# St. Patrick's University Hospital

**ID Number:** AC0005

## 2017 Approved Centre Inspection Report (Mental Health Act 2001)

St. Patrick's University Hospital
James's St
Dublin 8.

**Approved Centre Type:**
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

**Most Recent Registration Date:**
1 March 2017

**Conditions Attached:**
None

**Registered Proprietor:**
Mr Paul Gilligan, CEO

**Registered Proprietor Nominee:**
N/A

**Inspection Team:**
Dr Enda Dooley MCRN004155, Lead Inspector
Orla O'Neill
Barbara Morrissey
Sandra McGrath
Noeleen Byrne
Siobhán Dinan

**Inspection Date:**
9 – 12 May 2017

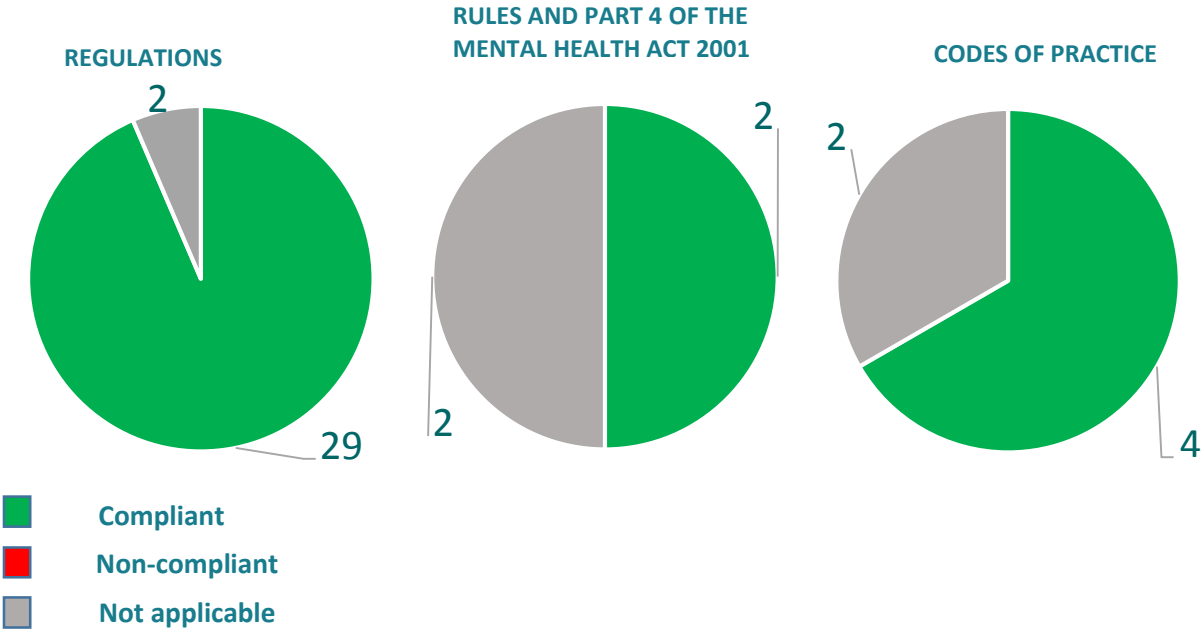
**Inspection Type:**
Unannounced Annual Inspection

**Previous Inspection Date:**
8 – 11 November 2016

**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Date of Publication:**
24 August 2017

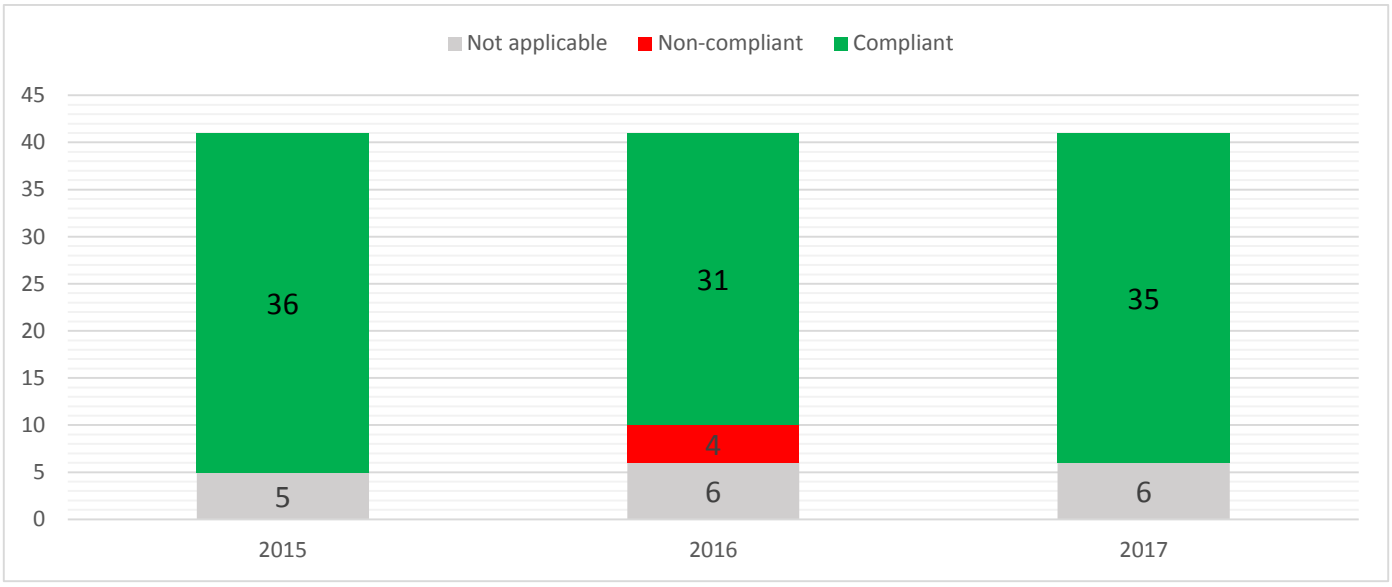
## COMPLIANCE RATINGS 2017



# RATINGS SUMMARY 2015 – 2017

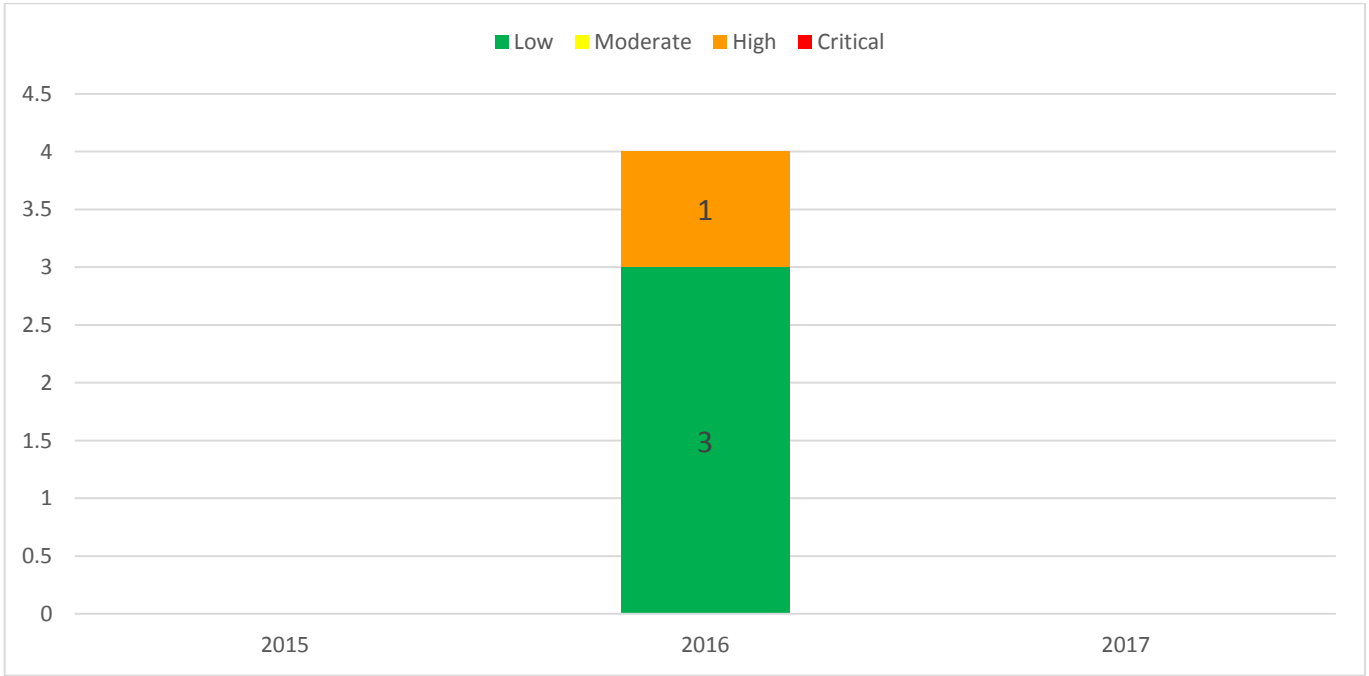
Compliance ratings across all 41 areas of inspection are summarised in the chart below.

## Chart 1 – Comparison of overall compliance ratings 2015 – 2017




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

## Chart 2 – Comparison of overall risk ratings 2015 – 2017




**The approved centre had no areas of non-compliance in 2015 and 2017 and, therefore, no associated risk ratings for those years.**

# Contents

# 1.0 Introduction to the Inspection Process

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

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

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

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

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

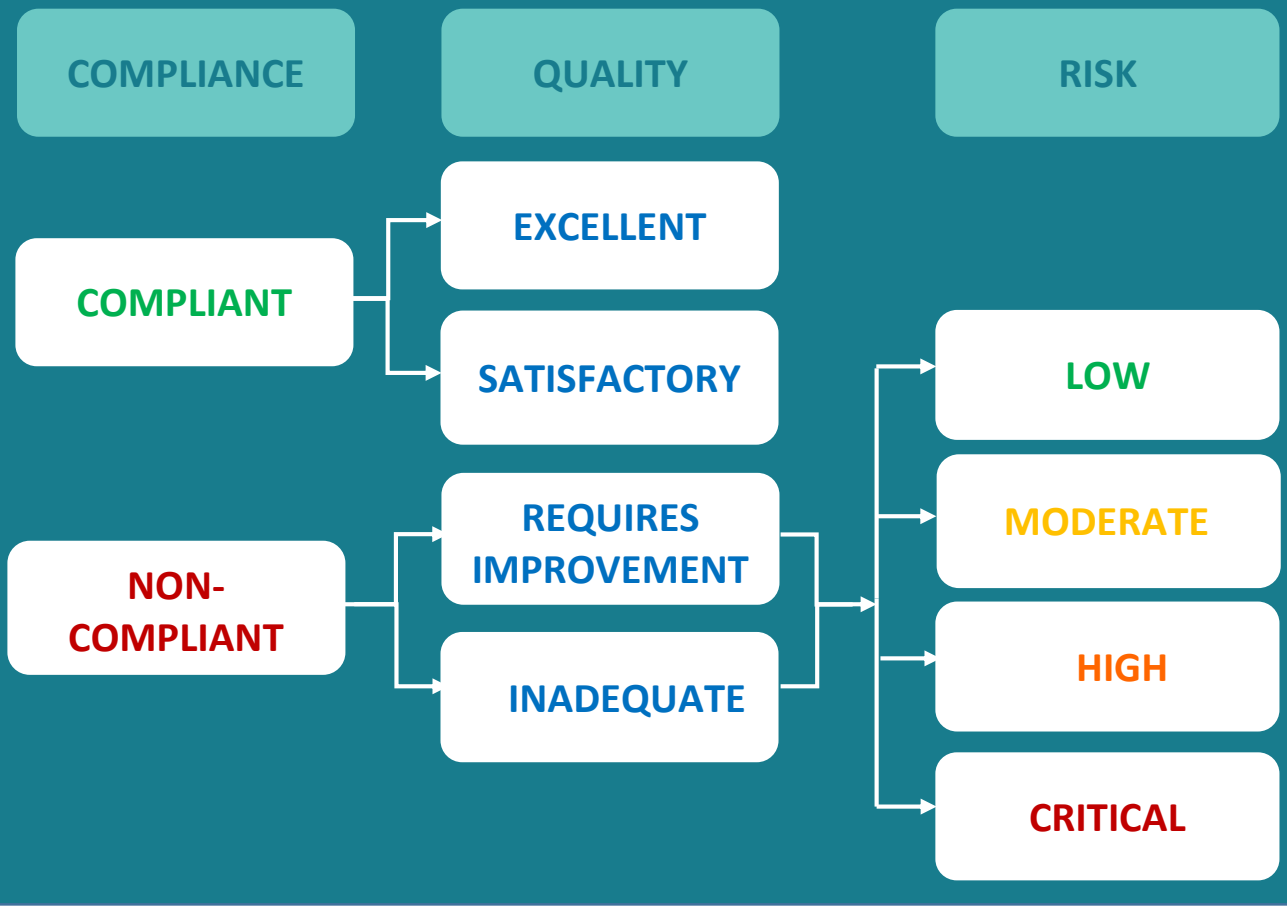
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

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

## COMPLIANCE, QUALITY AND RISK RATINGS

**The following ratings are assigned to areas inspected. COMPLIANCE RATINGS are given for all areas inspected. QUALITY RATINGS are given for all regulations, except for 28, 33 and 34. RISK RATINGS are given for any area that is deemed non-compliant.**




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

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, 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 Inspector of Mental Health Services – Summary of Findings

## Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of inspection findings under the headings below.

This summary is based on the findings of the inspection team under the regulations and associated *Judgement Support Framework*, rules, Part 4 of the Mental Health Act 2001, codes of practice, service user experience, staff interviews and governance structures and operations, all of which are contained in this report.

## Safety in the approved centre

The approved centre had a written policy in relation to health and safety and also had a Corporate Safety Statement. There were risk management policies and procedures in place. There was excellent food safety and the approved centre had been awarded a Food Safety Assurance award in relation to its food safety and hygiene procedures. Two appropriate resident identifiers were used before the administration of medication, the initiation of medical investigations, and the provision of other health care services. Medication ordering, prescribing, storage, and administration was satisfactory. The administration of ECT was compliant with the relevant Rule and Code of Practice. Physical restraint was carried out in accordance with the relevant Code of Practice.

**AREAS REFERRED TO**
**Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.**

## Appropriate care and treatment of residents

Residents expressed satisfaction with their treatment and accommodation within the approved centre and with the range of therapeutic options available. Some residents expressed the view that they did not have sufficient contact with their designated key worker. Where residents were identified as having special nutritional requirements, their needs were reviewed by the dietician. Residents had a multidisciplinary individual care plan. The range of available, evidence-based therapeutic programmes was appropriate to the assessed needs of the resident population, as outlined in individual care plans. A psychological group programme (SAGE) for older adults experiencing mental health problems had been developed and introduced. An excellent transfer process was in place for residents transferring to another facility. A primary care general practitioner service was available on-site, and a medical consultant visited weekly. Residents received appropriate general health care in line with their individual care plans, and their general health needs were monitored and assessed not less than every six months. Residents' records were observed to be securely stored, up to date, and in good order. The administration of ECT was compliant with the relevant Rule and Code of Practice. The approved centre was compliant with Part 4 of The Mental Health Act (2001): Consent to Treatment. Admission and discharge of residents was in line with the relevant Code of Practice.

**AREAS REFERRED TO**
**Regulations 5, 14, 15, 16, 17, 18, 19, 23, 25, 27, Part 4 of the Mental Health Act 2001, Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint, Rule Governing the Use of ECT, Code of Practice on Physical Restraint, Code of Practice on the Admission of Children, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, Code of Practice on Admission, Transfer and Discharge, service user experience, and interviews with staff.**

## Respect for residents' privacy and dignity

Residents were supported to keep and wear their personal clothing, and each resident had an individual wardrobe and locker. Residents' clothing was observed to be clean and appropriate to their needs. Provision was made for residents to secure personal property and possessions. Where the approved centre assumed responsibility for residents' property, personal effects were stored securely. Searches, which were documented in the clinical files, were attended by at least two clinical staff and were implemented with due regard to the residents' dignity, privacy, and gender. The approved centre's layout and furnishings were conducive to resident privacy and dignity and staff were observed to treat residents with respect.

**AREAS REFERRED TO**
**Regulations 7, 8, 13, 14, 21, 25, Rule Governing the Use of Seclusion, Code of Practice on Physical Restraint, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.**

## Responsiveness to residents' needs

Residents were provided with a range of wholesome and nutritious food choices. Food, including modified diets, was properly prepared and presented in an attractive and appealing manner. Residents had access to an extensive range of appropriate recreational activities and had access to a multi-faith oratory and to multi-faith chaplains. Residents said that staff were supportive and engaged with them. Visiting times were appropriate and reasonable and there were a number of rooms throughout the approved centre that were suitable for visits, including a family room, which had facilities suitable for visiting children. Residents had access to mail, fax, telephone, and e-mail. While residents in the special care units did not have access to their own phones, they were facilitated in using a cordless phone. Information was provided to residents and/or their representatives at admission in the form of a service user information booklet. The hospital information centre, which was accessible to all residents, contained comprehensive medical information, including details of medication risks and potential side-effects of medication. The approved centre was in a good state of repair, inside and out, and was clean and hygienic. There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. Complaints procedures were clearly displayed.

**AREAS REFERRED TO**
**Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.**

## Governance of the approved centre

St. Patrick's Hospital was part of St. Patricks Mental Health Services and came under the overall management of a board of governors established by charter. The direct operation of the hospital came within the competence of a senior management team. A detailed clinical and corporate governance structure was in place. There was an active process involving senior management and, as appropriate, members of various disciplines within the approved centre. The governance process addressed both clinical and operational issues relating to the effective functioning of the centre. Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders. All operating policies and procedures required by the regulations were reviewed within the required three-year time frame. Risks were addressed or escalated as required. There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre. An appropriately qualified staff member was on duty and in charge at all times in the approved centre, as indicated by staff rotas.

**AREAS REFERRED TO**
**Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.**

# 3.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

1. A new clozapine booklet had been introduced to inform residents of the nature of the medication and the oversight processes required.
2. A psychological group programme (SAGE) for older adults experiencing mental health problems had been developed and introduced.
3. The approved centre had been awarded a Food Safety Assurance award in relation to its food safety and hygiene procedures.

# 4.0 Overview of the Approved Centre

## 4.1 Description of approved centre

The approved centre was an independent hospital and part of the St. Patrick's Mental Health Service. It was located in central Dublin. The original hospital structure was an 18th century listed building. A variety of extensions had been developed over the years. The centre was registered for up to 241 residents. It was well maintained and decorated. Residents had access to a variety of recreational and garden facilities within the hospital grounds.

The approved centre comprised eight wards: Dean Swift, including Special Care Unit (acute admissions); Stella, Grattan, Delaney, and Kilroot (general admissions); Vanessa (care of the elderly); Clara (eating disorders); and Temple (addictions service). A wide range of therapeutic services was offered and residents had access to newly developed primary care services within the approved centre. Children were not admitted.

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

| Resident Profile | |
|---|---|
| ***Number of registered beds*** | ***241*** |
| **Total number of residents** | **218** |
| Number of detained patients | 4 |
| Number of Wards of Court | 0 |
| Number of children | 0 |
| Number of residents in the approved centre for more than 6 months | 2 |

## 4.2 Conditions to registration

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

## 4.3 Reporting on the National Clinical Guidelines

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

## 4.4 Governance

St. Patrick's Hospital was part of St. Patricks Mental Health Services and came under the overall management of a board of governors established by charter. The direct operation of the hospital came within the competence of a senior management team. A detailed clinical and corporate governance structure was in place. Minutes of all governance committee meetings, which included Clinical Council meetings, senior staff meetings, Clinical Governance Committee meetings, and Risk & Safety Committee meetings, were provided to the inspectors. There was an active process involving senior management and, as appropriate, members

of various disciplines within the approved centre. The governance process addressed both clinical and operational issues relating to the effective functioning of the centre. Risks were addressed or escalated as required.

# 5.0 Compliance

## 5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 8 – 11 November 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

| Regulation/Rule/Act/Code | 2017 Inspection Findings |
|---|---|
| Regulation 13: Searches | Compliant |
| Regulation 15: Individual Care Plan | Compliant |
| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines | Compliant |
| Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre | Compliant |

## 5.2 Non-compliant areas on this inspection

No areas of non-compliance were identified on this inspection.

## 5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

| Regulation |
| --- |
| 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 21: Privacy |
| Regulation 22: Premises |
| Regulation 26: Staffing |
| Regulation 27: Maintenance of Records |
| Regulation 29: Operating Policies and Procedures |
| Regulation 30: Mental Health Tribunals |
| Regulation 31: Complaints Procedures |
| Regulation 32: Risk Management Procedures |

# 6.0 Service-user Experience

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

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

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

A total of ten residents met with the inspection team. A further 14 residents returned a service user experience questionnaire. Residents expressed satisfaction with their treatment and accommodation within the approved centre and with the range of therapeutic options available. They felt that staff were supportive and engaged with them. Some residents expressed the view that they did not have sufficient contact with their designated key worker. This matter was raised with management during the feedback meeting for consideration and review.

# 7.0 Interviews with Heads of Discipline

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following individuals:

- Chief Executive Officer
- Medical Director
- Director of Operations
- Director of Nursing
- Head of Psychology
- Head of Occupational Therapy
- Head Social Worker

These meetings clarified issues of overall service goals and strategic aims. They also provided clarity regarding risk management within the approved centre, processes for supervision and appraisal of staff, and specific operational risks affecting areas of service provision.

# 8.0 Feedback Meeting

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

- Chief Executive Officer
- Medical Director
- Director of Operations
- Director of Nursing
- Acting Head of Pharmacy
- Senior Clinical Psychologist
- Head of Occupational Therapy
- Head Social Worker
- Programme Manager
- Nurse Practice Development Coordinator
- Administrator – Clinical Governance Department

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

# 9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

## Regulation 4: Identification of Residents

**COMPLIANT**

**Quality Rating** **Excellent**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the identification of residents, which was last reviewed in September 2015. It included all of the requirements of the *Judgement Support Framework.*

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

**Monitoring:** An annual audit of 77 clinical files and Medication Prescription and Administration Records had been undertaken to ensure the use of appropriate resident identifiers. Analysis had been completed to identify opportunities for improving the resident identification process.

**Evidence of Implementation:** An inspection of clinical files indicated that the following person-specific resident identifiers were used on all clinical records: date of birth, medical record number, and photographic ID. Two appropriate resident identifiers were used before the administration of medication, the initiation of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. A red caution stamp was used to alert staff to the presence of residents with the same or a similar name.

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

## Regulation 5: Food and Nutrition

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had five written policies in relation to the provision of appropriate food and nutrition to residents. These related to patient meal orders (May 2016), therapeutic meal orders (July 2015), nutritional care (May 2016), safe fresh drinking water (September 2016), and catering for individual requests (May 2016). Together, these included all of the requirements of the *Judgement Support Framework.*

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

**Monitoring:** A systematic review of menus was undertaken every three weeks by the dietician to ensure that residents received wholesome and nutritious food in accordance with their needs. Analysis had been completed to ensure that residents received a nutritious and varied diet appropriate to their needs.

**Evidence of Implementation:** Menus were analysed for nutritional adequacy every three weeks by a dietician in cooperation with the catering department. Residents were provided with a range of wholesome and nutritious food choices, and low-fat and gluten-free options were available. Food, including modified diets, was properly prepared and presented in an attractive and appealing manner. Hot meals were provided daily, including six lunchtime and four teatime options. Residents had access to hot and cold drinks throughout the day. Fresh water dispensers were available on each ward.

The St. Andrew's Nutrition Screening Instrument (SANSI) nutrition assessment tool was in use in the approved centre. The clinical files of five residents were inspected. These indicated that nutritional and dietary needs were assessed and documented in individual care plans. Weight charts were implemented, monitored, and acted upon, where appropriate. Where residents were identified as having special nutritional requirements, their needs were reviewed by the dietician.

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

## Regulation 6: Food Safety

**COMPLIANT**

**Quality Rating** **Excellent**

(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 two written policies in relation to food safety: a policy on the catering department service plan, dated July 2016, and a waste management policy, dated September 2015. The policies combined included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed could articulate the processes for food safety, as set out in the policies. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). The training was documented.

**Monitoring:** Food safety audits had been completed on the facilities for the refrigeration, storage, preparation, cooking, and serving of food and on adherence to the relevant food safety legislative requirements. Food temperatures were recorded in line with food safety recommendations, and a temperature log sheet was maintained and monitored. Analysis had been completed to identify opportunities for improving food safety processes.

**Evidence of Implementation:** Appropriate hand-washing areas were in place for catering services, and the catering equipment was suitable and adequate, with appropriate facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Catering areas and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

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

## Regulation 7: Clothing

**COMPLIANT**

**Quality Rating** **Excellent**

The registered proprietor shall ensure that:

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to clothing. Dated March 2017, it was entitled *Service User Access to their Clothing and Personal Property and Possessions.* It included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes in relation to residents' clothing, as set out in the policy.

**Monitoring:** The availability of an emergency supply of clothing for residents was monitored on an ongoing basis. A record of residents who were prescribed night attire during the day was maintained.

**Evidence of Implementation:** Residents were supported to keep and wear their personal clothing, and each resident had an individual wardrobe and locker. Residents' clothing was observed to be clean and appropriate to their needs. An emergency supply of clothing was stored in the laundry area of the hospital. Emergency attire took account of the residents' preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of their nightclothes during the day unless otherwise specified in their individual care plans. All residents had an adequate supply of individualised clothing.

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

## Regulation 8: Residents' Personal Property and Possessions

**COMPLIANT**

**Quality Rating** **Excellent**

(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 four written policies in relation to residents' personal property and possessions. These related to service user property (September 2015); property storage post-discharge (September 2015); service user access to clothing, personal property, and possessions (March 2017); and processing service user property (March 2017). Together, the policies included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed could articulate the processes relating to residents' personal property and possessions, as set out in the policies.

**Monitoring:** Personal property logs were maintained in clinical files and monitored. Analysis had been completed to identify opportunities for improving the processes around residents' personal property and possessions. The approved centre conducted audits on personal property and possessions approximately every six months.

**Evidence of Implementation:** Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to them or others, as indicated in their individual care plans. Provision was made for residents to secure personal property and possessions. Where the approved centre assumed responsibility for residents' property, personal effects were stored securely.

Examination of 24 resident files indicated that signed property checklists were maintained. The checklists were available to residents and were kept separately to the residents' individual care plans. Two members

of staff oversaw the process of providing residents with access to their money, and signed records of staff issuing money were maintained and, where possible, countersigned by the resident or a representative.

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

## Regulation 9: Recreational Activities

**COMPLIANT**

**Quality Rating** **Excellent**

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

### INSPECTION FINDINGS

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

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to recreational activities, as set out in the policy.

**Monitoring:** A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake/attendance. Audits were undertaken twice a year to elicit service users' feedback on recreation and identify opportunities for improving the processes in relation to recreational activities.

**Evidence of Implementation:** Residents had access to an extensive range of appropriate recreational activities. The available resources included reading materials, board games, walking groups, TV, movie nights, arts and crafts, jewellery making, bingo, Tai Chi, yoga, quizzes, and pool. A hairdresser attended the approved centre once a week. Recreational activities were scheduled in the approved centre on weekdays, and residents attended evening and weekend activities as part of the Twilight Programme.

Recreational activities were developed, maintained, and implemented with resident involvement, and they were appropriately resourced. Opportunities were available for indoor and outdoor exercise and physical activity. Residents had access to a gym, a mini-golf course, and garden areas. There were suitable indoor areas for recreation, including arts and crafts, music, pottery, and computer rooms as well as a library and computer room. Residents' decisions on whether or not to participate in activities were respected. Records of resident attendance at recreational activities were maintained in the clinical files.

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

## Regulation 10: Religion

**COMPLIANT**

**Quality Rating** **Excellent**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in September 2015. The policy included all of the requirements of the *Judgement Support Framework.*

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

**Monitoring:** An audit of the policy's implementation had been completed to ensure that residents' identified religious needs were met.

**Evidence of Implementation:** Residents were facilitated in the practice of their religion insofar as was practicable. They had access to a multi-faith oratory and to multi-faith chaplains. Residents could also attend religious services outside of the approved centre, if it was deemed appropriate following a risk assessment.

The care and services provided within the approved centre were respectful of residents' religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes. Particular religious requirements relating to the provision of services, care, and treatment were documented.

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

## Regulation 11: Visits

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had two written policies in relation to visits: a service user visitor control policy, dated March 2017, and a contractors' identification policy, dated September 2015. The policies combined included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes relating to visits, as set out in the policies.

**Monitoring:** Restrictions on residents' rights to receive visitors were monitored and reviewed on an ongoing basis. Audits had been completed to identify opportunities for improving visiting processes, specifically in relation to visitor information signage.

**Evidence of Implementation:** Visiting times, which were appropriate and reasonable, were displayed in the main reception of the approved centre and at the entrance to all ward areas. There were a number of rooms throughout the approved centre that were suitable for visits, including private visits: bedrooms, quiet areas, multi-functional rooms, a large restaurant and lobby area, and the "Wishing Well" family room, which had facilities suitable for visiting children. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits. Children were welcome when accompanied at all times.

At the time of the inspection, there were no restrictions on visits.

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

## Regulation 12: Communication

**COMPLIANT**

**Quality Rating** **Excellent**

(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 four written policies in relation to resident communication. These addressed service user access to communication facilities (March 2017), the accessing of interpretation and translation services (March 2017), guidelines for digital Media (March 2017), and literacy friendly practice (March 2016). Together, the policies included all the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes for facilitating residents' communication, as set out in the policies.

**Monitoring:** Residents' communications needs and restrictions on communication were monitored on an ongoing basis. Analysis had been completed to identify opportunities for improving communication processes in the form of an audit of the variety of communication methods available in the approved centre.

**Evidence of Implementation:** Residents had access to mail, fax, telephone, and e-mail. Residents on Dean Swift ward could use personal mobile phones or the computer room, following a risk assessment. Residents of the special care units did not have access to their own phones, as per the approved centre's policy, but they were facilitated in using a cordless phone. A senior member of staff could examine resident communication only where there was reasonable cause to believe that the communication may result in harm to the resident or others. No resident communication had required examination since the last inspection.

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

## Regulation 13: Searches

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had three written policies in relation to searches. These addressed service user searches (March 2017), the processing of service user property (March 2017), and the possession and use of illegal drugs and consumption of alcohol (September 2015). The policies covered all of the requirements of the *Judgement Support Framework,* including those relating to the following:

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

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policies. Staff were aware of the policy and procedures but not all staff queried could accurately outline the searching processes, as set out in the policies.

**Monitoring:** A search log was available to the inspectors, and it indicated a process for systematically reviewing each search to ensure compliance with the requirements of the regulation. Documented analysis had been completed to identify opportunities for improvement of search processes.

**Evidence of Implementation:** The policy and processes relating to searches were communicated to all residents in the approved centre. A written record of every search of a resident and every property search was available, which detailed the reasons for the search, the names of the staff members who undertook

the search, and details of who was in attendance. Where illicit substances were uncovered during a search, policy requirements were implemented.

Twenty search episodes were assessed by the inspection team. In all instances, a risk assessment was conducted in advance of the search. Resident consent was sought in all cases and obtained in 19 out of the 20 episodes. It was not possible to obtain consent in one instance for clinical reasons. The searches, which were documented in the clinical files, were attended by at least two clinical staff and were implemented with due regard to the residents' dignity, privacy, and gender. Residents were informed by those implementing the search of what was happening and why.

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

## Regulation 14: Care of the Dying

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the care of the dying, dated September 2015. It included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policy.

**Monitoring:** Systems analysis was undertaken in the event of a sudden or unexpected death in the approved centre. Analysis had been completed to identify opportunities to improve the processes relating to care of the dying.

**Evidence of Implementation:** No resident of the approved centre had required end of life care since the 2016 inspection. There had been two sudden deaths in the approved centre and the relevant files were inspected. Both deaths were managed in accordance with legal requirements and in line with the residents' religious and cultural practice, with dignity and propriety, and in a manner that accommodated the residents' representatives, family, next of kin, and friends. The Mental Health Commission was notified of both deaths within the required 48-hour time frame.

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

## Regulation 15: Individual Care Plan

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to individual care plans (ICPs), which was last reviewed in March 2017. It included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** All clinical staff had acknowledged that they had read and understood the policy. Clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Multi-disciplinary team (MDT) members had received training in individual care planning.

**Monitoring:** Quarterly ICP audits were conducted, and analysis had been completed to identify opportunities for improving the individual care planning process.

**Evidence of Implementation:** Forty-five residents' ICPs were inspected. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. Each included details of goals, treatment, care required, and MDT reviews. The ICPs identified residents' assessed needs and the resources required to provide the care and treatment identified.

Residents were initially assessed at admission and an ICP was drawn up by the MDT within seven days of admission, following a comprehensive assessment. Evidence-based assessments were used where possible. In 44 of the 45 ICPs inspected, a key worker was identified to ensure continuity in the implementation of the ICPs. The ICPs were reviewed weekly by the MDT in consultation with the resident, where possible. They were subsequently updated, as indicated by residents' changing needs, condition, circumstances, and goals.

In nine ICPs, there was no evidence that residents had been offered a copy of their ICPs with no explanation as to why. In nine ICPs, it was not recorded whether residents had declined or refused copies of their ICPs.

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

## Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had 30 written policies in relation to the provision of therapeutic services and programmes to residents. These were in date and addressed such issues as dual diagnosis, alcohol and chemical dependency, anxiety disorders, bipolar disorder, cognitive behavioural therapy, referrals and appointments, and therapies provided by outside agencies. Together, the policies included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** All clinical staff had signed a log indicating that they had read and understood the policies. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as set out in the policies.

**Monitoring:** The range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents' assessed needs were met. Audits assessed such areas as programme participation, engagement, and outcomes; dual diagnosis and addiction services; social work records; and individual services and programmes. Analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes and was documented.

**Evidence of Implementation:** The range of available, evidence-based programmes was appropriate to the assessed needs of the resident population, as outlined in individual care plans. Individual and group programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

A list of all available services and programmes in the approved centre was available on each unit. Where residents required a service or programme that was not offered internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. There was an activities centre as well as group and interview rooms on each unit. A log was maintained of residents' participation and engagement in therapeutic services or programmes and of outcomes achieved.

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

## Regulation 17: Children's Education

NOT APPLICABLE

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.

## Regulation 18: Transfer of Residents

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in March 2017. Entitled *Transfer of Care to Another Approved Centre or Healthcare Facility,* it included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log indicating that they had signed the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy.

**Monitoring:** The approved centre's discharge co-ordinator maintained a transfer log, and each transfer was reviewed to ensure that all relevant information was sent to the receiving facility. Analysis had been completed to identify opportunities for improving the provision of information during transfers.

**Evidence of Implementation:** One clinical file was inspected in relation to transfer. It contained evidence of the resident's consent to transfer and confirmed that a pre-transfer assessment had been completed, with details forwarded to the receiving facility. Comprehensive communication records with the receiving facility were available.

The clinical file contained a letter of referral, a resident transfer form, a list of current medications, and a list of required medications for the resident during transfer. The approved centre completed a checklist to ensure that the resident's records were transferred to the receiving facility, and copies of all relevant records were retained in the clinical files.

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

## Regulation 19: General Health

**COMPLIANT**

**Quality Rating** **Excellent**

(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 three different policies in relation to the provision of general health care to residents: a medical emergency response policy dated March 2017, a physical examination and general health management policy dated September 2015, and a referral to external or visiting physician policy, also dated September 2015. Together, the policies addressed all of the requirements of the *Judgement Support Framework.*

**Training and Education:** All clinical staff had signed a log indicating that they had read and understood the policies. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policies.

**Monitoring:** Residents' take-up of national screening programmes was recorded and monitored, where applicable. Where a resident was in the approved centre for more than six months, a systematic review was undertaken to ensure that six-monthly general health checks occurred. A length of stay report was used to alert staff when a resident was approaching six months in the approved centre and required a physical examination. A number of audits had been 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 External Defibrillator. These were checked weekly. Information was available on all medical emergencies in the form of minutes from the resuscitation committee's meetings and details contained in medical emergency response forms.

Residents had their medical and general health needs assessed by a registered medical practitioner on admission and were monitored on an ongoing basis. A primary care general practitioner service was available on-site, and a medical consultant visited weekly. Residents received appropriate general health care in line with their individual care plans, and their general health needs were monitored and assessed not less than every six months. Records were maintained of residents' completed general health checks and the associated results. Adequate arrangements were in place for residents to be referred to other health services, as required.

Residents had access to age- and gender-appropriate national screening programmes. Information leaflets were provided on national screening programmes available through the approved centre.

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

## Regulation 20: Provision of Information to Residents

**COMPLIANT**

**Quality Rating** **Excellent**

(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 policy in relation to the provision of information to residents. Entitled *Service User and Family Education Journey,* it was last reviewed in March 2017. The policy included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** All staff had signed a log indicating that they had read and understood the policy. Staff interviewed could articulate the procedure for providing information to residents, as set out in the policy.

**Monitoring:** The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, and amendments were made as required. Audits of information provision had been undertaken, and analysis had been completed to identify opportunities for improving the processes around the provision of information.

**Evidence of Implementation:** Required information was provided to residents and/or their representatives at admission in the form of a service user information booklet. This outlined available care and services as well as details of the housekeeping arrangements, complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents' rights.

Residents were provided with information on their multi-disciplinary team. The hospital information centre, which was accessible to all residents, contained comprehensive medical information, including details of medication risks and potential side-effects of medication. Residents received written and verbal information on their diagnosis, unless the provision of such information might be detrimental to their health and well-being. A variety of written or electronic medication-related information was readily available. The information was derived from evidence-based sources: the Royal College of Physicians, the

mental health organisation Mind, and a pharmacy database. Residents had access to interpretation and translation services as required.

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

## Regulation 21: Privacy

**COMPLIANT**

**Quality Rating** **Excellent**

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

### INSPECTION FINDINGS

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

**Training and Education:** All staff had signed a policy log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

**Monitoring:** An annual review was undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis was completed to identify opportunities for improving processes relating to resident privacy.

**Evidence of Implementation:** Residents were addressed by their preferred names. Staff spoke to residents in a friendly and respectful way and sought permission before entering residents' rooms. All conversations relating to residents' clinical and therapeutic needs took place in private. Residents were observed to be dressed in a manner that respected their privacy and dignity.

The approved centre's layout and furnishings were conducive to resident privacy and dignity. Bathrooms, showers, and toilet doors had locks on the inside, with an override facility. Rooms were accessed by a fob. Where residents shared a bedroom, appropriate screening was in place around the beds to ensure privacy was not compromised. All windows in bedrooms were fitted with opaque glass and curtains, and all observation panels in doors also had opaque glass. Rooms were not overlooked by public areas. Residents were facilitated in making and taking private phone calls.

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

## Regulation 22: Premises

**COMPLIANT**

**Quality Rating** **Excellent**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to its premises, which was last reviewed in September 2015. It included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to the upkeep and maintenance of the premises, as set out in the policy.

**Monitoring:** The approved centre had completed a hygiene audit and a ligature audit, and analysis had been completed to identify opportunities for improving the premises.

**Evidence of Implementation:** The approved centre's physical environment provided an opportunity for residents to maintain and improve their mental and general health, with adequate indoor and convenient outdoor spaces available. Residents had access to personal space. Each ward had a sitting room, dining area, activity rooms, and adequate communal seating. Dean Swift ward also had a multi-sensory room.

Resident accommodation was suitable and comfortable, and residents could control the temperature in their bedrooms. The approved centre was heated to a comfortable temperature throughout, and rooms were well ventilated. The lighting in communal rooms suited the needs of residents and staff.

Appropriate signage and sensory aids were provided to support residents' orientation, and all rooms were numbered. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, hard or rough surfaces, and ligature points, were minimised.

The approved centre was in a good state of repair, inside and out. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. A maintenance reporting process was in operation, and records were maintained. A cleaning schedule was in place, and current national infection guidelines were followed. The approved centre was clean, hygienic, and free from offensive odours. There were adequate toilet and bathroom facilities, including assisted needs facilities, with at least one assisted toilet per floor. There were designated sluice, cleaning, and laundry rooms, as well as therapy/examination rooms.

Bedrooms were appropriately sized to address residents' needs, and furnishings throughout the approved centre supported residents' independence and comfort.

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

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

**COMPLIANT**

**Quality Rating** **Satisfactory**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had 32 policies/appendices in relation to the ordering, storing, prescribing, and administration of medication. These included policies on the control and security of prescription pads, the prescribing of antipsychotic medication, the reporting of medication safety events, prescribing practice, therapeutic leave medications, and hand-washing and hygiene procedures. Together, the policies included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** All nursing, medical, and pharmacy staff had signed a log indicating that they had read and understood the policies. Staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policies. Staff had access to comprehensive, up-to-date information on medications. All nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents.

**Monitoring:** Quarterly audits of Medication Prescription and Administration Records (MPARs) were undertaken to determine compliance with the policies and procedures and with the relevant legislation and guidelines. Medication incidents, errors, and near misses were recorded in an incident report folder. Analysis had been completed to identify opportunities for improving medication management processes.

**Evidence of Implementation:** A Medication Prescription and Administration Record (MPAR) was maintained for each resident, and 61 of these were inspected. Two appropriate resident identifiers were used when medication was being administered. The Medical Council Registration Numbers of medical practitioners prescribing medication to residents were recorded. The allergy section was completed in each MPAR.

Names of medications were written in full, and the MPARs contained dedicated space for recording routine, once-off, and as-required medication. The frequency of administration, the dosage, and the administration route for medications were recorded, as were the dates of initiation and discontinuation for each medication.

Generic names of medications had not been recorded on a number of MPARs and were subsequently added or rewritten by the pharmacist. Similarly, in a small number of MPARs, the pharmacist had rewritten dosage amounts to provide micrograms in full rather than in abbreviated form.

Residents' medication was reviewed weekly by the multi-disciplinary team (MDT) and the assigned pharmacist for each ward. Where there was an alteration in a medication order, the medical practitioner rewrote the prescription. Medications were administered by a registered nurse or registered medical practitioner. Controlled drugs were checked by two staff members against the delivery form and recorded. The controlled drug balance available corresponded with the balance recorded in the controlled drug book. Medicinal products were administered appropriately, and the expiration date of medication was checked prior to administration. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. Where medication was refused by or withheld from a resident, the justification was recorded in the MPAR and the clinical file. Direction to crush medication was only prescribed by a registered medical practitioner and was documented on the prescription sheet.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Where medication required refrigeration, a daily log of fridge temperatures was maintained. The medication trolley was locked and secured, and scheduled controlled drugs were secured separately. A system of stock rotation was in place. Medication dispensed to residents was stored securely, and an inventory of medications was completed monthly.

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

## Regulation 24: Health and Safety

**COMPLIANT**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to health and safety, which was last reviewed in June 2016. It also had a Corporate Safety Statement, dated January 2017. These documents combined included requirements of the *Judgement Support Framework,* with the exception of staff training requirements in relation to health and safety.

**Training and Education:** All staff had signed a log indicating that they had read and understood the policies. Staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy.

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

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

**The approved centre was compliant with this regulation.**

## Regulation 25: Use of Closed Circuit Television

NOT APPLICABLE

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

As CCTV was not in use in the approved centre, this regulation was not applicable.

## Regulation 26: Staffing

**COMPLIANT**

**Quality Rating** **Excellent**

(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 multiple written policies in relation to staffing, which had been reviewed and were in date. These covered the requirements around roles and responsibilities for the recruitment, selection, vetting, and appointment of staff. They included details of staff planning requirements, staff rosters and their communication, and the reassignment of staff. They also addressed training and orientation for new staff, ongoing staff training requirements, frequency of training, job description requirements, and the required qualifications of training personnel.

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

**Monitoring:** The approved centre had a staff training log, which outlined the implementation of required training for all staff. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre's registration. Regular analysis was undertaken to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

**Evidence of Implementation:** There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Planned and actual staff rotas were in place, and the number and skill mix of staff were appropriate to the assessed needs of residents and the size and layout of the approved centre. Staff were recruited and selected in line with the approved centre's policies and procedures, and all were qualified for their roles. An appropriately qualified staff member was on duty and in charge at all times, as indicated by staff rotas.

| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
|---|---|---|---|
| Grattan | CNM2/1 | 1 | 0 |
| | RPN | 4 | 3 |

There was an up-to-date staffing plan, which was drawn up on the basis of the ward structure and of the programmes provided. All staff had individual training plans, and all training was documented. Where agency staff were employed, the approved centre entered a formal agreement with the employing agency.

All staff had completed orientation and induction training, and all health care professionals had up-to-date training in fire safety, Basic Life Support, the Therapeutic Management of Aggression and Violence, and the Mental Health Act (MHA) 2001. An adequate number of staff had received training in Children First.

All staff were trained in accordance with the assessed needs of the residents, and training included manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, risk management, and incident reporting.

Resources were available to staff for further training and education, and all in-service training was delivered by appropriately qualified staff. The MHA (2001), the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were made available to staff throughout the approved centre.

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

| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
|---|---|---|---|
| Clara | CNM2 | 1 | 0 |
| | RPN | 2 | 1 |
| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
| Dean Swift | CNM2 | 1 | 1 |
| | CNM1 | 1 | 0 |
| | RPN | 7 | 5 |
| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
| Delaney | CNM2/1 | 1 | 0 |
| | RPN | 4 | 2 |
| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
| Kilroot | CNM2/1 | 1 | 0 |
| | RPN | 4 | 2 |
| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
| Stella | CNM2/1 | 1 | 0 |
| | RPN | 4 | 2 |

| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
|---|---|---|---|
| Temple | CNM2/1 | 1 | 0 |
| | RPN | 4 | 2 |

| *Ward or Unit* | *Staff Grade* | *Day* | *Night* |
|---|---|---|---|
| Vanessa | CNM2/1 | 1 | 0 |
| | RPN | 5 | 3 |

***Other Staff Providing Cover in the Approved Centre***

Consultant psychiatrist
Clinical Psychologist
Non-consultant hospital doctors
Social workers
Occupational therapists

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN),*

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

## Regulation 27: Maintenance of Records

**COMPLIANT**

**Quality Rating** **Excellent**

(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 number of up-to-date written policies in relation to the maintenance of records. They addressed the creation of a clinical file, confidentiality and secure access, and retention and destruction of records. Together, the policies addressed all of the requirements of the *Judgement Support Framework.*

**Training and Education:** All clinical staff and other relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records, as set out in the policies. All clinical staff were trained in best-practice record keeping at induction and as part of their clinician training.

**Monitoring:** Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had been conducted to identify opportunities for improving the processes relating to the maintenance of records.

**Evidence of Implementation:** Residents' records were observed to be securely stored, up to date, and in good order. They were developed and maintained in a logical sequence, and they were maintained appropriately, with factual, complete, and accurate entries that facilitated information retrieval. Records were written legibly in black ink, and each entry noted the date and time using the 24-hour clock and was accompanied by a signature.

Each resident had an individual clinical file, containing all relevant documentation, which was prepared on admission. Appropriate identifiers were in use: medical record number, name, and date of birth, and photograph, where possible. Records were reflective of the residents' current status and the care and treatment being provided, and they were accessible only to authorised staff, who had authority to make entries in them. Records were stored in locked file rooms and were appropriately secured from loss or destruction, tampering, and unauthorised access or use.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre. Records were retained/destroyed in accordance with legislative requirements and the approved centre's policy and procedures.

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

## Regulation 28: Register of Residents

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

**Quality Rating** **Excellent**

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 two written policies on the development and review of operating policies and procedures. There was a policy on the development and approval of policies, dated September 2015, and a policy on the communication and dissemination of policies, dated August 2015. The policies included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff had received training on approved operational policies and procedures. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policies.

**Monitoring:** An annual audit was undertaken to determine compliance with review time frames by senior staff and the Clinical Governance Committee. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

**Evidence of Implementation:** Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, and they were communicated to all relevant staff. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines. All operating policies and procedures required by the regulations were reviewed within the required three-year time frame.

Obsolete versions of policies and procedures were removed from circulation. Policies and procedures were presented in a standardised format that included title, reference and version number, details of the document owner, date of implementation, and details of approvers and reviewers.

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

## Regulation 30: Mental Health Tribunals

**COMPLIANT**

**Quality Rating** **Excellent**

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

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the facilitation of Mental Health Tribunals, dated September 2015. It included all of the requirements of the *Judgement Support Framework.*

**Training and Education:** Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

**Monitoring:** The implementation of the policy and procedures was monitored by the Mental Health Act administrator to ensure that the rights and needs of the patient were appropriately supported. There was documentary evidence that analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

**Evidence of Implementation:** The approved centre had a large, comfortably furnished tribunal room. Adequate resources were provided in support of the tribunals process, and staff assisted and supported residents to attend and participate, where necessary.

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

## Regulation 31: Complaints Procedures

**COMPLIANT**

**Quality Rating** **Excellent**

(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 in relation to making, handling, and investigating complaints, which was last reviewed in March 2017. There were also separate policies relating to protected disclosures (July 2016) and confidentiality (September 2015). The policies included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had received training on the complaints policy. All staff had signed a log indicating that they had read and understood the complaints policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

**Monitoring:** Audits of the complaints log were completed, and complaints data were analysed for the purpose of identifying and implementing required actions to ensure continuous improvement of the complaints management process.

**Evidence of Implementation:** There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. Complaints, whether verbal or written, were logged. The methods that residents and their representatives could use to lodge a complaint were detailed in the complaints policy, in the resident information booklet, and on the hospital's website. The approved centre's management of complaints was well publicised on signs in each ward.

All complaints were documented, investigated promptly, and handled with sensitivity. Serious complaints were escalated to the complaints officer. Minor complaints, lodged via the suggestion box, from feedback/suggestion forms, or the hospital website, were logged and dealt with appropriately.

The quality of service, care, and treatment of a resident was not adversely affected by reasons of a complaint being made. Details of complaints, investigations, and investigation outcomes were recorded and kept separately from the resident's individual care plan.

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

## Regulation 32: Risk Management Procedures

**COMPLIANT**

**Quality Rating** **Excellent**

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to risk management procedures, which was dated March 2017. It addressed all the requirements of the *Judgement Support Framework,* including processes for the following:

- Identification, assessment, treatment, reporting, and monitoring of risks.
- Rating identified risks.
- Controlling resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Managing incidents involving residents.
- Responding to emergencies.

**Training and Education:** Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes, and management staff were trained in organisational risk management. All staff had training in incident reporting and documentation. All staff had signed a log indicating that they had read and understood the policy, and staff interviewed were able to articulate the risk management processes, as set out in the policy.

**Monitoring:** The risk register was audited at least quarterly to determine compliance with the approved centre's risk management policy. All incidents were logged and risk-rated. Incidents were reviewed regularly at committee level, and opportunities were identified for improving risk management processes.

**Evidence of Implementation:** The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management. Risk management procedures actively sought to reduce identified risks to the lowest practical level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Health and safety risks were identified, assessed, treated, reported, and monitored. Structural risks, including ligature points, were removed or mitigated.

The approved centre completed resident risk assessments at admission to identify individual risk factors. Assessments were also completed before and during episodes of physical restraint and specialised treatment, prior to resident transfer and discharge, and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of individual risk management processes. Residents and/or their representatives were involved in risk management processes. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated using a standardised form from patient safety software provider Datix. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. The approved centre had a medical emergencies plan and policies that addressed evacuation procedures during the day and at night.

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

## Regulation 33: Insurance

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 34: Certificate of Registration

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was prominently displayed in the main reception area of the hospital.

**The approved centre was compliant with this regulation.**

# 10.0 Inspection Findings – Rules

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

## Section 59: The Use of Electro-Convulsive Therapy

**COMPLIANT**

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 written policy in relation to the use of Electro-Convulsive Therapy (ECT). It addressed all criteria of this rule, including provisions relating to the following:

- The storage of dantrolene.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.
- Obtaining consent for maintenance/continuation of ECT.

**Training and Education:** All staff members involved in delivering ECT were trained in line with best international practice. Staff were subject to ongoing competency assessment and were peer reviewed by consultants. Staff delivering ECT had appropriate Basic Life Support training, and four staff had Advanced Cardiovascular Live Support training.

**Evidence of Implementation:** The approved centre had a dedicated ECT suite, which included a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid response area, and the recovery room was spacious enough to accommodate the number of patients receiving ECT. Material and equipment for ECT were in line with best international practice, and there was documentary evidence that ECT machines were regularly maintained.

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed in the treatment area. A named consultant and named consultant anaesthetist had responsibility for ECT, and two registered nurses, including a designated ECT nurse, were in the ECT suite at all times.

The clinical file of one patient who was prescribed ECT was inspected. This indicated that the patient received appropriate information about the treatment, including details of likely adverse effects. The patient was also informed of his/her rights to an advocate.

A capacity to consent assessment was undertaken. It indicated that the patient was unable to give informed consent for ECT, and this was documented in the clinical file. ECT was administered in accordance with section 59(1)(b) of the Mental Health Act 2001. A Form 16: Treatment without Consent Electro-Convulsive Therapy Involuntary Patient (Adult) was completed and placed in the clinical file, and a copy was sent to the Mental Health Commission within five days.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file, which also contained a pre-anaesthetic assessment and an anaesthetic risk assessment. The consultant psychiatrist in consultation with the patient reviewed progress and the need for continuation of ECT. The ECT record was retained in the clinical file, as were post-ECT assessments.

**The approved centre was compliant with this rule.**

## Section 69: The Use of Seclusion

NOT APPLICABLE

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 not applicable.

## Section 69: The Use of Mechanical Restraint

NOT APPLICABLE

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 apply mechanical means of bodily restraint to residents, this rule was not applicable.

# 11.0 Inspection Findings – Mental Health Act 2001

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

## Part 4 Consent to Treatment

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

There was one involuntary patient in the approved centre for more than three months and in continued receipt of medication. A capacity assessment had been completed, and a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed. A copy of the form was retained in the clinical file. It included the following:

- The name(s) of the medication prescribed.
- Confirmation of an assessment of the patient's ability to understand the nature, purpose, and likely effects of the medication.
- Discussions with the patient in terms of the nature and purpose and effects of the medication.
- Views expressed by the patient.
- Supports provided to the patient in terms of the discussion and their decision-making process.
- Authorisation by a second consultant psychiatrist.

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

# 12.0 Inspection Findings – Codes of Practice

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

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

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

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

## Use of Physical Restraint

**COMPLIANT**

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 two written policies on the use of physical restraint, both dated September 2016: a physical restraint policy and a policy on the management of aggression and violence. The policies had been reviewed annually and included details of the following:

- The provision of information to residents regarding physical restraint.
- The individuals authorised to initiate and conduct physical restraint.
- The training requirements relating to physical restraint.

**Training and Education:** All staff had acknowledged that they had read and understood the policies. Staff training procedures specified who should receive training, areas to be addressed during training, frequency of training, the identification of appropriately qualified individuals to deliver training, and the mandatory nature of training. A record of attendance at training was maintained. Physical restraint was never used to ameliorate staff shortages.

**Monitoring:** An annual report on the use of physical restraint had been completed.

**Evidence of Implementation:** The clinical files of three residents were inspected in relation to physical restraint. These indicated the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others. Episodes of physical restraint were initiated after staff had first considered other interventions and following a risk assessment. Physical restraint was not prolonged beyond the period necessary in any case. Gender sensitivity was demonstrated during the episodes.

The consultant psychiatrist was notified of the use of physical restraint as soon as was practicable, and a registered medical practitioner reviewed the residents within three hours of the start of physical restraint and conducted a physical examination. The consultant psychiatrist signed and dated the clinical practice form within 24 hours, and there was documentary evidence that members of the multi-disciplinary team reviewed and recorded the episode in the clinical file within two working days.

**The approved centre was compliant with this code of practice.**

## Admission of Children

NOT APPLICABLE

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.

## Notification of Deaths and Incident Reporting

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a risk management policy in place in relation to the notification of deaths and incident reporting to the Mental Health Commission (MHC). The policy met all the criteria of this code of practice. It specified the risk manager, and it outlined the roles and responsibilities of staff in relation to the following:

- The reporting of deaths and incidents.
- The completing of death notification forms.
- The submission of forms to the MHC.
- The completion of six-monthly incident summary reports.

**Monitoring:** Deaths and incidents were reviewed to identify and correct any problems as they arose and to improve quality.

**Evidence of Implementation:** The approved centre was compliant with Regulation 32: Risk Management Procedures. It had an incident reporting system in place and used a standardised report form. A six-monthly summary of all incidents was sent to the MHC.

There had been two deaths in the approved centre since the last inspection. Both were reported to the MHC within the required 48-hour time frame.

**The approved centre was compliant with this code of practice.**

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

NOT APPLICABLE

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 none of the residents of the approved centre had been diagnosed with an intellectual disability, this code of practice was not applicable.

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

**COMPLIANT**

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 written policy in relation to the use of Electro-Convulsive Therapy (ECT). It addressed all criteria of this code of practice, including provisions in relation to the following:

- The storage of dantrolene.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.
- Obtaining consent for maintenance/continuation of ECT.

**Training and Education:** All staff members involved in delivering ECT were trained in line with best international practice. Staff were subject to ongoing competency assessment and were peer reviewed by consultants. Staff delivering ECT had appropriate Basic Life Support training, and four staff had Advanced Cardiovascular Live Support training.

**Evidence of Implementation:** The approved centre had a dedicated suite for the delivery of ECT, including a private waiting room and adequately equipped treatment and recovery rooms. High-risk voluntary residents were treated in a rapid response area, and the recovery room was spacious enough to accommodate the number of patients receiving ECT. Material and equipment for ECT were in line with best international practice, and there was documentary evidence that ECT machines were regularly maintained.

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant and named consultant anaesthetist had responsibility for ECT, and two registered nurses, including a designated ECT nurse, were in the ECT suite at all times.

The files of three voluntary residents who were prescribed ECT were inspected. Each had an ECT treatment plan, which indicated that they had received appropriate information about the treatment, including details of likely adverse effects. Patients were informed of their rights to an advocate and had the opportunity to raise questions at any time. A comprehensive capacity-to-consent assessment was undertaken and documented in each clinical file. Consent was obtained in writing for each ECT treatment by the responsible consultant psychiatrist or a registered medical practitioner under supervision of the consultant psychiatrist.

A programme of ECT was prescribed by the responsible clinical psychologist and recorded in the clinical files, which also contained a pre-anaesthetic assessment and an anaesthetic risk assessment. The clinical psychologist in consultation with the voluntary patients reviewed progress and the need for continuation of ECT. The ECT record was retained in the clinical files, as were post-ECT assessments.

**The approved centre was compliant with this code of practice.**

## Admission, Transfer and Discharge

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had separate policies in relation to admission, transfer, and discharge.

**Admission:** There was an admission assessment and process policy dated September 2015 and a separate policy on the protocol for involuntary admission. The policies included all of the criteria of this code of practice, including processes relating to pre-admission assessments, eligibility for admission, and referral letters. They detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. They contained protocols for urgent referrals, self-presenting individuals, and timely communication with primary care and community mental health teams. There were separate policies on confidentiality, privacy, and consent.

**Transfer:** The transfer policy, which was dated March 2017, detailed how a transfer is arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary, emergency, and transfer abroad, and it addressed the safety of the resident and staff during a transfer.

**Discharge:** The approved centre had two main discharge policies, both dated March 2017: a discharge process policy and a discharge summaries policy. There was also a series of related policies. These referenced prescriptions and supply of medication on discharge and documented the roles and responsibilities of staff in relation to providing follow-up care. Details were included of crisis management plans and relapse prevention strategies and of when and how much follow-up contact residents should have. A method for following up and managing missed appointments was addressed in a separate policy.

The policies outlined procedures for discharging involuntary patients, homeless people, and older people. There were separate policies that addressed discharge against medical advice and discharge of people with an intellectual disability.

**Training and Education:** Staff had signed a log indicating that they had read and understood the policies on admission, transfer, and discharge.

**Monitoring:** There was documented evidence that audits had been completed on the implementation of and adherence to the admission and discharge policies.

**Evidence of Implementation:**

**Admission:** Clinical files inspected in relation to admission indicated that the approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was taken by the registered medical practitioner (RMP). An admission assessment was completed by the RMP and detailed in clinical notes, and assessments and examinations were documented in the clinical files. Residents were admitted to the unit most appropriate to their needs.

The approved centre's admissions process was compliant with Regulation 7: Clothing, Regulation 8: Residents' Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, Regulation 32: Risk Management, and Regulation 27: Maintenance of Records.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical files of two residents who had been transferred to a general health care facility were inspected. The decision to transfer was made by the RMP, and a pre-transfer assessment was undertaken. Family members/carers/advocates were involved in the transfer process, as were members of the MDT. Copies of the referral letters were retained in the clinical files. In both cases, there was documented evidence that the residents' wishes or consent regarding transfer was obtained.

**Discharge:** The files of three residents who had been discharged from the approved centre were examined. In each case, the decision to discharge was made by the RMP. A comprehensive assessment was completed prior to discharge and documented. All of the files indicated family consultation, risk assessment and management, and follow-up planning. Discharge meetings were held, and each discharge was coordinated by the relevant key worker. There was appropriate input into the process from the MDT, and communication with the primary care/community mental health teams was documented. Comprehensive discharge summaries were sent to the relevant primary care teams within three days. Timely follow-up appointments were arranged.

**The approved centre was compliant with this code of practice.**