improvements in documentation had been put in place.

Evidence of Implementation: There was no activation nurse or occupational therapist in the approved centre. There was an activity room and relaxation room. Therapeutic services and programmes were only carried out when nurses were available, but there were efforts to have two programmes a day. An occupational therapy assessment of the needs of residents had been carried out and a report had just been completed. Therapeutic services and programmes were not based on needs identified in the ICPs. In the activity programme timetable, which was displayed, the only therapeutic programmes were goal setting and relaxation. The remainder (quizzes, DVDs, walks, cooking and arts and crafts) were recreational. “Music therapy” consisted of listening to CDs and no music therapist was available. There was also a “discussion group”.

The approved centre had implemented three out of four of the Corrective and Preventative Action Plans submitted to the Mental Health Commission following the rating of non-compliance in this regulation in 2015

The approved centre was not compliant with this regulation because;

(a) there was insufficient access for residents to therapeutic services and programmes (Regulation 16 (1));
(b) the requirement for therapeutic services and programmes was not reflected in residents’ ICPs (Regulation 16 (1));
(c) therapeutic services and programmes provided were not sufficiently directed towards restoring and maintaining optimal levels of psychosocial functioning of the residents (Regulation 16(2)).

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

Risk Rating			
Low	Moderate	High	Critical
			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

This regulation was not applicable as no child had been admitted to the approved centre since the previous inspection.

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 were two written policies in relation to transfer of residents: one for transfer of voluntary residents and one for transfer of involuntary patients. The policies included the roles and responsibilities of staff; communication with the receiving centre; and the provision of information about the transfer to the resident and their next of kin. It also included the criteria for transfer, consent by the resident for transfer and recording of the transfer.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of transferring a resident to another hospital or approved centre.

Monitoring: There was no documentary evidence of systematic review of the transfer processes and no analysis had been carried out to improve the processes.

Evidence of Implementation: One resident in the approved centre had been transferred to a medical ward and their clinical file was examined. Relevant information had been sent to the receiving ward including medication, a transfer form and the clinical file.

	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 written policy in place with regard to medical emergencies. It stated that it was the responsibility of all healthcare staff to respond to medical emergencies with cardio-pulmonary resuscitation (CPR) and first aid. The processes for management, response and documentation of medical emergencies were clearly laid out.

There was a policy in place with regard to the provision of general health. The policy stated that it was the responsibility of the registered proprietor to ensure access to general health assessment and care. It was the responsibility of all staff to "foster attainment and maintenance of best possible general health". Resources were not stated in the policy, nor was the protection of residents' privacy and dignity during general health assessment and care. The process for recording and documentation of general health assessment and care was stated. The process for referral for assessment and care of physical needs was not in policy. Access to national screening programmes was outlined. There was no process in the policy with regard to supporting a healthy lifestyle. Therefore, the policy did not have all the elements of the Judgement Support Framework.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process with regard to medical emergencies and general health.

Monitoring: No current resident required any of the national screening programmes. There was a system in place to identify resident who had been in the approved centre for more than six months and required a physical examination. No current resident had been in the approved centre for more than six months.

Evidence of Implementation: There was an emergency trolley in the approved centre and the cardiac arrest team in the MMUH attended if there was a cardiac arrest.

All nine residents had a physical examination at the time of their admission and on an ongoing basis, as required. There was evidence that appropriate examinations and tests were carried out if necessary. Consultations from medical and surgical staff were available and residents could be transferred to the general hospital if required. No resident was in the approved centre for six months or longer.

There was a smoking cessation programme in place. There was no opportunity for exercise in the approved centre.

National screening programmes were not indicated for any resident who was in the approved centre at the time of inspection. There was no information for residents on national screening programmes.

The approved centre was not rated excellent on quality assessment as it did not meet all the requirements of the Judgement Support Framework.

	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 written policy in place on provision of information to residents. It stated that it was the responsibility of the registered proprietor to provide information to residents. The policy stated that information would be provided at admission and on an ongoing basis. The policy included having regard for residents' ability to understand and retain information and that information must be given in a manner that the resident could understand. There was no reference to interpreter services in the policy. The policy stated that information should also be given to next of kin, with the resident's consent, and that there should be access to advocacy.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of providing information to residents.

Monitoring: There was no auditing of the information given to residents and no analysis carried out with the aim of improving the information provided.

Evidence of Implementation: An information leaflet was given to each resident on admission and displayed on the noticeboard. The leaflet contained information on housekeeping, personal property, complaints and visiting. There was no information on residents' rights or of the residents' multi-disciplinary team; there was a space in the information leaflet for only the medical and nursing team to be documented. Staff were unable to access appropriate information about diagnosis and medication during the inspection. The inspection team were told subsequently that two appropriate websites were used to access this information. However, the inspection team found that not all staff were fully aware of this.

There was a noticeboard that was well stocked with general health information leaflets and included notices about advocacy services.

The approved centre was not compliant with this regulation because:

(a) there was no provision for informing the resident of their MDT (Regulation 20(1)(a));

(b) staff were unable to access appropriate information about medication and diagnosis for residents. (Regulation 20(1)(c),(e)).				
	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	
Risk Rating				
Low	Moderate	High	Critical	
	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 written policy in place with regard to ensuring residents' privacy and dignity. The policy stated that it was the responsibility of the registered proprietor to have the policy in accordance with the regulations. No other responsibilities were outlined. The policy did not contain methods for identifying and ensuring residents' privacy, the approved centre's layout to ensure privacy or the processes to be applied when privacy and dignity was not respected.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of providing privacy. For example, the staff articulated how they would take as many residents as possible out of the ward while workmen were present.

Monitoring: There was no annual review carried out to ensure privacy was maintained. No analysis was carried out to identify areas for improvement in ensuring privacy and dignity.

Evidence of Implementation: Residents were called by their preferred name. The general demeanour and behaviour of staff was courteous, professional and caring towards residents. Staff were appropriately dressed and wore name badges as well as hospital identification. There was no evidence that residents' details were discussed except in the closed nurses' station. Staff were observed knocking on bedroom doors prior to entry. All residents wore clothes that respected their privacy and dignity.

All bathrooms and toilets had locks that staff could over-ride. One curtain around a bed did not offer full privacy from other residents. The six-bed room was too small, with only 80 cm between beds and privacy was therefore compromised. Observation panels in doors were screened. No area was overlooked by public areas. Residents' details were not displayed on public noticeboards. Cordless phones were provided to ensure privacy when making a phone call.

The approved centre was not compliant with this regulation because:
(a) privacy was not provided in bedroom areas due to lack of privacy curtain around one bed
(b) beds in the six-bed room were too close together to allow privacy.

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

Risk Rating			
Low	Moderate	High	Critical
	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 on premises. It stated that it was the responsibility of the registered proprietor to ensure that the premises was maintained in good structural condition. It was also the responsibility of all staff who identified faults or defects to report to their line manager to enable reporting to the technical services department.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of ensuring that maintenance problems were reported to the technical services department.

Monitoring: Hygiene and infection control audits were regularly carried out as part of the MMUH audits. A ligature audit was completed and the issues identified were being addressed. On completion of the structural works, another audit would be carried out. Analysis was carried out on the identified deficits in the approved centre and improvements were taking place.

Evidence of Implementation: During the inspection, there was extensive structural and renovation work going on, to correct a number of deficits in the premises. Ceiling and lighting had been replaced. Floor coverings were in the process of being replaced and two showers and two toilets were being constructed. Work had commenced on the garden and it was reported that there would be access to it through the dining area by end of May 2016. A new pantry was planned but this had not yet been funded. The smoking room was due to be removed. A new waiting room/visiting room was almost completed. The approved centre was to be painted at the conclusion of the structural works.

The approved centre was well-lit, warm (22 degrees Celsius), ventilated and clean. Signage was clear on all doors, including toilets and showers. At the time of inspection, there was no access to outside space.

The approved centre was not compliant with this regulation because at the time of inspection there was no access to an outside space.

	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 written policy in relation to medication management. There were also MMUH guidelines on drug storage. The policy and guidelines outlined the responsibilities of the registered proprietor; clinical director; director of nursing; and all clinical staff. The policy referred to the MMUH policies on ordering, prescribing, administration and storage of medication, as well as other policies relating to medication management. These were available in the approved centre.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process for managing medication. Staff could access medication information through the MMUH intranet. Training was provided on reporting near misses and medication errors during induction.

Monitoring: An audit of the medication prescription and administration record (MPAR) had been completed in the previous few weeks and this was being analysed to improve compliance. The pharmacist attended the approved centre on a weekly basis to monitor medication management.

Evidence of Implementation: Seven MPARs were examined. All had three identifiers recorded. The allergies section was completed in all cases. Prescriptions were correctly documented, signed and the Medical Council Registration Number (MCRN) was recorded. One dose of medication was illegible and could be read as 10 mgs instead of 1 mg. The date of stopping medication was not recorded in one case. Two administration records were left blank and no reason was recorded for the resident not receiving the prescribed medication was recorded. The pharmacist had identified these errors and noted them on the MPARs for correction.

The medication was stored in a locked cupboard and locked drugs trolley. The controlled drugs were stored in a double locked cupboard and checked by two nursing staff. The amount of controlled drugs corresponded with the controlled drug register. The clinical room was clean and tidy. The fridge had a digital thermometer and a log was kept of the daily temperature. There were facilities for hand washing.

Medication received from the pharmacy was checked against the order. There was a system of stock rotation and an inventory was taken every week.

The approved centre was not compliant with regulation because:

(a) one dose of medication was illegible and could be read as 10 mgs instead of 1 mg;
(b) the date of stopping medication was not recorded in one case;

(c) two administration records were left blank and no reason for the resident not receiving the prescribed medication was recorded.

	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: The approved centre had a written policy in relation to health and safety of staff, residents and visitors. The policy outlined the roles and responsibilities of staff. The policy referred to the hospital safety statement and the ward safety statement. The policy referred to fire safety, infection control and accident reporting.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the details of the health and safety policy.

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

Evidence of Implementation: The written operational policies and procedures accurately reflected the operational practices in the approved centre.

	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: The approved centre had a written policy in relation to CCTV. The policy included the use of CCTV; roles and responsibilities of staff in relation to CCTV; purpose and function of CCTV; disclosure and signage; and observation of privacy and dignity while CCTV was in use.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of using CCTV.

Monitoring: There was no documentation of quality checks of CCTV and no evidence of analysis to promote improvement in the processes.

Evidence of Implementation: CCTV was only used in the seclusion room to monitor the health and safety of the resident. There was clear signage in place. The CCTV camera and monitor were disclosed to the inspection team. The CCTV was not capable of recording and images were only monitored by healthcare professionals.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of the Judgement Support Framework.

	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 written policy on recruitment, selection and vetting of staff dated March 2012.

The roles and responsibilities of staff were outlined in the policy. The policy stated that the procedure for recruitment, selection and vetting of staff as laid out in the MMUH recruitment and selection policy be adhered to.

Training and Education: Staff had signed that they had read and understood the policy and were able to articulate the processes in relation to staffing in the approved centre.

Monitoring: The staff training plan was constantly reviewed and updated to ensure adequate staffing. The number and skill mix of staff was reviewed against the number of staff specified in the Mental Health Commission registration of the approved centre. Analysis was completed to identify areas for improvement.

Evidence of Implementation: The staff rota was completed by the CNM2 and was available in the approved centre. There was a full complement of staff on duty and available for rostering. All staff were Garda-vetted including agency staff. All staff had qualifications appropriate to their roles.

There was a CNM1 or CNM2 on duty during day. A staff nurse was on duty at night and the night supervisor was based in the Mater Hospital. There was also availability of an assistant director of nursing (ADON) based in St Vincent's Hospital, Fairview.
A staff plan was available in the approved centre which took into account resident profile, numbers of residents and challenging behaviours. The staffing plan outlined staff qualifications and competencies. The required number of staff was outlined in the staff plan to safely manage the approved centre. Agency staff were not used at the time of inspection. However, the agency supplying staff when required guaranteed that all staff had certified qualifications and were Garda-vetted.

There was no occupational therapist assigned to the approved centre and no access to a social worker.

A staffing matrix was provided to the inspection team with respect to training of nursing staff and catering staff. No training records were available for other disciplines in the MDT. Fourteen out of 17 nursing staff had trained in cardio-pulmonary resuscitation; manual handling; therapeutic management of violence and aggression; the Mental Health Act; and care of the elderly. One nurse had completed training in protection and welfare of children.

The following is a table of nursing staff based in the approved centre on a 24-hour basis.

Ward or Unit	***Staff Grade***	***Day***	***Night***
St Aloysius Ward	ADON CNM2 CNM1 RPN HCA Occupational therapist Social worker Psychologist	1 1or 1 4 0 0 0 Attends MDT meeting and individual sessions as required	0 0 0 3 0 0 0 0

Assistant Director of Nursing (ADON), Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

The approved centre was not compliant with this regulation as

(a) there was no occupational therapist assigned to the approved centre and no access to a social worker (26(2))

(b) not all staff had been trained in basic life support, therapeutic management of violence and aggression,

	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 were policies on the creation of, access to, retention of and destruction of healthcare records which referred to the MMUH policy entitled the *Management of Healthcare Records* which was available in the approved centre.
There were also policies on the confidentiality and security of healthcare records and administrative access to healthcare records.

Training and Education: Staff had signed that they have read and understood the policies and were able to articulate the processes contained in the policies. Staff received training in records management at induction.

Monitoring: No audit of clinical files had been carried out and there was no analysis completed to improve the process of maintenance of records.

Evidence of Implementation: Clinical files were kept in the locked nurses' station. Three out of the nine clinical files examined were in poor order with loose pages, including legal documents. One care plan was tucked inside the front cover of a clinical file. In another file, all the pages were loose. Progress notes and assessments were not always in logical order. One file had clinical notes dated non-sequentially. Nursing files were completely separate from clinical files which meant that risk assessment and nurse progress notes were not in the clinical files. Clinical files reflected current care and treatment. Hospital registration numbers were used as identifiers on clinical files and on the MPARs.

The environmental health officer's report, fire safety report and health and safety report were maintained in the approved centre.

While one Corrective and Preventative Action Plan (CAPA) submitted to the Mental Health Commission had been completed, the other CAPA to integrate nursing notes into the clinical file had not.

The approved centre was not compliant with this regulation as
(a) records and reports were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval;
(b) records were not kept up-to-date and in good order (Regulation 27(1)).

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

Risk Rating			
Low	Moderate	High	Critical
	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

Processes: There was a written policy on the register of residents. Processes were in place with regard to the register of residents in the approved centre. The roles and responsibilities in relation to the maintenance and access to the register were evident. A standard and agreed practice was applied in updating and maintenance of the register, involving the ward clerk and the nursing staff.

Training and education: Relevant staff were informed of the processes relating to the updating and maintenance of the register.

Monitoring: The nursing staff and ward clerk ensured that the register of residents contained up-to-date and accurate information.

Evidence of implementation: There was a documented register, in hard copy, of all residents admitted to the approved centre. The register of residents contained information as per Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. The register of residents was up to date and was made available to the inspection team.

	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 in place with regard to developing policies. It stated that it was the responsibility of the registered proprietor to ensure that policies were developed and were in line with MMUH policies. It contained the provision that all policies must be renewed every three years.

Training and Education: Staff had signed the policy to say that they had read and understood it. They were also able to articulate the process of developing policies.

Monitoring: There was no annual audit, review or analysis of the policies.

Evidence of Implementation: There was no policy committee to oversee the development or review of policies. The inspection team were informed that one would be set up shortly. Not all policies were in date; policies on staffing and maintenance of records were dated 2012. All policies were accessible in the nurses' station. The policies had been approved by a previous clinical director. Each policy had a standardised format and incorporated relevant legislation, guidelines and codes of practice.

The approved centre was not compliant with this regulation because two policies had not been reviewed within three years.

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

Risk Rating			
Low	Moderate	High	Critical
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 no written policy in relation to mental health tribunals.

Training and Education: Staff were able to articulate the process for facilitating mental health tribunals.

Monitoring: The processes for facilitating mental health tribunals were monitored by the mental health act administrator. No analysis was carried out to identify opportunities for improvement.

Evidence of Implementation: There was a private room available for mental health tribunals. Adequate resources were provided to enable the process. Staff provided assistance to residents to attend mental health tribunals.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet all the elements of the Judgement Support Framework.

	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 written policy on the management of complaints in place. The roles and responsibilities of staff in relation to receiving and investigating complaints were outlined in the policy. The processes for management of complaints, displaying the complaints procedure and recording complaints were in the policy. The methods of making a complaint; confidentiality; timeframes; communication with the resident making the complaint; the process to escalate complaint if it could not be dealt with by the nominated person and the appeals process were not in the policy.

Training and Education: Training in complaints management was completed at induction. Staff had signed that they had read and understood the policy and were able to articulate the procedure.

Monitoring: No complaints had been received in the approved centre since the previous inspection.

Evidence of Implementation: No complaints had been received in the approved centre since the previous inspection. There was a nominated person to deal with complaints in the approved centre. The advocate attended the approved centre weekly and facilitated the making of complaints by residents, if required. The complaints procedure was contained in the information leaflet and there was a notice displayed on the noticeboard on how to make a complaint.

There was a system in place for addressing minor complaints at ward level. The nominated person dealt with complaints that were not dealt with by the CNM2. If necessary, complaints could be escalated through the MMUH complaints procedure.

All complaints remained confidential to the nominated person and complaints officer in the Mater Hospital.

The approved centre was not deemed excellent on quality assessment for this regulation as it did not meet 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: There was no specific policy on risk management for the approved centre. There was an overall risk policy for the MMUH but there was no statement stating that this was the risk policy of the approved centre. There were separate policies on assault, suicide and deliberate self-harm, absent without leave and accidental injury to staff and residents. The available policies did not identify the risk manager. Roles and responsibilities of staff were outlined in the policies and there were defined processes for maintenance and review of the risk register.

Training and Education: Staff had signed the individual policies to say that they had read and understood them. They were also able to articulate the process of risk management in the approved centre. There was no training in risk management of incident reporting.

Monitoring: There was no evidence that the risk register had been audited in relation to the approved centre or that analysis had been carried out. Incidents were recorded.

Evidence of Implementation: The staff were aware of the identity of the risk manager. Clinical risks were identified and documented. Ligature anchor points in the approved centre were being addressed by remedial work. There was evidence that risks due to the structural works were identified and addressed.

Individual risk assessment was carried out on admission, but not for any other treatments or therapy. The risk assessment documentation was in the nursing file and not in the clinical file and there was no evidence of multi-disciplinary input.

There was an emergency plan in place. There was an arrangement for the protection of vulnerable adults and children.
Incidents were recorded in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their weekly meeting. The risk manager reviewed all incidents. Incident report forms were available and used throughout the approved centre. 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.

The approved centre was not compliant with his regulation as there was no risk management policy for the approved centre.

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

Risk Rating			
Low	Moderate	High	Critical
	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

Processes: Processes were available for maintenance of insurance cover in the approved centre:

Training and Education: Relevant staff were aware of the processes relating to the approved centre's insurance cover.

Monitoring: The scope of the approved centre's insurance cover was reviewed by the registered proprietor.

Evidence of Implementation: The insurance was available in documentary form and provided to the inspection team. The approved centre's insurance covered public liability; employers' liability; clinical indemnity; and property.

	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

Processes: Defined processes were available to support the maintenance of an up-to-date certificate of registration.

Training and education: Relevant staff are aware of the processes relating to the approved centre's certificate of registration.

Monitoring: The registered proprietor monitored the approved centre's certificate of registration.

Evidence of implementation: There was evidence of the processes for displaying the certificate of registration being implemented and there was an up-to-date certificate of registration prominently displayed in the approved centre.

	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 was a policy in relation to ECT. There were no facilities in the approved centre for administering ECT. No resident had received ECT since the previous admission so this rule was not applicable.

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 were policies in place with regard to seclusion and training of staff in seclusion. This was renewed annually. The policy on seclusion outlined the processes and procedures in carrying out seclusion; the roles and responsibilities of staff; review of seclusion; and outline of how to reduce the rates of seclusion. The policy on training of staff in seclusion included who would receive training, although this only applied to nursing staff and not medical staff. The policy also addressed what was to be covered in training, the frequency of training and identified appropriate staff to give training.

Training and Education. Fourteen out of 17 nursing staff were trained in Therapeutic Management of Violence and Aggression (TMVA). There was no record of training of medical staff.

Monitoring: An annual report was compiled regarding the use of seclusion and this was available to the inspection team.

Evidence of Implementation: The seclusion facilities consisted of a seclusion room, an en suite and a small lobby area. A notice regarding CCTV was on the door. The facilities were clean and well ventilated.

Four seclusion registers and two clinical files of residents who had been secluded were examined. The reasons for seclusion were documented risk to residents themselves or others. There was an opportunity to discuss the episode of seclusion with members of the MDT. Next of kin was informed of the episode of seclusion and this was noted in the clinical files of two residents.
Two seclusion orders had not been signed by the consultant psychiatrist and one copy of the seclusion register had not been placed in the clinical file.

The approved centre was not compliant with this rule as

(a) two seclusion orders had not been signed by the consultant psychiatrist (3.5);
(b) one copy of the seclusion register had not been placed in the clinical file (9.3).

	Compliant	Non-Compliant	
Compliance with Rule		X	
Risk Rating			
Low	Moderate	High	Critical
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

Mechanical restraint was not used in the approved centre. Therefore, 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

There were no detained patients in the approved centre for a continuous period of three months. Therefore, this section was not applicable.

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: There was a written policy on physical restraint which outlined the processes involved, which was reviewed annually. The policy on training staff included who would receive training, although this only applied to nursing staff and not medical staff. The policy also addressed what was to be covered in training, the frequency of training and identified appropriate staff to give training.

Training and Education: Fourteen out of 17 nursing staff were trained in TMVA. There was no record of training of medical staff.

Monitoring: An annual report on the use of physical restraint was available to the inspection team.

Evidence of Implementation: The clinical files of one resident who had been physically restrained and the clinical practice forms were examined. All clinical practice forms were completed correctly. Physical restraint was documented in the clinical file. Next of kin had been informed and the patient had the opportunity to discuss the episode with his MDT. Physical examination was not carried out for clinical reasons. The completed form was placed in the clinical file.

	Compliant	Non-Compliant
Compliance with Code of Practice	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

There was a policy in relation to the admission of children. There had been no children admitted to the approved centre since the previous inspection. Therefore, this code of practice was not applicable.

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 policies for care of the dying and sudden death included the requirements for notification of deaths to the Mental Health Commission. The MMUH risk management policy and the approved centre's health and safety policy did not refer to the requirement that a summary of incidents be notified to the Mental Health Commission. The policies did not identify the risk manager. The policies for care of the dying and sudden death included the responsibilities of staff in relation to notification of a death. The MMUH risk management policy and the approved centre's health and safety policy did not specify responsibilities of staff in relation to the completion of six month summary reports of incident for the Mental Health Commission.

Training and Education: Staff had signed the policies on sudden death and care of the dying to say that they had read and understood them. They were also able to articulate the processes regarding notification of deaths and reporting of incidents.

Monitoring: No death had occurred in the approved centre since the previous inspection. Incidents were monitored by the risk manager.

Evidence of Implementation: No death had occurred in the approved centre since the previous inspection. Incidents were recorded in the incident book. A six monthly summary of incidents was submitted to the Mental Health Commission.

The approved centre was not compliant with this code of practice because
(a) the MMUH risk management policy and the approved centre's health and safety policy did not refer to the requirement that a summary of incidents be notified to the Mental Health Commission (4.1);
(b) the policies did not identify the risk manager (4.2).

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
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

There was a policy with regard to people with an intellectual disability and mental illness. No person with intellectual disability had been admitted to the approved centre since the previous admission. Therefore, this code of practice did not apply.

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

There was a policy in relation to ECT. There were no ECT facilities in the approved centre. No resident had received ECT since the previous admission so this code of practice was not applicable.

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:
Admission: There was a policy in relation to the admission of residents. It did not include the procedure for admission of an involuntary patient. The policy included reference to planned admissions, self-referrals and urgent referrals. The policy included the roles and responsibilities of staff in relation to admission, communication with primary care teams and community mental health teams (CMHTs); and procedures for privacy, confidentiality and consent.
Transfer: There were two policies in relation to transfer: one for voluntary residents and one for transfer of involuntary patients. The policy included arrangements for transfer, emergency transfer and safety of residents and staff. The policy included the roles and responsibilities of staff in relation to transfer of residents.
Discharge: There was a discharge policy in place in the approved centre, which included a provision for discharge of involuntary patients. The policy outlined the process for provision of prescriptions and supply of medication on discharge. There was a protocol for discharge of homeless people. There was a process outlined in the policy for follow-up after discharge. The policy also outlined the procedures for discharges against medical advice, discharge of people with an intellectual disability and discharge of older people.

Training and Education: Staff had signed the policies to say that they had read and understood them.

Monitoring: There was no audit of implementation of and adherence to the admission, transfer and discharge policies.

Evidence of Implementation:
Admission: The approved centre was not compliant with Regulation 32 Risk Management Procedures, Regulation 20 Provision of Information to Residents, Regulation 15 Individual Care Plan and Regulation 27 Maintenance of Records as required by this code of practice. The approved centre was compliant with Regulation 7 Clothing and Regulation 8 Residents' Personal Property and Possessions.
A key worker system was in place through the allocation of a primary nurse. Not all MDT members recorded in the clinical file; the nursing staff had their own files, which were kept separately.
Three clinical files were examined. In all cases, the decision to admit was made by a registered medical practitioner. Each resident received a full assessment at admission and this was documented in the clinical files. In one case, the resident's family were involved in the admission.
Transfer: The approved centre was compliant with Regulation 18 as required by this code of practice. No resident in the approved centre had been transferred to another approved centre or hospital.
Discharge: Three clinical files were examined in relation to discharge processes. In two clinical files, there was a discharge plan in the ICP. Only one discharge plan had an estimated date of discharge, follow-up plan, early warning signs of relapse and a risk assessment. Two discharge plans had documented communication with the primary care team and CMHT. Discharge planning meetings took place for all residents, attended by the

resident and available MDT members, and two days' notice of discharge was given. Each resident had a comprehensive assessment prior to discharge. A preliminary discharge summary was sent to the primary care team and CMHT within three days. Discharge summaries included diagnosis, prognosis and medication. Signs of relapse and follow-up arrangements were not included in one discharge summary. Timely follow-up appointment was given where there was a history of self-harm or suicide risk. In the case of one detained patient, relevant statutory forms were completed required by the Mental Health Act 2001.

The approved centre was not compliant with this code of practice because:
(a) there was no audit of implementation of and adherence to the admission, transfer and discharge policies (4.19);
(b) the approved centre was not compliant with Regulation 32 Risk Management Procedures, Regulation 20 Provision of Information to Residents, Regulation 15 Individual Care Plan or Regulation 27 Maintenance of Records (7.1; 16.3(c); 17.1; 22.6);
(c) not all discharge plans had an estimated date of discharge, follow-up plan, early warning signs of relapse and a risk assessment (34.2).

	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

Completed by approved centre: ST ALOYSIUS WARD, MATER MISERICORDIAE UNIVERSITY HOSPITAL **Date submitted:** 1st July 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). The Commission has not made any amendments to the returned CAPA plans, including content and formatting. Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission

Regulation 6: Food Safety (inspection report reference 3.6)				
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. There was insufficient space for the preparation of food for serving (Regulation 6(1)(b))	Corrective action(s): The Mater has plans to renovate the kitchen. There is no food preparation in this room, all food is prepared centrally. Beverage preparation only. Mr Alan Shape- Director of Estates and Facilities	The Approved Centre renovations programme will now be a standing item on the Psychiatry Governance Committee Meeting until all work is complete.	Minor capital is available for this work therefore is achievable and realistic	Six months
	Preventative action(s): N/A	N/A	N/A	N/A
2. The cupboards were broken and therefore unsuitable for storage (Regulation 6(1)(b))	Corrective action(s): Plans are in place for the installation of a new cupboards and work surfaces within the pantry. Mr Alan Shape- Director of Estates and Facilities	The Approved Centre renovations programme will now be a standing item at the regular Psychiatry Governance Committee Meetings until all work is complete.	Minor capital is available for this work therefore is achievable and realistic	Six months
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 9: Recreational Activities (inspection report reference 3.9)				
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. There was insufficient access to recreational activities for residents.	Corrective action(s): The Mater will develop more recreational activities and access to outside space. Mr Gordon Dunne-CEO Mr Alan Sharp-Director of Estates and Facilities	This will be placed as a standing item on the Psychiatry Governance Committee until action is complete. Building work is currently in progress to achieve access to open space.	The CEOs office has agreed to fund items to assist such as wifi, fuzball, football, exercise bike, ping pong table etc.	Three months
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 11: Visits (inspection report reference 3.11)				
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. There was no private space for visits	Corrective action(s): Dedicated rooms for visits in planning stage will be operational in three months. As an interim measure another room has been identified to facilitate visits during designated visiting times. Mr Alan Sharp-Director of Estates and Facilities Mr Gerry Gilligan-ADON	This will be a standing item on Psychiatry Governance Committee meeting agenda until it is resolved.	Funding is available and work in progress therefore achievable and realistic.	Three months
	N/A	N/A	N/A	N/A

Regulation 13: Searches (inspection report reference 3.13)				
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. No explicit consent was obtained for these searches.	Corrective action(s): The relevant policy will be amended. All patients will be asked for consent prior to all searches. All searches, consent for searches, the reason for the searches and the outcome of search will be documented in the clinical notes and in addition will be recorded in a new log book which will allow monitoring Dr Molyneux-CD Mr Gerry Gilligan	A local CAPA monitoring group has been established to oversee the implementation of this and other actions. A log book will allow monitoring of adherence to the new policy	Action is achievable and realistic	Three months
	Preventative action(s): N/A	N/A	N/A	N/A
6. Searches were not documented and the reason for conducting the search was not documented.	Corrective action(s): The documentation as noted above will be filed in the clinical record. A written log of all searches will be maintained. The relevant policy will be amended and regular audits will take place. Dr Molyneux-CD Mr Gerry Gilligan-ADON	A new document to be introduced to record all searches and will included reasons for search, consent obtained outcome of search and signatories of staff and patients involved. Audit process will commence.	Actions are achievable and realistic	Three months for policy rewriting, document implementation, log book commencement and audit start

	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 15: Individual Care Plan (inspection report reference 3.15)				
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. The ICPs did not contain appropriate goals.	Corrective action(s): The ICP has been redesigned to help clinical staff identify and document appropriate goals. A workshop to be organised by the CD to educate staff in this and the requirement for patients involvement in the own ICP. Dr Molyneux-CD Mr Gerry Gilligan-ADON	Quarterly Audit	Achievable and realistic	Six months
	Preventative action(s): N/A	N/A	N/A	N/A
8. There was a lack of MDT involvement.	Corrective action(s): There are currently no dedicated MDT members other than doctors and nurses in the Approved Centre. A review of the HSCPs involvement has been conducted and submitted with a business plan to the service commissioners (HSE) to develop HSCP input and enhance the MDT approach to the audit. Mr Gordon Dunne- CEO	HSCP deficit is to become a standing item on Psychiatry Governance group agenda.	Dependent on the commissioning agents (HSE) response to business proposal submitted	2017

	Preventative action(s): N/A	N/A	N/A	N/A
9. There was lack of involvement by residents in their ICPs.	Corrective action(s): The ICP document has now been redesigned and staff have been made aware by their line manager of the need to improve patients in the completion of their ICP. The ADON will also circulate a MEMO to the MDT tram stressing the importance of the requirement. A monthly audit will be conducted around this requirement. A workshop on the importance will be delivered to all clinicians. Dr Molyneux-CD Mr Gerry Gilligan-ADON	Approved Centre CNM2 will be auditing this and other aspects of the ICPs on a monthly basis. CAPA monitoring group to assure action achieved.	Achievable and realistic Achievable and realistic	Audit commenced already Three months
	Preventative action(s): N/A	N/A	N/A	N/A
10. The ICP was not contained in one composite set of documentation.	Corrective action(s): The ICP is now filed in the composite clinical record. As requested it is not to be filed amongst the clinical progress notes section of the record. Mr Gerry Gilligan-ADON	Monthly audit as above	Achievable and realistic	This action is now complete
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 16: Therapeutic Services and Programmes (inspection report reference 3.16)				
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)*
11. There was insufficient access for residents to therapeutic services and programmes (Regulation 16 (1)).	Corrective action(s): A Business plan for the HSCP resourcing has been submitted to the service commissioner (HSE) to improve the availability and skill mix of staff in the Approved Centre in order to deliver sufficient therapeutic services and programmes. In the interim the Nursing staff currently endeavours to deliver two one hourly therapeutic sessions per day. The therapeutic program has now been reviewed and updated to include psychological programmes including CBT and Mindfulness, where existing staff have qualifications. The Therapeutic Services and Programmes including Psychological Programmes are nurse delivered. Mr Gordon Dunne-CEO Mr Gerry Gilligan	Log book of activity and attendance to be maintained and signed by nursing staff leading the activity. The CAPA implementation group will monitor the therapeutic services and programmes via the log book.	The availability of these groups will be determined by staffing limitations	August 2016
	Preventative action(s): N/A	N/A	N/A	N/A

12. The requirement for therapeutic services and programmes was not reflected in residents' ICPs (Regulation 16 (1)).	Corrective action(s): ICP has been redesigned to include a more extensive range of activities, and the requirement and subsequent attendance at and progress in activities will be reflected in ICP. Dr Molyneux-CD Mr Gerry Gilligan	Audit in progress	Achievable and realistic	Already Commenced
	Preventative action(s): N/A	N/A	N/A	N/A
13. Therapeutic services and programmes provided were not sufficiently directed towards restoring and maintaining optimal levels of psychosocial functioning of the residents (Regulation 16(2)).	Corrective action(s): Psychological programmes have now been included in the range of therapeutic services available and will be led by nursing staff. Mr Gerry Gilligan	All programs to be logged and will be recorded in the patients ICP	Achievable and realistic	August 2016
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 20: Provision of Information to Residents (inspection report reference 3.20)				
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)*
14. There was no provision for informing the resident of their MDT (Regulation 20(1)(a)).	Corrective action(s): We are not currently in a position to inform the patients about their complete 'MDT' due to having no other MDT members but for doctors and nurses. Information leaflet is currently being reviewed to list the members of MDT. Mr Gerry Gilligan-ADON	CAPA monitoring group to monitor implementation of new information leaflet.	Achievable and realistic	August 2016
	Preventative action(s): N/A	N/A	N/A	N/A
15. Staff were unable to access appropriate information about medication and diagnosis for residents. (Regulation 20(1)€,€).	Corrective action(s): All staff are now aware of how to access information on medication via internet. The hospital librarian to be invited to run training sessions for all staff on how to access information on medication and diagnosis. This training to become part of future staff induction programme. Training will be given to included access to Royal College of Psychiatrists website, Medicine.ie and self-help groups.	CAPA monitoring group to monitor actions	Achievable and realistic	Oct 2016

	Mr Gerry Gilligan-ADON			
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 21: Privacy (inspection report reference 3.21)				
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)*
16. Privacy was not provided in bedroom areas due to lack of privacy curtain around one bed.	Corrective action(s): The problem curtain has now been replaced. Mr Gerry Gilligan – ADON	Achieved	Achievable and realistic	Achieved
	Preventative action(s): N/A	N/A	N/A	N/A
17. Beds in the six-bed room were too close together to allow privacy.	Corrective action(s): We acknowledge that the ward is tight for space. The bed demand is such that we cannot decrease the bed numbers currently. Plans are in place between the Mater and HSE for the development of a new purpose built unit on the campus.	Standing item on psychiatric monitoring group agenda	Dependant on the SLA and funding by the service commissioner (HSE)	2018
	Preventative action(s): N/A	N/A	N/A	N/A

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)*
18. .At the time of inspection there was no access to an outside space	Corrective action(s): Access to outside space is currently being constructed (builders on site). Mr Alan Sharp-Director of Estates and Facilities	Standing item on Psychiatric Governance Committee meeting agenda until resolved	Achievable and realistic	Three months
	Preventative action(s): N/A	N/A	N/A	N/A

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)*
19. One dose of medication was illegible and could be read as 10 mgs instead of 1 mg.	Corrective action(s): The medication records were reviewed and rewritten. Dr Guy Molyneux-CD	Already achieved	Correction has been completed therefore achievable and realistic	Completed
	Preventative action(s): Regular in-house training will continue on medication management for all clinicians. The primary nurse for each patient will now check their patient's medication records on a daily basis to check for errors. A monthly audit will take place using 'metrics' tools. The policy will be amended to reflect this. Dr Molyneux-CD Mr Gerry Gilligan-ADON	Monthly metrics monitoring programme includes section on medications	Already running therefore realistic	Achieved
20. The date of stopping medication was not recorded in one case.	Corrective action(s): The medication records were reviewed and rewritten	Monthly metrics	Already running therefore realistic	Achieved
	Preventative action(s): Regular in house training will continue on Medication management for all clinicians. The primary nurse for each patient will	Monthly metrics monitoring programme includes section on medications	Already running therefore realistic	Achieved

	now check their patient's medication records on a daily basis to check for errors. A monthly audit will take place using 'metrics' tool. The policy will be amended to reflect this. Dr Molyneux-CD Mr Gerry Gilligan-ADON			
21. Two administration records were left blank and no reason for the resident not receiving the prescribed medication was recorded.	Corrective action(s): N/A	N/A	N/A	N/A
	Preventative action(s): This issue was addressed by ADON and key worker now provides cross check on all prescription charts on a daily basis. Mr Gerry Gilligan-ADON	Monthly Metrics	Already occurring therefore realistic	Already occurring

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)*
22. There was no occupational therapist assigned to the approved centre and no access to a social worker (26(2)).	Corrective action(s): We are aware that the Approved Centre needs the regular input of other Health and Social Care Professionals and a review of this need has been prepared and sent to the HSE. Mr Gordon Dunne-CEO	This will now be a standing item on the psychiatric Governance meeting agenda	This depends on the commissioning agent's response to the business plan submitted	2017
	Preventative action(s): N/A	N/A	N/A	N/A
23. Not all staff had been trained in basic life support, therapeutic management of violence and aggression..	Corrective action(s): A training matrix is now in place and a training needs analysis has taken place. Training needs analysis is now completed and the training plan for 2016 is in place. All Staff will receive this training on a phased basis. Mr Gerry Gilligan-ADON	Record of all training attended by staff to be maintained on matric	Influenced by availability of courses and safe staffing levels but is achievable and realistic currently	Corrective action is completed
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 27: Maintenance of Records (inspection report reference 3.27)				
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)*
24. Records and reports were not maintained in a manner so as to ensure completeness, accuracy and ease of retrieval..	Corrective action(s): The Clinical Director to send a MEMO to all staff outlining their responsibilities for the management and hygiene of charts. Medical Records department to be contacted regarding providing educational training on maintenance of records. An audit of chart content of hygiene will be conducted. The Ward Clerk's role in this process is currently under review with the ADON. Dr Molyneux-CD Mr Gerry Gilligan-ADON	CAPA monitoring group to monitor adherence to action plan. Annual audit See attached templates on audit chart hygiene. We will be designing a local Audit tool based on the attached.	Achievable and realistic	Three months
	Preventative action(s): N/A	N/A	N/A	N/A
25. Records were not kept up-to-date and in good order (Regulation 27(1).	Corrective action(s): *The Clinical Director to send a* MEMO to all staff outlining their responsibilities for the management and hygiene of charts. Medical Records department to be contacted regarding providing educational training on	CAPA monitoring group to monitor adherence to action plan. Annual audit See attached templates on audit chart hygiene. We will be designing a	Achievable and realistic	Six months

	maintenance of records. An audit of chart content and hygiene will be conducted. The ward clerk's role in this process is currently under review with the ADON. Dr Molyneux-CD Mr Gerry Gilligan	bespoke audit tool based on the attached.		
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 29: Operating Policies and Procedures (inspection report reference 3.29)				
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)*
26. The approved centre was not compliant with this regulation because two policies had not been reviewed within three years.	Corrective action(s): This was a simple clerical error - all policies were amended and re-dated in 2015. The old policies which were erroneously in the folder will be removed and replaced by the up to date policies. Mr Anil kumar-CNM2	Local CAPA monitoring group to monitor adherence to action plan	Achievable and realistic	Three months
	Preventative action(s): N/A	N/A	N/A	N/A

Regulation 32: Risk Management Procedures (inspection report reference 3.32)				
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)*
27. The approved centre was not compliant with his regulation as there was no risk policy for the approved centre.	Corrective action(s): The approved centre falls within the general governance of the hosp. The Hospitals risk management policy will be amended to reference to the MHA Approved centre. This will be available on the unit. Mr Gordon Dunne-CEO	This will be a standing item on the Psychiatry Governance Committee agenda until resolved	Achievable and realistic	Three months
	Preventative action(s): N/A	N/A	N/A	N/A

Rules Governing the Use of Seclusion (inspection report reference 4.2)				
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)*
28. Two seclusion orders had not been signed by the consultant psychiatrist.	Corrective action(s): The CD and MHA administrator reviewed the seclusion register on receipt of the Draft report and found that since the inspection all orders has been signed. Dr Guy Molyneux-CD Ms Mary Wall-MHA Administrator	Mental Treatment Act administrator will review all seclusion records on a weekly basis	Achievable and realistic	July 2015
	Preventative action(s): The CD will issue a memo reminding all clinicians to sign the Order promptly, to familiarise themselves with the Seclusion Policy, and to use the Approved Centre Seclusion Checklist. Dr Guy Molyneux-CD	CAPA monitoring group to monitor adherence to action plan	Achievable	One month
29. One copy of the seclusion register had not been placed in the clinical file.	Corrective action(s): The CD and MHA administrator review the Seclusion Orders on receipt of the Draft report and found that since the inspection all Orders had been filed. Dr Guy Molyneux-CD Ms Mary Wall-MHA Administrator	Completed	Achievable and realistic	Completed

	Preventative action(s): The CD will issue a memo reminding all clinicians to sign the Order promptly, to familiarise themselves with the Seclusion Policy, and to use the Approved Centre Seclusion Checklist which includes a reminder to file the Order. Dr Guy Molyneux	CAPA monitoring group to monitor adherence to action plan.	Realistic	One month

Code of Practice on Notification of Deaths and Incident Reporting (inspection report reference 6.3)				
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)*
30. The MMUH risk management policy and the approved centre's health and safety policy did not refer to the requirement that a summary of incidents be notified to the Mental Health Commission.	Corrective action(s): The Mater Risk Manager will be asked to amend the Mater Risk policy to reflect this requirement, to submit a summary of incidents to MHC, and to make specific reference to the approved centre. A member of St Aloysius nursing staff will be invited to represent St Aloysius at the Hospital Risk Management Group. Mr Gordon Dunne-CEO	This will be a standing item on the Psychiatry Governance Committee meeting agenda until completed.	Achievable and realistic	Three months
	Preventative action(s): N/A	N/A	N/A	N/A
31. The policies did not identify the risk manager.	Corrective action(s): The Approved Centre policy and the wider hospital policy regarding risk will be reviewed and amended where needed to ensure the Risk Manager is identified. Mr Gordon Dunne-CEO Dr Guy Molyneux-CD	This will be a standing item on the Psychiatry Governance Committee meeting agenda until completed.	Achievable and realistic	Three months

	Preventative action(s): N/A	N/A	N/A	N/A

Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (inspection report reference 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)*
32. There was no audit of implementation of and adherence to the admission, transfer and discharge policies (4.19).	Corrective action(s): The approved centre is committed to developing an audit process regarding the adherence to the Admission, Transfer and Discharge policies.	Annual Audit	Achievable and realistic	Six months
	Preventative action(s): N/A	N/A	N/A	N/A
33. The approved centre was not compliant with Regulation 32 Risk Management Procedures, Regulation 20 Provision of Information to Residents, Regulation 15 Individual Care Plan or Regulation 27 Maintenance of Records (7.1;16.3(c);17.1;22.6).	*Please note that CAPAs pertaining to these specifici regulations are submitted as above* *Reg 32= CAPA 27,30,31* *Reg 27= CAPA 24,25* *Reg 20=CAPA. 14,15* *Reg 15= CAPA 7,8,9,10*			
34. Not all discharge plans had an estimated date of discharge,	Corrective action(s): N/A			

follow-up plan, early warning signs of relapse and a risk assessment (34.2).	Preventative action(s): *Clinical director to discuss discharge planning with colleagues and three months audit will be conducted to measure adherence to policy.*			