Mental Health Commission

Approved centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME	St Patrick's University Hospital
IDENTIFICATION NUMBER	AC0005
APPROVED CENTRE TYPE	Acute Adult Psychiatric Service
REGISTERED PROPRIETOR	Mr Paul Gilligan
MOST RECENT REGISTRATION DATE	01 March 2014
NUMBER OF RESIDENTS REGISTERED FOR	238
INSPECTION TYPE	Unannounced
INSPECTION DATE	8, 9, 10 and 11 November 2016
PREVIOUS INSPECTION DATE	3 and 4 December 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Ms Marianne Griffiths
INSPECTION TEAM	Ms Sandra McGrath Ms Siobhan Dinan Mr Donal O'Gorman Mr David Mc Guinness
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty MCN 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 an independent hospital and part of the St. Patrick's Mental Health Service. Located in Dublin city, St. Patrick's University Hospital was an 18th century listed building and was decorated to a high standard. The approved centre was set in a garden to which residents had access. In total, the approved centre had 238 beds.

It comprised eight wards: Dean Swift with the Special Care Unit (acute admission), Vanessa (care of the elderly), Stella (general admission), Grattan (general admission), Kilroot (general admission), Delany (general admission), Clara (eating disorders) and Temple (addictions service). The approved centre offered a wide range of therapeutic services, including dietician, occupational therapy, social work and psychology services. There was also access to a newly developed general practice service within the approved centre. A twilight programme was in place that offered a series of recreational and psycho-educational activities whereby service users, volunteers and creative artists collaborated on arts-based projects, once-off performances and specialist events. Children were not admitted to the approved centre.

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

St. Patrick's Mental Health Service had governance structures in place ensuring accountability at all levels. A range of established committees were included in the governance structure such as the clinical governance committee, the *Judgement Support Framework* committee and the drugs and therapeutics committee. A Clinical Council meeting took place monthly and the minutes of these meetings were available to the inspection team. The minutes indicated that the Clinical Council reviewed clinical activity data, updated policies and documented a thorough and robust agenda with appropriate actions and outcomes. Clinical and organisational risks within the hospital were escalated to the Clinical Governance Committee for review.

2.4 Inspection Scope

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

The inspection was undertaken on-site in the approved centre on the following dates and times:

08 November 2016 at 09:30 to 08 November 2016 at 18:00
09 November 2016 at 08:00 to 09 November 2016 at 18:00
10 November 2016 at 08:00 to 10 November 2016 at 18:00
11 November 2016 at 09:30 to 11 November 2016 at 16:00

2.5 Non-Compliant Areas from 2015 Inspection

The previous inspection of the approved centre on 03 and 04 December 2015 identified no areas of non-compliance.

2.6 Corrective and Preventative Action Plan

As there were no areas of non-compliance identified in the 2015 inspection, the approved centre did not have any Corrective and Preventative Action Plans (CAPAs).

2.7 Non-Compliant Areas on this Inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 13: Searches	Low
Regulation 15: Individual Care Plan	Low
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	High
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	Low

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

2.8 Areas of Compliance Rated Excellent on this Inspection

Regulation/Rule/Act/Code
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 7: Clothing
Regulation 8: Residents' Personal Property and Possessions
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 11: Visits
Regulation 12: Communication
Regulation 14: Care of the Dying
Regulation 16: Therapeutic Services and Programmes
Regulation 18: Transfer of Residents
Regulation 19: General Health
Regulation 20: Provision of Information to Residents
Regulation 22: Premises
Regulation 24: Health and Safety
Regulation 26: Staffing
Regulation 29: Operating Policies and Procedures
Regulation 30: Mental Health Tribunals
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

2.9 Areas Not Applicable

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

Regulation/Rule/Act/Code
Regulation 17: Children's Education
Regulation 25: Use of Closed Circuit Television
Rules Governing the Use of Seclusion
Rules Governing the Use of Mechanical Means of Bodily Restraint
Code of Practice Relating to the Admission of Children under the Mental Health Act 2001
Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities

2.10 Areas of Good Practice Identified on this Inspection

- Literacy friendly initiative: St Patrick's Mental Health Services facilitated a quarterly Literacy Committee, with multi-disciplinary, senior management, facilities, finance, and service-user representation. This committee was tasked with promoting awareness within the approved centre of the literacy needs of service users and removing unnecessary literacy- and numeracy-related barriers to accessing services.
- The approved centre had received a commendation for Best Hospital Project at the *Irish Medical Times'* Irish Healthcare Awards for Walk in My Shoes Radio (Break the Cycle of Stigma).
- The household department had recently become a Cleanpass-accredited training centre.
- The pharmacy department had received a Hospital Professional News Award for the optimisation of lithium therapy.

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 approved leave at the time of inspection.

2.13 Resident Interviews

Residents were invited to speak with the inspection team. A total of 11 residents chose to speak with the inspectors. They indicated that a high standard of care was delivered by the approved centre. Residents also spoke in positive terms about the large range of programmes available. However, one resident commented on the delay in their orientation to the approved centre. Residents in Dean Swift clinic indicated that the availability of more activities during the day would be welcomed. Seven residents expressed high levels of satisfaction with the care and support that they received from nursing staff.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	221	1	0	222
	Involuntary Patients	9	0	0	9
DAY 2	Voluntary Residents	222	1	0	223
	Involuntary Patients	6	0	0	6
DAY 3	Voluntary Residents	221	1	0	222
	Involuntary Patients	7	0	0	7
DAY 4	Voluntary Residents	218	1	0	219
	Involuntary Patients	7	0	0	7

2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. Inspectors gave provisional feedback on their findings and invited discussion from the management team to provide clarifications and extra information. Those in attendance were:

Inspection team
Nurse Practice Development Coordinator
Director of Nursing
Principal Clinical Psychologist
Pharmacist
Head of Social Work
Medical Director
Director of Services
Mental Health Act Administrator
Occupational Therapy Manager
CEO
Programme Manager

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.

Processes: The approved centre had a written policy that outlined the processes in place for the identification of residents. It described the roles and responsibilities of staff in relation to the identification of residents. The policy specified the use of two appropriate identifiers prior to the administration of medications, therapies or medical investigations. There was a written process in place to ensure correct identification in cases of similar- or same-name residents.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre's policy on the identification of residents. Staff could articulate the processes in place for identifying residents.

Monitoring: An audit had been completed to ensure that appropriate resident identifiers were included on clinical files. Analysis had been undertaken to identify opportunities to improve the resident identification process.

Evidence of Implementation: The approved centre used a minimum of two resident identifiers when providing care and treatment to residents. Where residents had provided consent, a photograph was taken and used as an identifier. Residents' names, dates of birth and addresses were also used as forms of identification. Resident identifiers were appropriate to residents' communication abilities. There was a process in place to alert nurses to two similarly named residents; in these cases a red sticker was placed on all clinical documentation.

The approved centre was compliant with this regulation. As the approved centre adhered to every aspect of the *Judgement Support Framework*, this regulation was quality assessed as excellent.

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

3.5 Regulation 5: Food and Nutrition

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

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

Inspection Findings

Processes: The approved centre had a number of policies relating to food and nutrition. The main policy inspected was entitled *Nutritional Care*, which comprehensively defined staff roles and responsibilities in relation to food and nutrition. The policies reflected the use of a standardised nutritional assessment tool across the service. An additional assessment tool used on Clara ward provided care and treatment for residents with eating disorders.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre's policy on food and nutrition. Staff across three wards were able to clearly articulate the process for food and nutrition, as set out in the policy. Staff in the catering department gave clear and comprehensive information regarding the systems in place for assuring high standards in terms of food and nutrition throughout the service.

Monitoring: Senior staff within the catering department met with the dietician on a monthly basis, and the approved centre's menus were reviewed every three weeks. Resident dietary needs were reviewed regularly, and individual dietary preferences were facilitated. Audits had been completed and areas identified as requiring improvement had been addressed.

Evidence of Implementation: There was evidence of dietetic input into all meals, with clear assessment of nutritional needs for each resident as appropriate. Residents receiving treatment for eating disorders had one-to-one support from a dietician throughout the period of their admission.

The approved centre's menus were systematically reviewed to ensure the provision of wholesome and nutritious food choices. Low calorie options were provided, as per resident needs. There was a current campaign by catering staff, in collaboration with the dietician, to provide low fat desserts and offer healthier dessert options to residents. Meals suitable for diabetic residents were provided as required. Gluten-free options and halal meals were available when required. The head chef, assistant catering manager and dietician met every month to review and approve menus to best meet residents' nutritional needs.

Fresh drinking water was freely available to residents on all wards. On Vanessa ward, jugs of water were provided on trays at the end of each bed. On Clara ward, the management of ill residents with anorexia nervosa (MARSIPAN) evidence-based nutritional assessment tool was used. Healthy eating choices were encouraged, and the approved centre ran lectures for residents on nutrition. Fresh fruit was available every day and provided in communal areas. Weight charts were maintained, where appropriate, and recorded in the clinical files.

The approved centre was compliant with this regulation. As all aspects of the *Judgement Support Framework* were adhered to, the approved centre was quality assessed as excellent for this regulation.

	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: The approved centre had a number of policies in place that addressed different aspects of food safety. Each policy clearly outlined roles and responsibilities in relation to specific phases of the food safety process. There were policies for the preparation of food; handling of food, which was further broken down into handling requirements for different types of foods; and food storage, including storage instructions for dry food, meat, frozen food and dairy. There was a comprehensive policy on the management of food waste. The approved centre operated under the guidelines of Hazard Analysis and Critical Control Point (HACCP) and had developed its own food safety training.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policies on food safety. Food safety training for all catering staff was up to date. Staff were able to articulate the food safety processes, as outlined in the policy.

Monitoring: Staff in the catering department described ongoing audits and analysis within the department to ensure high standards in food safety. Temperature logs were maintained appropriately throughout the department. The approved centre was involved in a pilot scheme with the Food Safety Authority, whereby samples of food were sent for testing on an ongoing basis to ensure that foodstuffs were of the highest standard.

Evidence of Implementation: Staff in the kitchen at the time of inspection were observed to be wearing appropriate personal and protective equipment. There were separate areas for the preparation of different food types to prevent cross-contamination. The approved centre had facilities for the separate storage of pre-cooked dried foods, fruit and vegetables, baking/dessert products, meat and poultry, fish and dairy. Food allergens were clearly labelled, and food containing these allergens was stored appropriately to prevent cross-contamination.

Designated areas were allocated for the storage, preparation and cooking of foodstuffs within the approved centre. Each ward had its own food trolley and supply of crockery and cutlery suitable and sufficient for the resident cohort.

Hygiene standards were maintained to support food safety requirements. Catering areas were appropriately cleaned, and a cleaning schedule was maintained and signed by cleaning staff.

The approved centre was compliant with this regulation. As all aspects of the *Judgment Support Framework* were adhered to, the approved centre was quality assessed as excellent for this regulation.

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

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: The approved centre had a policy in relation to the processes for managing resident clothing. The policy included the procedure for providing clothing to residents, where necessary, with consideration to their preferences, dignity, bodily integrity and religious and cultural practices. The policy stipulated that nightclothes were not to be worn by residents during the day unless specified in their Individual Care Plan.

Training: There was a computer-based system in place indicating that staff had read the approved centre's policy on clothing. Staff were able to articulate the processes for residents' clothing, as set out in the policy.

Monitoring: Emergency clothing was available and was monitored on an ongoing basis. A record of residents wearing nightclothes during the day was maintained and reviewed.

Evidence of Implementation: All residents had an individualised supply of clothing and were supported to keep and use their personal clothing. Staff labelled clothes, where necessary. Resident clothing was clean and appropriate to the residents' needs. Laundry was outsourced and bags of laundry were picked up daily and returned within 24 hours to each resident. A stock of emergency clothing, including day and night wear for both genders, was kept by nursing administration. All residents were observed to be wearing day clothes during the period of inspection.

The approved centre was compliant with this regulation. As the approved centre adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent.

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

3.8 Regulation 8: Residents' Personal Property and Possessions

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had three policies for the management and safe keeping of residents' personal property and possessions. According to the policies, the process relating to personal property and possessions was explained to residents and their representatives on admission. The procedure for recording, storing and managing personal property and possessions submitted to the care of the approved centre was clearly defined. The policies outlined a clear process for giving residents access to and control over their personal property. The process of risk management with regard to personal property and possessions was detailed in the *Assessment and Reassessment Policy*.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre's policies on personal property and possessions. Staff interviewed on three different wards were able to articulate the processes in place for managing residents' personal property and possessions.

Monitoring: Property logs were completed on admission and updated as residents handed property over to the approved centre for safe keeping. Audits were conducted and included reviewing incident logs in relation to theft of property and possessions. Following the audits, the processes were improved, with better security measures to safeguard residents' possessions.

Evidence of Implementation: Residents were encouraged to send valuables home with family or friends but were facilitated to keep them when they chose to do so. The approved centre provided facilities to safeguard personal property and possessions, and there was a system of double-checking property when submitted to the approved centre for safe keeping. Residents signed the property logs to state that they accepted responsibility for property that they retained in their possession while residing in the facility.

Single bedrooms automatically locked when the doors were closed. Fob access to these rooms was restricted to the resident and the staff on the ward. There was a safe in all

residents' wardrobes, except on Clara ward, where residents were provided with a personal property cupboard. Laptops were difficult to store safely as they would not fit in the safes provided and wards were not locked.

Items that could not be stored safely on the wards could be safeguarded elsewhere – either in locked areas on the ward or in the general offices. Where residents requested access to such property, risk was assessed and relevant documentation was completed and signed by a nurse and the resident. The resident then presented the receipt at the general offices and the requested item was signed out by the resident and co-signed by a staff member there.

Residents were encouraged to retain their own money. When money was handed to staff for safe-keeping, the general offices storage processes were applied.

The approved centre was compliant with this regulation. As it adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent.

	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: The approved centre had policies in place for recreational activities. These outlined the roles and responsibilities relating to the provision of recreational activities and the process for determining residents' likes and dislikes. They specified the processes used to risk assess residents for recreational activities and to develop recreational activities. The policies indicated that an activities timetable was to be displayed in each ward in the approved centre in order to communicate the availability of activity programmes. The policies also documented the process for supporting resident involvement in developing the activities timetable and provided details of the facilities available for such activities.

Training and Education: There was a computer-based system in place, indicating that staff had read the approved centre's policies on recreational activities. Staff could articulate the processes for the provision of recreational activities.

Monitoring: A schedule of planned recreational activities and a record of resident attendance were maintained by the approved centre. The occupational therapy (OT) department conducted periodic audits of selected processes in relation to recreational activities in order to identify opportunities to improve them.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident profile on weekdays and at the weekends, including, but not limited to, guided meditation, Tai Chi, Music Matters, choir, arts group, art appreciation, a moving and making workshop and music groups. Information was provided to residents in an accessible format, appropriate to individual needs. Recreational activities programmes were developed, implemented and maintained with resident involvement and were facilitated by the OT department. Individual risk assessments were completed for residents in relation to outdoor activities and the use of gym equipment. Residents in Dean Swift ward indicated that they would appreciate the availability of a wider selection of recreational activities.

The recreational activities provided were appropriately resourced. The approved centre had dedicated rooms for music, arts and crafts, pottery, movies and computers as well as a library. Opportunities were provided for indoor and outdoor exercise, including access to a fully equipped gym. Documented records of attendance at recreational activities were retained.

The approved centre was compliant with this regulation. As it adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent.

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

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents. The policy included all the requirements of the *Judgement Support Framework.*

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre's policy on religion. Staff were able to articulate the processes for facilitating residents in the practice of their religion.

Monitoring: There was an audit completed in relation to Regulation 10: Religion. The approved centre assessed itself at 100% compliance, and no further actions resulted from this audit.

Evidence of Implementation: There was a chapel in the approved centre, to which all residents had access. A Catholic priest said mass at 4.30pm from Monday to Friday and every Sunday morning. Anglican residents had access to Church of Ireland clergy, who came to the approved centre every two weeks. Access to multi-faith chaplains was available on request and residents were facilitated to practice their religious beliefs as far as was practicable. For example, a past resident who was Buddhist was facilitated to use the gardens for religious practice.

The approved centre was compliant with this regulation. As it adhered to all aspects of the *Judgement Support Framework,* it was quality assessed as excellent.

	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 were four written policies relating to visits. They covered general visits, contractors on site, visitor identification and child visitors. The policies specified that all visitors were asked to check in at reception, where they were issued with visitors' badges. The policies stated that visits were only restricted on the basis of a resident's request or where there was an identified risk. All restrictions on visitors were to be documented in residents' files.

Training and Education: There was a computer-based system in place indicating that staff in the approved centre had read the policies on visits. Staff on all wards were able to articulate the process for visits, as outlined in the policy, including any practice relevant to the particular ward they worked on.

Monitoring: An audit had been completed on the visiting process. The approved centre assessed itself as 100% compliant, and no further analysis was identified as required. There were restrictions on visits for two residents at the time of inspection. The reasons for these restrictions were clearly documented, and there was evidence of review.

Evidence of Implementation: Visiting times were displayed at the entrance of the hospital and outside each ward. Visiting hours were flexible and stipulated that visitors arriving at the approved centre during mealtimes would wait in the coffee shop or another seating area. On Temple ward, visitors were observed coming and going outside of visiting times, and this was facilitated appropriately, based on the needs of the individual resident.

There were restrictions on visits to Dean Swift ward for two residents. The rationale for these was clearly documented and related to the safety and well-being of either the resident or another person. The front desk and switchboard were notified if a resident did not want to see a particular visitor or if there was a restriction in place. This was identified on the system with a "STOP" beside the person's name, and this informed reception staff not to admit a certain visitor.

Each ward had an area suitable for visits. Residents' bedrooms, quiet areas throughout

the hospital and multipurpose rooms were also used for visits. There was a designated visiting area for children called the Wishing Well Family Room, which had capacity for three families at a time. A small alcove within the room was designed with the needs of young children in mind. Another alcove had a PlayStation for older children. The room was open plan but designed in a way that allowed for privacy.

The approved centre was compliant with this regulation. As it adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent.

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

3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: The approved centre had a number of policies in place that outlined its processes in relation to communication. These detailed the roles and responsibilities of staff in providing residents with the correct access to communication facilities. They specified the communication services available in the approved centre: postal services, fax, e-mail access, internet and Wi-Fi and landline telephone. The policies included the process for assessing residents' communication needs and the circumstances in which resident communications may be examined by a senior staff member. Only the clinical director or a senior staff member were authorised to examine incoming or outgoing resident communications, and this was permitted solely when there was reason to believe that the communication could cause harm to the resident or another.

The policy *Accessing Interpreter Service* stated that access to an interpreter for residents was available as required and that Word Perfect Translations provided this service.

Training and Education: There was a computer-based system in place indicating that staff in the approved centre had read the policies on communication. Staff could articulate the processes for communication, as set out in the policy.

Monitoring: Residents' communication needs and restrictions were monitored on an ongoing basis, and a service user communication analysis had been conducted in order to identify opportunities to improve the communication process.

Evidence of Implementation: Individual risk assessments were completed for residents in relation to any risks associated with external communication, as required. The majority of residents had their own mobile phone, and those who did not, had access to a cordless phone in the nursing station on each ward. Wi-Fi was available throughout the approved centre, and residents had access to internet, fax and e-mail as required.

The approved centre was compliant with this regulation. As it adhered to all aspects of the *Judgement Support Framework,* it was quality assessed as excellent.

	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 detailing the processes to be followed in the event of a resident search. It described the following:

- The process for managing and conducting searches of a resident, their belongings and accommodation.
- The consent requirements to be followed in the event of a resident search.
- The process in place for dealing with illicit substances uncovered during a search.
- The policy roles and responsibilities in relation to the implementation of resident searches.
- The application of individual risk assessment in relation to searches.
- The processes for communicating the approved centre's search policy to residents and staff.
- The procedure for informing the resident being searched of what was happening and why.
- The considerations of the resident's dignity, privacy and gender during searches.
- The documentation of the required reasons for the search.

Training and Education: There was a computer-based system in place indicating that staff in the approved centre had read the policy on searches. Staff were aware of the processes for searching residents with and without consent; however, staff were not aware of the procedures to be followed in the event that they found illicit substances.

Monitoring: A log of personal and property searches was maintained by the approved centre. Environmental searches were recorded and documented. An audit had been completed in order to identify opportunities for improving the search process.

Evidence of Implementation: On admission, general written consent was sought for routine environmental searches, and consent or refusal was documented. Staff completed a risk assessment on each resident prior to each search. Consent was also sought, and the response was documented. The approved centre's search policy was communicated to all residents. The files of two residents who had been searched were examined. In both cases, there was a minimum of two clinical staff in attendance during the search.

While searches were implemented with due regard to the residents' dignity and privacy, one male resident was searched by two female staff members, which was not in keeping with due regard for gender.

A record of environmental searches was not maintained. A written record of every search of a resident and their property was maintained, and these included the reason for the search. The names of staff members who conducted the search and the details of those who were in attendance during the search were documented.

The approved centre was non-compliant with this regulation because searches were not undertaken with due regard to residents' gender, as required by Regulation 13, 7.

	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: The approved centre had a selection of written policies that outlined the processes for the care of a resident at end of life. These specified staff roles and responsibilities in relation to care of the dying and the process for identifying residents' physical, emotional, spiritual, social and psychological needs and pain management at end of life.

The approved centre had a policy entitled *Advance Healthcare Decisions,* which described the processes around implementation of a Do Not Attempt Resuscitation order and other advance directives at end of life. The policies addressed the following:

- The privacy and dignity requirements of residents, implemented as part of care of the dying.
- The involvement and accommodation of residents' representatives, family, next of kin and friends.

The policy entitled *Death of a Service User in Care* detailed the following:

- The process for managing the sudden death of a resident.
- The process and responsibility for reporting the death of a resident to the required external bodies.
- The process for notifying the Mental Health Commission (MHC) of the deaths of residents.
- The process for ensuring that the approved centre was informed of the death of a resident who had been transferred elsewhere.

Training and Education: There was a computer-based system in place, indicating that staff in the approved centre had read the policies on care of the dying. Staff were able to articulate the process for end of life care, as set out in the policies.

Monitoring: An audit was presented that examined the processes followed in the cases of nine deaths. A systems analysis was undertaken as required. Analysis was completed to identify opportunities to improve the processes for care of the dying.

Evidence of Implementation: The file of one resident who had passed away in the approved centre was examined. The end of life care provided to the resident was appropriate to their physical, emotional, social, psychological and spiritual needs. Religious and cultural practices were respected, as were the privacy and dignity of the resident. The resident was accommodated a single room, and family members were also accommodated. Pain management was prioritised, and a hospice team had input into the resident's care.

Advance directives relating to end of life care were documented, and all resident deaths were notified to the MHC within the required the 48-hour time frame.

The approved centre was compliant with this regulation. As the approved centre adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent.

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

3.15 Regulation 15: Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

Inspection Findings

Processes: The approved centre's written policy *Multidisciplinary Service User / Young Person Care Plan and Key Worker System* identified staff roles and responsibilities relating to the development of the Individual Care Plan (ICP). This included the necessity to complete comprehensive assessments of residents at admission and on an ongoing basis. The policy detailed the required content in the set of documentation comprising an ICP and the implementation of ICP reviews and updates. The care plan was to be reviewed in consultation with the resident, and resident involvement in ICP planning and the time frames for assessment and evaluation were specified in the policy. The ICP was to be in place within seven days of admission and reviewed weekly. The policy noted that service users were informed of their right to access their ICP at any time, on request.

Training and Education: There was a computer-based system indicating that staff in the approved centre had read the ICP policy. Staff could articulate the processes relating to individual care planning, as set out in the policy. All Multi-Disciplinary Team (MDT) members were trained in individual care planning.

Monitoring: Individual care plans were audited on a quarterly basis in order to assess compliance with the regulation. The audits included the following criteria: the involvement of the MDT in resident care, the key worker system, discharge planning and compliance with the regulation.

Evidence of Implementation: In total, 80 ICPs were reviewed. Each of these contained an admission assessment and an ICP. All ICPs were developed, regularly reviewed and updated by the MDT. The initial assessments included medical, psychiatric and psycho-social history; medication history; a current physical health assessment; a detailed risk assessment; and social, interpersonal and physical environment related issues, including resident resilience and strengths. All assessments were evidence-based. All ICPs identified residents' needs and the relevant interventions necessary to attain them. Resident involvement in the ICP process was documented.

Five ICPs did not contain documented resident goals, and six did not reference the resources required to provide the care and treatment identified. All ICPs contained a risk management plan, and the treating consultant psychiatrist allocated a key worker in every case. The ICP was held in a composite set of documents.

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

(a) Five ICPs did not contain a documented set of goals.
(b) Six ICPs failed to specify the necessary resources to achieve the identified goals.

	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: The approved centre had a suite of written policies that outlined processes in relation the provision of therapeutic activities. Staff roles and responsibilities were documented, as were the planning, provision, resource, and facility requirements of therapeutic services and programmes.

Training and Education: There was a computer-based system indicating that staff in the approved centre had read the policies on therapeutic services and programmes. Staff could articulate the processes for therapeutic activities and programmes provided by St. Patricks' Hospital Services.

Monitoring: There was ongoing monitoring of the range of services and programmes provided by the approved centre. Audits were completed to identify opportunities to improve therapeutic input.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in the residents' Individual Care Plan. Therapeutic services were evidence-based. A list of all therapeutic services and programmes, which was updated daily, was available to residents. Where a resident required a therapeutic service that was not provided directly by the approved centre, St. Patrick's Mental Health Services arranged for the service to be provided by an approved qualified health professional in an appropriate location. Examples of such services included forensic or neurological input.

Adequate resources and facilities were available to provide therapeutic services and programmes. There were a number of separate, dedicated rooms with space for individual and group therapies. The therapeutic services were provided by occupational therapy, psychology and social work and included the following:

- Eating disorder programme.
- Anxiety disorder group.
- Bipolar group.
- Cognitive behaviour therapy groups.
- Dual diagnosis, depression group.
- Evergreen, links to wellbeing.
- Psychosis recovery group.

Each residents' file contained a weekly record of the therapeutic activities that he or she had attended, along with a documented outcome of the therapy for that resident.

The approved centre was compliant with this regulation. As the approved centre adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent on this regulation.

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

3.17 Regulation 17: Children's Education

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

Inspection Findings

As the approved centre did not admit children, this regulation was not applicable.

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: The approved centre's policy *Transfer of Care to another Approved Centre or Healthcare Facility* detailed the roles and responsibilities in relation to the resident transfer process and documented the responsibilities of the approved centre's Multi-Disciplinary Team and the resident's key worker. The planning and management of the resident transfer in a safe and timely manner, the criteria for transfer, the process for making a decision to transfer from the approved centre and the interagency involvement in the transfer process were covered in the policy. The risk assessment process implemented prior to transfer was specified in the policy, as was resident involvement in and consent to the transfer. The processes for managing the transfer of involuntary patients and for emergency transfers were outlined in the policy.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on transfer. Staff could articulate the processes for transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained in the approved centre. Analysis was completed to identify opportunities to improve the transfer process.

Evidence of Implementation: The file of one resident who had been transferred out of St. Patrick's Mental Health Services was examined. It included full communication records with the receiving facilities, including the agreement of the receiving facility to accept the resident prior to transfer. A documented discussion with the receiving facility of the reasons for transfer and the residents' care and treatment plan were contained in the clinical file. The resident did not require an escort. Resident consent to the transfer was documented, and a clinical assessment of the resident, including a risk assessment, was completed prior to the transfer. Full and complete written information was transferred, and the clinical file contained a letter of referral, the resident transfer form and a list of the residents' required medication during the transfer.

The approved centre was compliant with this regulation. As the approved centre adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent on this regulation.

	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: The approved centre had a written policy outlining the processes in place for responding to medical emergencies. This included the management, response and documentation of a medical emergency, including cardiac arrest and anaphylaxis. The staff training requirements in relation to Basic Life Support were specified, as was the management of emergency response equipment. There was a separate policy in place that detailed the processes relating to the delivery of general health care, including the procedure for ensuring resident access to a registered medical practitioner and the ongoing assessment of residents' general health needs. The resource requirements for general health services, the protection of resident privacy and dignity during general health assessments and the incorporation of general health needs assessments were all documented within the policy. The processes for facilitating residents' access to national screening programmes and promoting healthy lifestyle choices were also included.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre's policies on medical emergencies and general health. Staff could articulate the processes for the provision of general health services and medical emergencies, as set out in the policy.

Monitoring: The approved centre had a system in place to ensure that resident uptake of national screening programmes was recorded and monitored. A systematic review was undertaken to ensure that there were six-monthly reviews of general health needs. Analysis was completed to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had a resuscitation trolley, and staff had access to an Automated Emergency Defibrillator at all times. The trolleys were checked on a weekly basis. Records of a medical emergency and the care that had been implemented were available to the inspection team. Registered medical practitioners assessed residents' health needs at admission and on an ongoing basis. A dedicated general practitioner and practice nurse attended the approved centre for a half day every weekday, and residents received appropriate general health care interventions in line with their Individual Care Plans.

The six-month physical check of one resident who had been in the approved centre for over six months was recorded. There was a clear pathway for residents who required health care interventions from external services. Opportunities were available for residents to pursue a healthy lifestyle, and there was a walking route, Slí na Sláinte (path to health), around the

approved centre's grounds. Residents had access to a gym and a weight management and diabetes group. Information was provided to residents on national screening programmes, and residents had access to them as appropriate to their age and gender.

The approved centre was compliant with this regulation. As the approved centre adhered to all aspects of the *Judgement Support Framework*, it was quality assessed as excellent.

	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: The approved centre had a written policy that detailed staff roles and responsibilities in relation to the provision of information to residents. It stipulated that the service user information booklet was to be provided to each resident on admission and that this was to be supplemented by verbal information from the admitting team. The process for identifying the residents' preferred ways of receiving and conveying information was described in the policy, as were the methods for providing information to residents with specific communication needs. The interpreter services available within the approved centre and the advocacy arrangements were both included in the policy.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on the provision of information. Staff could articulate the processes for providing information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis in order to ensure that the information delivered was appropriate, accurate and up to date. An audit was completed in March 2016 to identify opportunities to improve the process of providing information to residents.

Evidence of Implementation: Residents and their representatives were given a copy of the resident information booklet, which detailed the care and services provided by the approved centre. The booklet was available in the required formats to support resident needs, and the information was clear, accurate and simply written. The booklet contained details of the housekeeping arrangements, complaints procedure, visiting times and relevant advocacy agencies and resident rights.

Residents were informed verbally and in writing about their Multi-Disciplinary Teams and their diagnoses, as appropriate. There was a large, bright information centre, the Eolas Portal, beside the reception area, where residents and their representatives could access a range of written and electronic evidence-based information, including diagnosis-specific leaflets and facts about the possible adverse effects of medication. All information was

reviewed appropriately prior to distribution, and interpretation services were available as required. Health and safety procedures were displayed around the building in formats appropriate to the communication needs of the resident cohort.

The approved centre was compliant with this regulation. As it was in full adherence with all the aspects of the *Judgement Support Framework*, it was quality assessed as excellent.

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

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: The approved centre had a written policy that outlined the processes in place for respecting resident privacy and dignity. Staff roles and responsibilities with regard to the provision of resident privacy were detailed in the policy. The methods for identifying and fulfilling residents' privacy and dignity expectations were addressed: Every resident was to be informed of their rights in respect of maintaining privacy and dignity as part of the orientation process. The approved centre's process for addressing a situation when a resident's privacy and dignity were not respected by staff was detailed in the policy. The policy did not specify the approved centre layout and furnishing requirements to support resident privacy and dignity.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on privacy. Staff could articulate the processes for ensuring resident privacy and dignity.

Monitoring: An audit was undertaken in June 2016 to check that the privacy policy was implemented correctly and that the premises and facilities in the approved centre were conducive to resident privacy. This audit provided opportunities to improve the processes relating to resident privacy and dignity.

Evidence of Implementation: During the course of the inspection, the general demeanour of staff espoused an atmosphere of respect for resident privacy and dignity. Residents were called by their preferred names and staff discretion was noted when discussing residents' conditions or treatment. Staff sought residents' permission prior to entering their single rooms. Throughout the inspection, residents were observed wearing clothes that respected their privacy and dignity. All bathrooms, showers and toilets had locks on the doors, which had an override function. Where residents shared a room, a bed screen or curtain ensured that privacy was not compromised. Rooms were not overlooked by public areas, and rooms overlooking the garden areas had opaque glazing to ensure privacy. Noticeboards did not detail resident names or other identifying information. Public phones were located in a secluded area in each ward to facilitate privacy for residents' phone calls.

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

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

3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had written policies in place that specified the roles and responsibilities for the maintenance of its premises and related processes. These policies outlined legislative compliance requirements and the approved centre's maintenance, cleaning and infection control programmes. The policy detailed the approved centre's utility controls requirements and identified hazards and ligature points in the premises.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policies on premises. Staff could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed an audit of hygiene and infection control practices. A ligature audit was presented to the inspection team. A separate audit of the premises was conducted, which identified opportunities to improve the premises.

Evidence of Implementation: The approved centre was based in an 18th century refurbished building. The premises afforded residents access to personal space, and appropriately sized communal rooms with suitable furnishings supported resident independence and comfort. There was access to lifts and therapy rooms, and all resident bedrooms were appropriately sized to accommodate resident needs.

The lighting in communal rooms was adaptable, with signage and sensory aids provided to orientate residents accordingly. There were sufficient, easily accessible and clearly signed toilets and showers for residents, with at least one assistive toilet per floor. The temperature of rooms was regulated appropriately, and rooms were ventilated.

The approved centre had ample outdoor space, and the physical environment provided opportunities for resident engagement in meaningful activities. Hazards and ligature points were minimised.

The approved centre was kept in a good state of repair and there was a programme of general maintenance, cleaning, decontamination and repair of assistive equipment. The approved centre was clean, hygienic and free of offensive odours. There was a designated cleaning, laundry and sluice room.

Current national infection control guidelines were followed, and back-up power was available if required. Faults identified in relation to the premises were communicated using the appropriate reporting process.

The approved centre was compliant with this regulation. As it adhered to every aspect of the *Judgement Support Framework*, it was quality assessed as excellent for this regulation.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	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: The approved centre had 29 policies relating to the ordering, prescribing, storing and administration of medicines. These policies detailed the following:

- The roles and responsibilities for medication management.
- The legislative requirements and professional codes of practice to be complied with during the ordering, prescribing, storing and administration of medication.
- The distinct processes for ordering, prescribing, storing and administering medicines.
- The process for administering controlled drugs.
- The process for crushing medication.
- The process for withholding medication.
- The process for medication reconciliation.
- The procedure used when medication was refused by the resident.
- The process for the management of medication errors and/or adverse effects resulting from such an error, including external reporting requirements.
- The process for reviewing resident medication.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre's policies on medication. Staff could articulate the processes for ordering, prescribing, storing and administering medicines. Staff had access to comprehensive, up-to-date information on all aspects of medication management, and they had received training on the importance of reporting medication incidents and near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were systematically undertaken to determine compliance with the approved centre's policies and procedures. Incident report forms were completed for medication errors and near misses. Analysis was documented to identify opportunities for improvement of medication management processes.

Evidence of Implementation: In order to examine the prescription and administration processes within the approved centre, 50 MPARs were examined across five wards. All MPARs contained appropriate resident identifiers, and the allergy section in each record was completed correctly. The MPARs specified the dosage, administration route and frequency of medication administration. Medical Council Registration Numbers were present in all cases. Medication was reviewed regularly, at least on a six-monthly basis. There was a clear date of initiation for each medication, but in six records, the stop date for the medicine was not specified. In two entries, the time of medication was crossed out instead of being rewritten. In 17 prescriptions examined, it was not documented whether a registered nurse administered or withheld medications.

Medications were administered according to the directions of the prescriber, and the expiration dates were checked prior to administration. Good hand hygiene and cross-infection control techniques were implemented during the dispensing of medications.

Controlled drugs were checked by two staff members, and details were entered into a controlled drugs book. Directions to crush medication were only accepted from the resident's medical practitioner, and a documented reason as to why the medication was to be crushed was included in the MPAR. Medication arriving from the pharmacy was verified by the pharmacy technicians to ensure the order was correct and was accompanied by appropriate directions for use. Issues of poor legibility were noted in two MPARs.

Medication was stored in the appropriate environment: Medication requiring refrigeration was stored in a temperature controlled fridge – the temperatures were monitored. Medication storage areas were free from damp and kept clean at all times. Medication storage areas were included in the cleaning schedules, and cleaning staff were supervised by nurses while cleaning the medication rooms. Medication was stored securely at all times, and the medication trolleys remained locked. A system of stock rotation was implemented to avoid the accumulation of old stock. An inventory of medication was conducted on a six-weekly basis and medications that were no longer required were returned to the pharmacy.

The approved centre was not compliant with this regulation in terms of prescription and administration for the following reasons:

a) The omission of stop dates for medication in six cases, which is an unsuitable prescribing practice.
b) In two entries, the time of medication administration was crossed out instead of rewritten, which is an inappropriate prescribing practice.
c) The failure to sign to indicate whether or not medications had been administered to residents in 17 cases, which is an unsuitable administration practice.

	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 policy in place that detailed its roles and responsibilities in relation to ensuring the health and safety of staff, residents and visitors. Specific roles were allocated to the registered proprietor for the achievement of health and safety legislative requirements, and safety representative roles were allocated and documented. A health and safety statement and the health and safety risk management policy were presented to the inspection team. There was a documented fire management plan and details of the first aid response requirements. There was a separate policy on infection control measures, including the provision and required use of personal protective equipment, hand washing, covering of cuts and abrasions and the management and reporting of an infection outbreak. The process for ensuring vehicle controls was described in the policy. The staff training requirements in relation to health and safety were also documented in the policy.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on health and safety. Staff could articulate the processes relating to health and safety.

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

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

The approved centre was compliant with this regulation. As it adhered to every aspect of the *Judgement Support Framework*, the approved centre was quality assessed as excellent for this regulation.

	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

CCTV was used in the approved centre for security purposes only and not for monitoring residents. Therefore, it was assessed as non-applicable.

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: The approved centre had 70 policies relating to staffing and human resources management. These policies included details of the following:

- The roles and responsibilities for recruitment, selection, vetting and appointment, including the Garda vetting requirements.
- The roles and responsibilities in relation to staffing processes and staff training.
- The organisational structure of the approved centre.
- The process for developing a staffing plan that addressed the number and skill mix of staff appropriate to the assessed resident needs.
- The process for developing and communicating the staff rota.
- Orientation and induction training, ongoing training requirements and the evaluation of training programmes.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on staffing and recruitment.

Monitoring: The implementation and effectiveness of the staff training plan was reviewed on an annual basis, and this was presented as part of the 2016 staffing plan. A significant investment had been made to ensure that all clinical staff had up-to-date training in fire safety, Basic Life Support (BLS), therapeutic management of aggression and violence (TMAV) and the Mental Health Act (2001). There was documented evidence of ongoing analysis to improve staffing processes in response to the changing needs and treatment requirements of residents.

Evidence of Implementation: An organisational chart outlining the governance and reporting structures within the approved centre was presented to the inspection team. The number and skill mix of staff were sufficient to meet resident needs, and staff were recruited and selected in accordance with the policies on recruitment, selection and appointment. All staff were vetted in accordance with the policy on Garda vetting. Staff had appropriate qualifications, skills and knowledge to do their job, and an appropriately qualified staff

member was in charge at all times. There was a written staffing plan in place for the approved centre. This included an analysis of staff skill mix, competencies and qualifications as well as the assessed needs of residents. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency, which was presented to the inspectors on request.

Orientation and induction training was completed for all staff. All health care professionals were trained in fire safety, BLS, TMAV and the Mental Health Act (2001). Staff were also trained in accordance with the assessed needs of the resident group in terms of manual handling, infection control, dementia care, resident rights, risk management, recovery-centred approaches and incident reporting. Staff were trained in the protection of children and vulnerable adults. Opportunities were made available to staff to complete further education. In-service training was provided by appropriately trained and competent individuals, and facilities and equipment were available for staff in-service education and training. The Mental Health Act (2001), the associated regulations and the Mental Health Commission Rules and Codes of Practice were available to staff throughout the centre.

The approved centre was compliant with this regulation. As it adhered to every aspect of the *Judgement Support Framework,* the approved centre was quality assessed as excellent for this regulation.

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

Ward or Unit	***Staff Grade***	***Day***	***Night***
Clara	CNM1 RPN	1 2	0 1
Ward or Unit	***Staff Grade***	***Day***	***Night***
Dean Swift Ward (Including Special Care Unit & Main Ward)	CNM1 RPN	2 7	1 5
Ward or Unit	***Staff Grade***	***Day***	***Night***
Delany	CNM1 RPN	1 4	0 2
Ward or Unit	***Staff Grade***	***Day***	***Night***
Grattan	CNM1 RPN	1 4	0 3
Ward or Unit	***Staff Grade***	***Day***	***Night***
Kilroot	CNM1 RPN	1 4	0 2
Ward or Unit	***Staff Grade***	***Day***	***Night***
Stella	CNM1 RPN	1 4	0 2

Ward or Unit	*Staff Grade*	*Day*	*Night*
Temple	CNM1 RPN	1 4	0 2
Ward or Unit	***Staff Grade***	***Day***	***Night***
Vanessa	CNM1 RPN	1 5	0 3

Although not allocated to a specific ward, the following staff provided service within the approved centre:

Consultant Psychiatrists – 19.5 WTE

Non-Consultant Hospital Doctors – 2 1 WTE

Social Workers – 12.5 WTE

Occupational Therapists – 7 WTE

Psychology – 12.2 WTE

Pharmacy – 5.8 WTE

Catering Department – 42.265 WTE

Household – 45.24 WTE

Administration – 39 WTE

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment	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: The approved centre had a suite of policies in place that outlined the processes for safely maintaining clinical records. These outlined the following:

- The roles and responsibilities for creating, accessing, retaining, and destroying records.
- Those authorised to access and make entries into resident records.
- The privacy and confidentiality of residents' records.
- The record retention periods.
- The processes for record destruction.
- The relevant legislative requirements relating to record maintenance and the implementation of the Data Protection and Freedom of Information Acts.
- The process for making retrospective entries in residents' records.
- The manner in which entries into resident records were to be made, corrected and overwritten.
- The general safety and security measures in place in relation to resident records.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policies on the maintenance of records. Staff could articulate the processes for the creation of, access to, retention of and destruction of records, as set out in the policies. All clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy and ease of retrieval. The audits included a check of the following criteria: confidentiality, security and storage of resident medical records; creation of clinical records; data retention and disposal of confidential materials; and access to and tracking of service user medical records. The audits identified opportunities to improve the maintenance of records process.

Evidence of Implementation: All resident records were secure, up to date, in good order and stored in accordance with the Data Protection Act 1988 and 2003. All resident records were stored together within each ward. A record was initiated for every resident and reflected the resident's current status. Resident records were maintained using a unique identifier, and they were developed and maintained in a logical sequence. Only authorised staff made entries in residents' records. Clinical notes and other sections in the clinical file were legible

and followed by a signature. Entries were factual, consistent and jargon-free. A log of staff signatures was maintained in the approved centre. The resident's name and date of birth was detailed on all documentation and transcribed correctly.

An entry in one record was written in blue ink. In two cases, an error was crossed out but not dated or signed. Two Medication Prescription and Administration Records contained prescriptions that were difficult to read.

The approved centre was compliant with this regulation. It was quality assessed as satisfactory not excellent because it did not adhere to all the criteria of the *Judgement Support Framework* under evidence of implementation.

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

3.28 Regulation 28: Register of Residents

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

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

Inspection Findings

The approved centre maintained a register of residents. It contained all the information specified in Schedule 1. Only relevant staff had access to the register, which was maintained in electronic format. The register was made available to the inspection team on request, and it was updated on a daily basis to reflect the resident admission and discharge process.

	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: The approved centre had a suite of written policies and protocols in place with regard to the development of operating policies and procedures. These policies included the roles and responsibilities around the development, management and review of policies. Policies were to incorporate relevant legislation and include evidence-based best practice. The approvals process for operating policies and the process for disseminating policies were documented. The process for reviewing and updating polices was included in the written protocols, and a policy entitled *Communication of New Policy or Policy Change* outlined the process for training on operating policies. The standardised operating policy and procedure layout used by the approved centre was described, and the process for collaboration between clinical and managerial teams was documented in terms of policy development.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policies on operating policies and procedures. Staff were able to articulate the process for developing and reviewing operating policies.

Monitoring: An annual audit was undertaken to determine compliance with policy review time frames. Ongoing analysis was completed to identify opportunities to improve the process of developing and reviewing policies. The Policy Committee and the Judgement Support Framework Committee met to discuss issues pertaining to policy development and implementation of the *Judgement Support Framework.*

Evidence of Implementation: The approved centre's operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. The policies incorporated relevant legislation, evidence-based practice and clinical guidelines. The Policy Committee developed service policies that were subsequently approved by senior management, and policies were communicated to staff at senior management meetings who then disseminated the information to all staff. Policies were also communicated to staff by e-mail and online. There was an up-to-date policy in place for every regulation that required one. Obsolete versions of operating policies were removed from the online repository. The format of each policy was standardised with a policy title, reference number, policy approvers and scheduled review date documented on each.

The approved centre was compliant with this regulation. It was quality assessed as excellent as it adhered to all aspects of the *Judgement Support Framework*.

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

3.30 Regulation 30: Mental Health Tribunals

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

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

Inspection Findings

Processes: The approved centre had a documented policy outlining the roles and responsibilities of staff in relation to the provision of Mental Health Tribunals. It incorporated the relevant legislative requirements in relation to the tribunals and the approved centre's processes around the tribunals. It identified the provision of information to residents pertaining to the Mental Health Act (2001) and detailed the communication processes among the approved centre, the patient, the Mental Health Commission and the approved centre's clinical governance office, which included the Mental Health Act administrator. It outlined the resources and facilities provided by the approved centre to support patients attending Mental Health Tribunals and the availability of staff to attend the tribunal as necessary.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on Mental Health Tribunals. Staff could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: The implementation of the policy and procedures in relation to facilitating Mental Health Tribunals was monitored by the Mental Health Act administrator to ensure that the rights and needs of the patient were appropriately supported. An audit had been completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: The approved centre provided facilities to support the Mental Health Tribunal processes, including a tribunal room with a dedicated waiting area and appropriate access to toilet facilities for patients and tribunal members. Staff were available to attend Mental Health Tribunals should residents require or request assistance.

The approved centre was compliant with this regulation. It was quality assessed as excellent as it adhered to all criteria 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: The approved centre had a written policy describing the approved centre's processes around making and managing complaints. The policy included details of the following:

- The roles and responsibilities of in the complaints process.
- The identity of the nominated complaints officer.
- The communication of the complaints policy to residents.
- The methods available to make complaints.
- The confidentiality requirements in relation to the complaints management process.
- The process around escalating complaints and the complaints appeals process.

Clear time frames for the handling of complaints were set out, and the staff role in documenting complaints were outlined.

Training and Education: Relevant staff were trained in the complaints management process. There was a computer-based system in place indicating that staff had read the approved centre's policy on complaints. Staff could articulate the process for making, handling and investigating complaints, as set out in the policy.

Monitoring: The approved centre had completed an audit of the complaints procedure and the complaints log. The outcomes of this audit had been acted upon in order to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated complaints officer responsible for dealing with all complaints within the approved centre. A consistent and standardised approach was implemented for the management of all complaints. Residents, their families and their representatives were informed that they could make a complaint in verbal or written form, over the telephone or by completing and submitting a comment and suggestion form.

The approved centre's management of the complaints process was well publicised and accessible to residents and their representatives. Advocates were provided by the approved centre to facilitate resident participation in the process. All complaints were recorded appropriately, investigated promptly and handled in a sensitive manner. Where minor complaints could not be addressed locally, they were escalated to the complaints officer. Acknowledgement of a complaint was made in writing within five days of its receipt, and the outcome of the investigation was communicated to the complainant within 30 days. If this time frame could not be met, the complainant was informed of the reason for the delay. The complainant's satisfaction or dissatisfaction with the investigation findings were documented, and all information obtained during complaints and associated investigation was treated in a confidential manner.

The approved centre was compliant with this regulation. It was quality assessed as excellent as it adhered to all criteria 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: The approved centre had a suite of written policies that covered all aspects of risk management. These identified the roles and responsibilities in relation to risk management, including the individuals responsible for risk management and for the completion of six-monthly incident summary reports. The policies detailed the approved centre's defined quality and safety oversight, which included organisational risks, potential health and safety risks and the risks identified to the resident group during the provision of general care and services. The methods for controlling for the following specific risks were documented:

- Resident absence without leave.
- Suicide and self-harm.
- Assault.
- Accidental injury to residents or staff.

The policies documented processes for the following:

- Maintaining and reviewing the risk register.
- Managing incidents involving residents in the approved centre.
- Roles and responsibilities regarding incident reporting.
- Rating risk incidents.
- Investigating, documenting and reviewing incidents.
- Notifying the Mental Health Commission about incidents involving residents.

Training and Education: Staff had completed training on the identification, assessment and management of risk; health and safety risk management; and individual risk management. All staff were trained in incident reporting and documentation. There was a computer-based system in place indicating that staff had read the approved centre's policies on risk management. Staff could articulate the risk management processes, as set out in the policy.

Monitoring: The risk register was audited on a quarterly basis to ensure compliance with the approved centre's risk management policy. All incidents were recorded and risk rated. The clinical governance department reviewed incidents and analysed trends that emerged from the data.

Evidence of Implementation: Responsibilities for risk management were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified. Risk management procedures actively reduced identified risks to the lowest level. Clinical risks were identified, assessed, treated, reported and monitored by the approved centre. Individual risk assessments were completed as required, and Multi-Disciplinary Teams (MDTs) were involved in the development, implementation and review of individual risk management. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented throughout.

Incidents were recorded in a standardised format, and all clinical incidents were reviewed by the MDT at their weekly meeting. Access to the incident reporting system was available throughout the service. The clinical governance department reviewed incidents for trends or patterns, and 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 Incidents. There was an emergency plan in place in the approved centre that specified staff responses to possible emergencies, and it included evacuation procedures.

The approved centre was compliant with this regulation. It was quality assessed as excellent as it adhered to all aspects of the *Judgement Support Framework*.

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

3.33 Regulation 33: Insurance

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

Inspection Findings

The approved centre was insured in respect to property, employer liability, public liability and clinical indemnity. A certificate confirming this was available to the inspection team.

	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

The certificate of registration was displayed in the approved centre. It included the name of the approved centre, the registered proprietor and the date of registration.

	Compliant	Non-Compliant
Compliance with Regulation	X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The Use of Electro-Convulsive Therapy

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

Inspection Findings

Processes: The approved centre had a comprehensive policy covering all elements of the process for using Electro-Convulsive Therapy (ECT). Roles and responsibilities throughout the process were clearly defined. Evidence-based processes were included for managing emergencies such as cardiac arrest, anaphylaxis or malignant hypothermia during treatment. The process for assessing capacity and gaining resident consent for the procedure was explicitly outlined within the policy, as was the process for providing ECT treatment to a patient who was unable to provide consent. The policy was reviewed annually.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on ECT. All staff involved in the ECT process were trained in ECT. Staff were also trained in Advanced Cardiovascular Life Support (ACLS).

Monitoring: The approved centre was inspected by the Electroconvulsive Accreditation Service (ECTAS) in February 2016 and accredited as excellent. The approved centre also completed internal audits on the use of ECT.

Evidence of Implementation: The ECT suite in the approved centre had been recently refurbished. There was a waiting room with eight chairs, a large monitor playing relaxing scenes and a water cooler. From this room, a door led into a spacious interview room where the patient met with the prescribing consultant and ECT nurse to have capacity reassessed and give consent to treatment. All necessary medical checks were completed prior to ECT treatment. Residents were talked through the process of ECT and given information before each programme was administered.

The ECT treatment room was off the interview room and resourced with all of the necessary equipment to safely carry out the procedure. Equipment was serviced and a record of maintenance was maintained.

There was an eight-bed recovery room off the main treatment room. Staff explained they did not have more than five residents in recovery at any one time. There were two nurses allocated to the recovery room where residents were monitored until fully recovered. An Electroconvulsive Therapy Treatment Pack was commenced at the beginning of a programme of ECT and maintained in each resident's file. Three files were inspected, and all aspects of the ECT rule were adhered to throughout each administration of ECT. The ECT process, including reviews and outcomes of treatment, were clearly documented for each patient.

As the approved centre adhered to all aspects of this rule, it was assessed as compliant.

	Compliant	Non-Compliant
Compliance with Rule	X	

4.2 Section 69: The Use of Seclusion

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

Inspection Findings

As the approved centre did not use seclusion, this rule was non-applicable.

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

As the approved centre did not use mechanical restraint, this rule was non-applicable.

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

The files of two patients who had been resident in the approved centre for more than three months were examined. In one case, the patient had capacity to consent; in the other case, the patient did not have capacity to consent.

The file of the patient who consented to medication contained an assessment of capacity record. The clinical file contained a written record of patient consent to medication, which

listed the specific medication for which the resident had provided consent. The record included the nature and purpose of the proposed treatment and its likely adverse effects. The documented clinical notes also included a written record of the consequences of not accepting the medications as well as the treatment alternatives available. It was documented that this information was explained to the resident.

The file of the patient who did not have capacity to consent to medication indicated that an assessment of capacity had been performed and documented. A Form 17 (Administration of Medication for More than Three Months Involuntary Patient [Adult] – Unable to Consent) had been completed within the required time frame and a copy of it was kept in the patient's clinical file. Provision of information to the resident about the nature and purpose of proposed treatment was documented. The likely benefit of the treatment was documented, as were the likely adverse effects of the medications. There was a written record contained in the clinical file indicating that the treatment was in the patient's best interests.

The approved centre was compliant with Part 4 of the Mental Health Act (2001).

	Compliant	Non-Compliant
Compliance with Part 4	X	

6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: The approved centre had a written policy on physical restraint, which was reviewed annually. The policy detailed the process in relation to the provision of information to residents, explaining the reason for using physical restraint. The policy indicated which staff members were authorised to initiate and perform physical restraint. The child protection process, used in the event of the restraint of a child, was included in the policy, as were the training requirements.

Training and Education: There was a written policy in place indicating which staff were to receive training in physical restraint, the areas to be addressed during training, the frequency of training and the mandatory nature of the training. The policy identified the appropriately qualified persons to provide the training and stipulated that a record of attendance should be maintained. The policy stated that physical restraint should never be used to ameliorate staff shortages. There was a computer-based system in place indicating that staff had read the approved centre policy on physical restraint.

Monitoring: The approved centre had completed an annual report on the use of physical restraint.

Evidence of Implementation: The files of four residents who had been physically restrained were inspected. In all cases, the physical restraint took place in rare and exceptional circumstances, with staff considering other interventions to manage resident behaviour prior to employing physical restraint. In no case was the restraint prolonged beyond the period

strictly necessary to prevent serious harm. The use of physical restraint was based on risk assessment in all four cases. Cultural awareness and gender sensitivity was displayed during the use of physical restraint, and this was documented accordingly.

Examination of the four files illustrated that physical restraint was initiated by members of the Multi-Disciplinary Team (MDT) and that a staff member was always designated as the lead. The consultant psychiatrist was notified about the physical restraint, and in all cases, it was documented that a registered medical practitioner conducted a medical examination of the resident who had been restrained within the designated three-hour time frame. The order for physical restraint lasted no longer than the maximum duration of three hours in all cases.

Each episode of physical restraint inspected was recorded in the residents' clinical file and a clinical practice form was completed, as required. There was documentary evidence that the resident was informed of the reasons for, the likely duration of and the circumstances that would lead to the discontinuation of the physical restraint. Residents' next of kin were informed about the physical restraint, as appropriate, and each episode of physical restraint was reviewed by members of the MDT within two working days. This also facilitated the opportunity for residents to discuss the episode of physical restraint with their MDT. In all cases, same-sex staff members were present at the physical restraint and staff displayed awareness of relevant considerations in the Individual Care Plan pertaining to specific requirements. No holds that deliberately inflicted pain were used, and the prone position was not used. A completed clinical practice form was placed in each residents' clinical file as required.

The approved centre was compliant with all aspects of the Code of Practice on the Use of Physical Restraint.

	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

As the approved centre did not admit children, 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 approved centre had a suite of risk management policies in place that documented the process for the notification of deaths and incident reporting to the Mental Health Commission (MHC). These policies identified the risk manager and clearly stated the roles and responsibilities of staff in relation to reporting deaths and incidents. The policies detailed roles and responsibilities in relation to completing death notification forms and submitting these forms to the MHC. The policies included the process for completing six-monthly incident summary report forms.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre's policies on the notification of deaths and incidents. Staff were able to articulate the policies in place.

Monitoring: Deaths and incidents were reviewed to identify and correct any inaccuracies in the forms as they arose and to improve the quality of service provided.

Evidence of Implementation: The approved centre was compliant with Regulation 32: Risk Management. There was an incident reporting system in place and a standardised incident report form was used. A six-monthly summary of all incidents was provided to the MHC and access to the incident reporting system was available throughout the approved centre. All deaths were notified to the MHC within the required time frame.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

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

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

Inspection Findings

As the approved centre did not admit people with an intellectual disability, this Code of Practice was not applicable.

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

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

Inspection Findings

Processes: The approved centre had a comprehensive policy covering all elements of the process for using Electro-Convulsive Therapy (ECT). Roles and responsibilities throughout the process were clearly defined within the policy. Evidenced-based processes were included for managing emergencies such as cardiac arrest, anaphylaxis or malignant hypothermia during treatment. The process for assessing capacity and gaining resident consent for the procedure was explicitly specified within the policy. The process for giving treatment to residents without capacity was clearly defined. The policy was reviewed annually.

Training and Education: There was a computer-based system in place indicating that staff had read the approved centre policy on admission, transfer and discharge. All staff involved in the ECT process were trained in ECT. Staff were also trained in Advanced Cardiovascular Life Support (ACLS).

Monitoring: The approved centre was inspected by the Electroconvulsive Accreditation Service (ECTAS) in February 2016 and accredited as excellent. The approved centre also completed internal audits on the use of ECT.

Evidence of Implementation: The ECT suite in the approved centre had been recently refurbished. There was a waiting room with eight chairs, a large monitor that played relaxing scenes and a water cooler. From this room, a door led into a spacious interview room where the patient met with the prescribing consultant and the ECT nurse to have capacity reassessed and give consent to treatment. All necessary medical checks were completed prior to ECT treatment. Residents were talked through the process of ECT and given information prior to the administration of each programme. The ECT treatment room was off the interview room and resourced with all of the necessary equipment to safely perform the procedure. Equipment was serviced and a record of maintenance was maintained.

There was an eight-bed recovery room off the main treatment room. Staff explained they did not have more than five residents in recovery at any one time. There were two nurses allocated to the recovery room where residents were monitored until fully recovered. An Electroconvulsive Therapy Treatment Pack was initiated at the beginning of a programme of ECT and maintained in residents' files. Three files were inspected, and all aspects of the ECT Code of Practice were adhered to throughout each administration of ECT. The ECT process for each resident, including reviews and outcomes of treatment, were clearly documented.

	Compliant	Non-Compliant
Compliance with Code of Practice	X	

6.6 Admission, Transfer and Discharge

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

Inspection Findings

Processes:
Admission: The approved centre had an admission process in place that specified the procedure for involuntary admission and the protocol for planned admissions, with reference to pre-admission assessment, including the roles and responsibilities of the Multi-Disciplinary Team (MDT) in relation assessment. The protocols for individuals who self-present and for urgent referrals were documented in the policy.

Transfer: There was a policy in place detailing the processes for transferring residents. This policy included details of how the transfer was to be arranged, the provisions for an emergency transfer and the safety of residents and staff during the transfer process. The policy did not outline the process in place in the case of resident transfer abroad.

Discharge: There was a discharge policy in place that documented the process for discharging involuntary patients. The policy included reference to prescriptions and the required supply of medications to a resident on discharge. A follow-up policy was in place, which included details of relapse prevention strategies, roles and responsibilities in providing follow-up care and the timing and amount of follow-up care that residents should have. The policy did not include crisis management plans for residents. The policy included the procedure for discharge against medical advice.

Training and Education: There was a computer-based system in place indicating that all staff had read and understood approved centre's policies on admission, transfer and discharge.

Monitoring: Data was collected from a patient-experience survey, which evaluated residents' experience of the admission and discharge processes.

Evidence of Implementation: The approved centre was compliant with Regulation 7: Clothing, Regulation 8: Residents' Personal Property and Possessions, Regulation 20: Provision of Information to Residents and Regulation 27: Maintenance of Records. The approved centre was non-compliant with Regulation 15: Individual Care Plan.

Admission: The approved centre had a key worker system in place, and the entire MDT record was held in one clinical file. Admission to the approved centre was because of mental illness or disorder, and the decision to admit residents was made by the registered medical practitioner. Admission assessments were completed, and these included the history of the presenting problem and family, medical and social history. Every resident was assigned a key worker. There was evidence of family involvement in the admission process.

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The file of one resident who had been transferred was examined. This indicated that the resident was transferred for specialised treatment in another facility. The decision to transfer the resident was made by a registered medical practitioner, and a risk assessment was

performed prior to the transfer. An effort was made to obtain the resident's consent prior to the transfer and family involvement in the transfer process was appropriate. A copy of the referral form was kept in the resident's file.

Discharge: The files of three residents who had been discharged were examined. In each case, the decision to discharge the resident was taken by a registered medical practitioner and a discharge plan was in place as part of the Individual Care Plan. The discharge plans contained the estimated date of discharge and documented communication with primary care teams, follow-up plans and potential risks to the resident. A discharge meeting took place in advance of the discharge. Comprehensive assessments were completed prior to discharge, and these included an assessment of psychiatric and psychological needs, a mental state examination, an assessment of housing needs and a comprehensive risk management plan. Appropriate MDT input was allocated to discharge planning, which was coordinated by a key worker. Discharge summaries were sent to primary care teams within the specified time frames. These summaries included diagnosis, prognosis, medication, outstanding health or social issues and follow-up arrangements. Family involvement in the discharge process was documented, and a timely follow-up appointment was scheduled.

The approved centre was non-compliant with this Code of Practice for the following reasons:

(a) The approved centre was non-compliant with Regulation 15: Individual Care Plan as required by the Code of Practice 17.1.
(b) The transfer policy did not outline the process for transferring residents abroad as required by the Code of Practice 4.13.
(c) The discharge policy did not refer to crisis management plans, as required by the Code of Practice, 4.14.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
X			

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

Completed by approved centre: St Patrick's University Hospital **Date submitted: 21/2/2017**

<<*To be included in the final report*:>> For each finding of non-compliance the registered proprietor was requested to provide a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.
The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.
<<*Instruction to registered proprietor (or nominees); to be removed from the final report*: Please provide a corrective action and a preventative action (CAPA) plan for each area of non-compliance, listed below. The areas of non-compliance have been taken directly from the Inspector's findings in the draft inspection report. The corrective action must address the specific area of non-compliance and the preventative action must mitigate the risk of non-compliance reoccurring. CAPA plans must be **Specific**, **Measureable**, **Achievable**, **Realistic** and **Time-bound** (SMART).
Please note, the CAPAs will be published as submitted, including spelling, grammar, font, formatting etc>>

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)*
1. Searches were not undertaken with due regard to the resident's gender as required by the Regulation, part 7.	Corrective action(s): This issue was reviewed at the time of inspection in November 2016. Post-holder(s): Ms Evelyn McCarthy, Director of Nursing	The implementation of the corrective action was supervised by the post holder.	This was a feasible corrective action with no barriers encountered.	November 2016
	Preventative action(s): 1) The relevant clinical staff will continue to be orientated to the Search Policy in regard to the requirement for one member of staff to be the same gender as the service user while conducting a search. 2) An audit of searches will continue to be conducted to identify opportunities for improvement. Each search record will continue to be reviewed to ensure compliance. Post-holder(s): Ms Evelyn McCarthy, Director of Nursing	The implementation of the preventative actions will be supervised by the post holders and will utilize clinical audit.	This is a feasible preventative action with no barriers anticipated.	Orientation to Search Policy Q1 2017 Audit of search process Q1 2017

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)*
2. Five individual care plans did not contain a documented set of goals.	Corrective action(s): All of the clinical records were checked for completeness and appropriately updated Post-holder(s): Prof Jim Lucey, Clinical Director, Mr Tom Maher, Director of Services Ms Evelyn McCarthy, Director of Nursing	The checking and updating of clinical records was conducted by the multi-disciplinary teams under the supervision of the post holders.	This was a feasible corrective action with no barriers encountered.	November 2016
	Preventative action(s): 1) The SPUH clinical staff will continue to be orientated to the Multi-disciplinary Care Planning and Key-Working Policy in regard to the requirement to have a documented set of goals. 2) An audit of care planning will continue to be conducted quarterly to include measurement of compliance. 3) In the longer term the introduction of an Electronic Healthcare Record will	The implementation of the preventative actions will be supervised by the post holders and will utilize clinical audit.	This is a feasible preventative action with no barriers anticipated.	Orientation to policy Q1 2017. Clinical audit of care planning quarterly. The introduction of the Electronic Healthcare Record is scheduled for Q 4 2017.

	include functionality that clearly documents goals. Post-holder(s): Prof Jim Lucey, Clinical Director, Mr Tom Maher, Director of Services Ms Evelyn McCarthy, Director of Nursing			
3. Six individual care plans failed to specify the necessary resources to achieve the identified goals.	Corrective action(s): All of the clinical records were checked for completeness and appropriately updated. Post-holder(s): Prof Jim Lucey, Clinical Director, Mr Tom Maher, Director of Services Ms Evelyn McCarthy, Director of Nursing	The checking and updating of clinical records was conducted by the multi-disciplinary teams under the supervision of the post holders.	This was a feasible corrective action with no barriers encountered.	November 2016
	Preventative action(s): 1) The SPUH clinical staff will continue to be orientated to the Multi-disciplinary Care Planning and Key-Working Policy in regard to the requirement to specify the necessary resources to achieve identified goals. 2) An audit of care planning will continue to be conducted quarterly to include measurement of compliance. 3) In the longer term the introduction of an Electronic	The implementation of the preventative actions will be supervised by the post holders and will utilize clinical audit.	This is a feasible preventative action with no barriers anticipated.	Orientation to policy Q1 2017. Clinical audit of care planning quarterly. The introduction of the Electronic Healthcare Record is scheduled for Q 4 2017.

	Healthcare Record will include functionality that clearly specifies necessary resources. Post-holder(s): Prof Jim Lucey, Clinical Director, Mr Tom Maher, Director of Services Ms Evelyn McCarthy, Director of Nursing			

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)*
4. The omission of stop dates for medication in six cases; an unsuitable prescribing practice.	Corrective action(s): All of the clinical records were checked for completeness and appropriately updated. Post-holder(s): Prof Jim Lucey, Medical Director	The checking and updating of clinical records was conducted by the multi-disciplinary teams under the supervision of the post holders.	This was a feasible corrective action with no barriers encountered.	November 2016
	Preventative action(s): Medical Staff will continue to be orientated to the requirement to insert stop dates on completion of a prescription. Post-holder(s): Prof Jim Lucey, Medical Director	The post holder will ensure that the orientation of medical staff will be completed.	This is a feasible corrective action with no barriers anticipated.	Q 1 2017
5. In two entries, the time of medication administration was crossed out instead of re-written, an inappropriate prescribing practice.	Corrective action(s): All of the clinical records were checked for completeness and appropriately updated. Post-holder(s): Ms Evelyn McCarthy, Director of Nursing	The checking and updating of clinical records was conducted by the multi-disciplinary teams.	This was a feasible corrective action with no barriers encountered.	November 2016

	Preventative action(s): Nursing staff will be orientated to the requirement to rewrite prescriptions where the time of administration is changed. Post-holder(s): Ms Evelyn McCarthy, Director of Nursing	The post holder will ensure that the orientation of nursing staff will be completed.	This is a feasible corrective action with no barriers anticipated.	Q 1 2017
6. The failure to sign to indicate whether or not medications had been administered to the resident in 17 cases; an unsuitable administration practice.	Corrective action(s): All of the clinical records were checked for completeness and appropriately updated. Post-holder(s): Ms Evelyn McCarthy, Director of Nursing	The checking and updating of clinical records was conducted by the multi-disciplinary teams.	This was a feasible corrective action with no barriers encountered.	November 2016
	Preventative action(s): Nursing staff administering medication will continue to be orientated to the requirement to indicate whether or not a medication has been administered Post-holder(s): Ms Evelyn McCarthy, Director of Nursing	The post holder will ensure that the orientation of nursing staff will be completed.	This is a feasible corrective action with no barriers anticipated	Q 1 2017

Code of Practice: Admission, Transfer and Discharge (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)*
7. The Transfer policy did not outline the process for transferring residents abroad.	Corrective action(s): The Transfer Policy was updated to outline the process for transferring residents abroad Post-holder(s): Prof Jim Lucey, Clinical Director, Mr Tom Maher, Director of Services Ms Evelyn McCarthy, Director of Nursing	The post holders monitored the updating of the policy to ensure it was completed.	This was a feasible corrective action with no barriers encountered	February 2017
	Preventative action(s): As per the corrective action above Post-holder(s): As above			
8. The Discharge policy did not refer to crisis management plans	Corrective action(s): The Discharge Policy refers to crisis management plans and the process for managing missed appointments.	The post holders monitored the updating of the policy to ensure it was completed.	This was a feasible corrective action with no barriers encountered.	February 2017

as required by the Code of Practice section 4.14.	This policy has been reviewed as necessary. Post-holder(s): Prof Jim Lucey, Clinical Director, Mr Tom Maher, Director of Services Ms Evelyn McCarthy, Director of Nursing			
	Preventative action(s): As per the corrective action above Post-holder(s): As above			