

Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)



APPROVED CENTRE NAME:	Jonathan Swift Clinic, St. James's Hospital, Dublin 8
IDENTIFICATION NUMBER:	AC0009
APPROVED CENTRE TYPE:	General Adult Psychiatry
REGISTERED PROPRIETOR:	Health Service Executive
REGISTERED PROPRIETOR NOMINEE:	Mr. Kevin Brady
MOST RECENT REGISTRATION DATE:	01 March 2014
NUMBER OF RESIDENTS REGISTERED FOR:	51
INSPECTION TYPE:	Unannounced
INSPECTION DATE:	28 - 30 July 2015
PREVIOUS INSPECTION DATE:	27 - 28 May 2014
CONDITIONS ATTACHED:	No
LEAD INSPECTOR:	Dr. Enda Dooley, MCN 004155
INSPECTION TEAM:	Ms. Orla O'Neill
THE INSPECTOR OF MENTAL HEALTH SERVICES:	Dr. Fionnuala O'Loughlin, MCN 008108 (Acting)

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1.0 Mental Health Commission Inspection Process

The principal functions of the 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 under this Act.

The Mental Health Commission strives to ensure its principal legislative functions are achieved through the registration 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). 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 Mental Health Act (2001), states that when making an inspection under section 51, the Inspector shall:

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

Each Approved Centre shall be assessed against all regulations, rules, codes of practice and Section 4 of the Mental Health Act 2001 at least once on an annual basis. Inspectors shall use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined the individual regulation, or rule, shall also be risk assessed.

The Approved Centre is required to act on all aspects identified as non-compliant or with a high / critical risk rating. Demonstration of immediate corrective rectifications, and ongoing preventative actions must be clearly identified. These actions are required to be specific, measurable, achievable and time-bound. All actions must have identified timeframes and responsibilities.

A copy of the draft report was forwarded to the service and comments and review on the report were invited from the Registered Proprietor. These comments were reviewed by the lead inspector and incorporated into the report, where relevant.

In circumstances where the Registered Proprietor fails to comply with the requirements of the Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules, the Mental Health Commission has the authority to initiate escalating enforcement actions up to, and including,

removal of an Approved Centre from the Register and the prosecution of the Registered Proprietor.

2.0 Approved Centre Inspection - Overview

2.1 Overview of the Approved Centre

The Jonathan Swift Clinic (JSC) was located in a two storey building within the St. James's Hospital campus. The unit was signposted within the general hospital. The JSC consisted of three wards with a total bed complement of 51 beds. William Fownes ward, located on the first floor, was a locked 26-bed acute unit. On the first day of inspection the ward had 24 residents, five of whom were involuntary patients. Two residents were Wards of Court. Becket ward was an open, 16-bed step down ward located on the ground floor. On the first day of inspection the ward had six residents, all voluntary. Conolly Norman ward was a nine bed, locked acute old age unit. On the initial day of inspection there were nine residents, one of whom was involuntary.

The Clinic provides acute in-patient care for much of Dublin South City which is part of Community Healthcare Organisation Area 7. The population served by the approved centre is approximately 130,000 comprising the following sectors: Owendower (66,000); Drimnagh (27,000); and Camac (45,000). Three adult sector teams and the Psychiatry of Old Age team admit residents to the clinic.

Accommodation on Fownes ward consisted of six single bedrooms, two of which were en suite, two 4-bed dormitories and two 6-bed dormitories. The ward was staffed during the day by a Clinical Nurse Manager (CNM) 2, four Registered Psychiatric Nurses (RPN), and one Health Care Assistant (HCA) who was shared with the other wards. A further 0.5 whole time equivalent (WTE) HCA was available to the clinic. Staffing at night consisted of a CNM (1 or 2), two RPNs and one HCA.

Accommodation on Becket ward consisted of two 6-bed dormitories and one 4-bed dormitory. The ward was staffed during the day by a CNM 1 and one RPN. The staffing at night consisted of one RPN.

Accommodation on Conolly Norman ward consisted of a 6-bed dormitory and three single rooms, none of which was en suite. Staffing by day consisted of a CNM 2, two RPNs and a shared HCA. At night this reduced to one RPN and one HCA.

In addition to the above staffing there was an Assistant Director of Nursing on site in the approved centre.

2.2 Governance

There were regular monthly management team meetings which outlined a clear governance structure and process in place. Minutes of those meetings were provided to the inspectors. The inspection team met with members of the senior management team who responded to queries and feedback from the inspection team. They were also able to provide an account of current service developments and improvements together with a number of challenges facing both the service and the approved centre. The development of a seven-storey building immediately adjacent to the JSC has already had a significant detrimental effect on the amenity and access to light in various areas of the clinic. The management team accepted the ongoing physical inadequacy of the unit, now exacerbated by recent developments and had commenced discussion with the hospital management with a view to considering re-locating

the clinic. There was positive acknowledgement of the fact that the acute unit was generally able to function at somewhat less than 100% occupancy. Management highlighted the difficulty in retention of skilled and experienced staff and the detrimental effect that this had on service development.

2.3 Inspection scope

This unannounced annual inspection was conducted in the Jonathan Swift Clinic from Tuesday 28 July 2015 at 0900h to Thursday 30 July at 1715h. There were no child admissions in the centre during this period and no resident of the centre was receiving ECT. Regulation 17 – Children's Education was not inspected.

2.4 Outstanding issues from previous inspection

The previous inspection in May 2014 identified that the approved centre was not fully compliant with the following regulations:

Regulation/Rule/Act/Code	Inspection Findings 2015
Regulation 16 – Therapeutic Services and Programmes	Compliant
Regulation 20 - Provision of Information to Residents	Compliant
Regulation 22 – Premises	Non-compliant
Regulation 26 – Staffing	Compliant
Regulation 28 – Register of Residents	Compliant

These issues were considered in the evaluation of the related regulations and rules, and the current findings are documented within part 3 of this report.

2.5 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
22 – Premises	Low
23 – Ordering, Prescribing, Storing and Administration of Medicines	Low
COP – Admission of Children	Moderate

The approved centre was requested to provide Correctative and Preventative Actions (CAPAs) for areas of non-compliance and these are included in the report, in the relevant areas.

2.6 Areas of compliance rated Excellent on this inspection

Regulation/Rule/Act/Code
Regulation 5: Food and Nutrition
Regulation 6: Food Safety
Regulation 8: Residents' Personal Property and Possessions
Regulation 15: Individual Care Plan
Regulation 16: Therapeutic Services and Programme
Regulation 20: Provision of information to Residents
Regulation 24: Health and Safety
Regulation 26: Staffing
Regulation 27: Maintenance of Records
Regulation 28: Register of Residents
Regulation 30: Mental Health Tribunals
Regulation 31: Complaints Procedures
Regulation 33: Insurance
Regulation 34: Certificate of Registration
Code of Practice on Admissions, Transfer and Discharge

2.7 Reporting on the National Clinical Guidelines

The clinic had access to an infection control nurse from the adjacent general hospital. The centre operated in compliance with the National Clinical Guidelines. Staff indicated that there had been no incidents of *C. difficile* in the approved centre since the last inspection.

2.8 Areas of good practice identified on this inspection

- The approved centre had commenced a process of review of policies with the intention of having them more suitable for service user consideration.
- Recently a process of designing and undertaking audits relevant to the functioning of the centre in the context of the Mental Health Commission (MHC) Judgement Support Framework document had been commenced.
- A process of renovation of bathroom facilities within the unit was ongoing and this included consideration of minimisation of ligature risk.
- The standard of clinical record keeping within the unit was excellent. Records were well laid out and the identification of relevant information was straightforward. A number of template documents had been incorporated within the file structure and these assisted the co-ordination and review of documentation.
- A staff Discharge Planning Group had been developed over the last year with the aim of expediting the overall discharge process and ensuring appropriate support arrangements are in place to minimise risk of early relapse.

2.9 Resident Interviews

The inspection team were particularly interested in hearing the views of residents in the clinic and met with a number of residents to elicit their view on their admission, treatment, facilities and discharge plans. Six residents met with the inspectors and provided a range of comments and insights regarding their hospital stay. While residents were generally positive regarding their relationship with staff and the support received, a common theme expressed was the lack of adequate therapeutic and personal space, particularly in the acute unit. A number of residents complained of inadequate access to a suitable outdoor facility. Some residents spoke negatively regarding overall standards of cleanliness and maintenance. In general, residents were aware of, and involved in, their individual care plans.

3.0 Inspection Findings and Required Actions - Regulations

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

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 Regulation 4: Identification of Residents

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

Inspection Findings

Processes: The centre had a document policy in place which outlined the process to be followed in identifying residents for treatment purposes, including administration of medication. Staff interviewed were familiar with this process and applied it consistently.

Training: As part of induction training, all staff were educated in procedures to be applied in ensuring consistent and reliable identification of residents, including those with similar names.

Monitoring of Compliance: There was no documented audit process yet in place. Review of incident reports did not indicate any evidence of non-compliance in this area.

Evidence of Implementation: The unit operated a minimum of two identifiers (date of birth and photo) and these were documented. These identifiers were appropriate to the location and needs of the residents. Both staff and residents were familiar with necessity for such identifiers.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.5 Regulation 5: Food and Nutrition

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

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

Inspection Findings

Processes: There was a policy on food and nutrition. The Catering Manager of St. James's Hospital had responsibility for all catering services in the approved centre. All meals were cooked in the main hospital kitchen. The drinking water provided to residents was monitored by the Environmental Health Technical Services Department. Where a resident required a special diet or assessment by a dietician, the Clinical Nurse Manager liaised with the Dietetics Department in St. James's Hospital and the Catering Manager to ensure provision of an appropriate diet. The admission assessment and weekly weight measurement informed nursing staff and the treating team as to whether diet and nutrition were issues to be included in the individual care plan. Nursing staff assisted in serving meals and observed residents' dietary intake. Clinical speech and language was provided where required in relation to swallow assessments.

Training: Catering staff were trained in food management and basic nutrition. Clinical dieticians provided input to both the catering department and to individual residents. Qualified nursing staff monitored dietary intake and weight.

Monitoring of Compliance: The Catering Manager surveyed residents' satisfaction with the meals provided on a monthly basis. Information provided informed quality assurance actions. Incident reporting took place as required. There were no reported incidents in relation to food and nutrition. Nursing staff observed residents' meal intake on an ongoing basis but this was not recorded unless there was an identified issue of concern.

Evidence of Implementation: The inspection team met with nursing staff, residents, the catering assistant and the Catering Managers to enquire about the catering processes and resident satisfaction. The team also visited Fownes dining room during lunch service.

There was a menu card posted in each dining room. Residents made their meal choice at the servery. There was a choice of eight meat dishes, two fish dishes, eight vegetarian dishes and standard special diets such as diabetic, gluten free, soft diets, low salt and healthy heart options for the main meal. Halal and Kosher diets were also available as a standard.

The inspection team observed that there was plenty of choice and sufficient portions to allow residents to have their preferred choice and a second helping if required. The meals were plated by a catering assistant and a nurse. Residents spoken with expressed satisfaction with the choice and quality of meals and the amount of food served. The inspection team observed that meals were plated such that the items were piled on a plate and not attractively presented. Three hot meals were served each day. Salad options were also available. The last meal was tea at 1700h and hot drinks and sandwiches were provided at

2030h. There was an adequate and appropriate supply of crockery and cutlery. One resident was required to use disposable tableware and this was recorded in the individual care plan (ICP).

The dining room in Fownes ward was dark and dreary and did not provide a comfortable or appropriate environment for resident meal times. The room required artificial light during a bright summer's day owing to an adjacent newly constructed seven storey building. The new build severely restricted natural light. Overall, the dining room in Fownes was small and décor was relatively sparse. Residents were observed to leave the dining room as soon as their meal was consumed. The dining rooms in Beckett and Conolly Norman wards were attractive spaces.

The Catering Manager advised that the menus had been developed in conjunction with the Dietetics Department. The clinical file of one resident who had required dietetic input was inspected. The dietetic assessment and meal plan was recorded in the file. Nursing staff monitored to ensure health gain. The dietician provided a report for the general practitioner on the discharge of the resident. The dietary needs of the resident were incorporated into the ICP. Nursing staff routinely completed weight charts for residents each week.

There were water filter dispensing machines with cups in Fownes and Beckett wards. Staff provided drinks at regular intervals to residents in Conolly Norman ward.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.6 Regulation 6: Food Safety

(1) *The registered proprietor shall ensure:*

- (a) the provision of suitable and sufficient catering equipment, crockery and cutlery*
- (b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and*
- (c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.*

(2) *This regulation is without prejudice to:*

- (a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;*
- (b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and*
- (c) the Food Safety Authority of Ireland Act 1998.*

Inspection Findings

Processes: There was a policy on food safety. The Catering Manager in St. James's Hospital was in charge of all catering and food management. There were clearly defined processes in place to ensure appropriate purchasing, receipt, storage, preparation, production, portioning, chilling, cold holding, distribution, regeneration and service of food.

Training: Staff were trained according to assigned roles. The catering assistants in the Jonathan Swift Clinic were trained in the safe handling and management of food (Hazard Analysis and Critical Control Points HACCP) and in manual handling. Nursing staff handling food were not HACCP trained.

Monitoring of Compliance: The catering department had a defined schedule of temperature monitoring and cleaning. The Environmental Health Officer conducted an inspection of catering facilities and services. The catering department conducted a monthly ward kitchenette audit in the approved centre. The results of which were provided to the Clinical Nurse Manager of each ward.

Evidence of Implementation: The inspection team visited the ward pantries and dining rooms. The team spoke with the Catering Manager in St. James's Hospital, nursing staff and catering assistants.

The kitchenette in Fownes ward was observed to be clean and tidy. The fabric of this kitchen was worn and in need of refurbishment. The Formica covered chipboard cupboards were chipped in several places. The wall tiles surrounding the worktop were cracked. The radiator, shelf and floor covering had rust like stains. The open window, which was covered by a wire mesh screen, opened directly onto a ledge where pigeons were feeding. The temperature logs for food, fridge, freezer and milk dispensing machine were seen and were up to date and counter signed by a catering supervisor.

The most recent Environmental Health Officer's report of the 17 July 2015 was provided to the inspection team. The inspection team noted that a separate kitchenette hygiene audit of the 27 April 2015 in Fownes ward had identified a number of items requiring attention. These

issues were raised with nursing and catering staff who indicated that senior management were seeking funding to refurbish this kitchenette.

There were separate handwashing facilities for catering staff within each catering kitchenette. There was a central changing room and showers in St. James's Hospital. Staff were observed to be wearing personal protective clothing during lunch service. All food related rubbish was returned to the main kitchen at the end of each meal service.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.7 Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

Inspection Findings

Processes: The centre had a policy covering the provision of appropriate clothing, including night clothes, to any resident who might not have an adequate supply of same.

Training: Staff interviewed were aware of the policy and of the procedures to provide residents with suitable clothing. Staff were aware of the existence of a small budget to fund such provision where necessary.

Monitoring of Compliance: An audit process was in place dealing with night attire.

Evidence of Implementation: Processes were in place to support residents in using their own clothing in the first instance, including the provision of appropriate storage facilities. Where a resident did not have access to suitable clothing, procedures were in place to provide same.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.8 Regulation 8: Residents' Personal Property and Possessions

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

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

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

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

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

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

Inspection Findings

Processes: The centre had a current policy dealing with residents' property and possessions. The policy documented responsibility for the documentation and storage of property and for communication with the resident regarding property. Provision for resident access to personal property was addressed in policy.

Training: Staff interviewed were familiar with the requirements of the policy and their role in implementing this.

Monitoring of Compliance: Regular audit of property was undertaken and steps were taken to ensure that property was safeguarded and returned when appropriate.

Evidence of Implementation: Secure facilities were provided to ensure the safety of valuables. Personal property could be stored securely although it was practice to encourage residents to have property sent home. Residents had access to their personal property. All admissions had a documented property list and a copy was maintained in the resident's file. Where a resident sought to have cash or other valuables retained by staff it was practice for two members of staff to sign for this.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.9 Regulation 9: Recreational Activities

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

Inspection Findings

Processes: There was a policy on recreation. This policy required that a plan of recreational activities be available in each unit in the Jonathan Swift Clinic. There was no defined process, responsibility or resourcing outlined in the recreation policy. Despite the vague policy, nursing and occupational therapy (OT) staff collaborated to provide a seven day timetable of activities, including recreational activities.

Training: Trained occupational therapists and art teachers provided activities including leisure activities. Staff were trained mental health nurses.

Monitoring of Compliance: Resident attendance and engagement in recreational activities were recorded and reviewed by nursing and OT staff. The CNM2 undertook a weekly audit of recreational activities. There was no structured forum to review and plan recreational provision.

Evidence of Implementation: The inspection team visited each of the units within the Jonathan Swift Clinic and spoke with residents, nursing staff and OT staff.

Fownes unit was small and cramped. There was a small room which contained a table, a chair and some art materials. There was a small sitting room with a television. There was a group room, again quite small and sparsely furnished. Adjacent to the unit was a large and spacious room used for clinical and educational meetings. This room contained a screen and film projector which had originally been purchased for resident use. This was reported not to be wired up or functioning. Nursing staff, resources allowing, used this room for resident recreational activities at the weekend. There was a small supply of table games. Fownes residents did not have access to an outdoor space unless risk assessed for unaccompanied leave or where accompanied by nursing staff. Therefore, access for acutely unwell residents depended on nursing staff availability. Overall, the unit was cramped and afforded residents with little opportunity to find a quiet place to engage in personal recreational interests such as reading or listening to music.

Beckett unit had a spacious library cum sitting room. There were comfortable chairs and a sofa, a small library of books, table games and two pianos. Residents in Beckett unit had direct access to the attractive courtyard garden. This garden featured paving, well planted shrubbery, art work and an outdoor exercise bike. Staff reported that there was funding in place and plans to install two more exercise machines in the garden.

The recreation timetable for Fownes and Beckett units featured current affairs, quizzes, board games, a music group, a book club, art and crafts and an accompanied walk. The provision of these activities depended on nursing staff availability. One resident expressed a wish to be able to buy a daily newspaper rather than wait for the current affairs group.

Conolly Norman day room and dining room were used for activities. An art group, watching movies and an aromatherapy group were provided for residents. Residents could read and engage in art and craft activities on an individual basis also.

The Jonathan Swift Clinic was rated as compliant in recreation provision. Better recreational facilities in Fownes unit and a clear process for resourcing and reviewing recreational provision in the approved centre were required.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.10 Regulation 10: Religion

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

Inspection Findings

Processes: The centre had a policy covering facilitation of access to religious needs. Staff were familiar with the policy and associated procedures and, where possible, residents were facilitated in their religious needs.

Training: Interview with staff indicated that, as part of induction, training procedures and processes dealing with religion had been covered. Staff indicated a clear understanding of their responsibilities in this area.

Monitoring of Compliance: Processes and needs were reviewed on an ongoing basis.

Evidence of Implementation: Residents had access to ministers for the main faiths and arrangements were in place whereby representatives of various other faiths could be contacted if necessary. Subject to clinical needs, residents were facilitated in attending services within the hospital or externally. Provision was in place to ensure end of life care in accordance with religious preference.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.11 Regulation 11: Visits

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

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

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

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

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

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

Inspection Findings

Processes: The centre had a written policy dealing with visiting arrangements. This policy defined roles and responsibilities in relation to the communication and monitoring of the policy. Provision was included for visits by children and for the refusal (in exceptional circumstances) of visits.

Training: Staff interviewed were familiar with the procedure regarding the facilitation of visits to residents.

Monitoring of Compliance: There was no documented incidence of failure to facilitate visits.

Evidence of Implementation: Visiting arrangements, including times, were documented on notice boards throughout the approved centre. Provision for children was outlined. Private visits were facilitated subject to space limitations, particularly on Fownes Ward.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: The centre had a current written policy dealing with communication by residents. This covered issues such as privacy and freedom to communicate without impediment.

Training: Staff were aware of the necessity to facilitate communication by residents and sought to facilitate this.

Monitoring of Compliance: Incident logs did not document any non-compliance with the requirements of this policy.

Evidence of Implementation: Any denial of access to means of external communication was risk assessed and documented. It was apparent from observation, interview and documentation that residents had free access to a variety of means of communication including personal mobile phones.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.13 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy on searches. The policy outlined the procedures for searches being conducted with and without consent. Two nursing staff conducted searches. There was a clear procedure for the finding and management of illicit substances. Searches were only carried out to ensure the safety of residents and others and were required to be conducted in a manner to ensure dignity and privacy. The policy made provision for the attendance of security personnel in certain circumstances, such as where there was concern about potential firearms or dangerous weapons. The policy stated that a decision to carry out a search must be made by the nurse in charge in consultation with medical staff. The policy required the reason for a search, the intervention and the outcome to be recorded in the individual clinical file.

Training: Nursing staff completed searches and the induction programme addressed the policy, duties and responsibilities. Heads of discipline were responsible for informing staff about the policy and procedures.

Monitoring of Compliance: Incident report forms were completed as required. There was no procedure in place to audit or monitor searches.

Evidence of Implementation: The inspection team spoke with nursing staff in all three units and inspected two individual clinical files in relation to searches completed.

No searches in relation to current residents had been carried out in Beckett or Conolly Norman units. Two searches had been completed in Fownes unit. One resident's belongings had been searched without consent at the time of admission and dangerous implements had been confiscated and placed in safe storage. Another resident's belongings had been searched with their consent and sharps placed in safe storage. In both instances there was a record in the clinical file which stated the reason for the search, whether the resident had consented or not and the outcome of the search. It was not clear that the clinical entries were made by the person/s who completed the search. The record did not state who had completed the searches other than to say nursing staff had carried out a search. Where the resident consented this was not written consent.

Good practice requires a record entry by the persons who conducted the search. This record should provide a clear account of the reason for the search, who made the decision to complete the search and who carried out the search, how the resident was informed about the decision and process involved, the time and place and outcome of the search. Where additional persons were in attendance, for example, security personnel or the Gardaí, the record should indicate this.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.14 Regulation 14: Care of the Dying

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

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

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: The centre had written policies covering both expected and unexpected death situations. These clarified procedures and responsibilities with a focus on dignity and respect, and the required notifications.

Training: Staff interviewed were aware of the requirements in relation to both expected and unexpected death.

Monitoring of Compliance: All deaths were appropriately notified and necessary review undertaken.

Evidence of Implementation: It was policy to involve a palliative care team, where appropriate, and to safeguard the dignity and privacy of any resident who was dying through care in a single room. Particular provision was made for relatives and other representatives. Where sudden death occurred steps were taken to respect religious needs subject to required legal processes.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.15 Regulation 15: Individual Care Plan

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

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

Inspection Findings

Processes: There was a policy on individual care plans (ICPs). The admitting doctor and nurse were charged with ensuring that an initial care plan was completed at the time of admission. The multidisciplinary team (MDT) were responsible for ensuring that an ICP was developed at the next MDT meeting for each resident. Each resident was assigned a care co-ordinator. The care co-ordinator was a member of the MDT nominated to facilitate communication between the resident and their team for the length of their admission. The care co-ordinator's responsibility was to manage the care plan and ensure that it was updated and reviewed at the MDT meeting. There was a process to record each resident's weekly expectations and goals in relation to their care and treatment. Residents attended the weekly MDT review meeting unless they wished not to do so. Residents were informed about the ICP process in the Jonathan Swift Clinic Information Booklet and in posters displayed within the units.

Training: Heads of Discipline were responsible for ensuring staff were informed about the ICP policy and procedures. The ICP policy and procedures were included in the induction programme for new staff.

Monitoring of Compliance: There was a weekly ICP audit completed by the Clinical Nurse Managers and the Assistant Director of Nursing. The results were communicated to each MDT. The Executive Clinical Director was informed of results.

Evidence of Implementation: The inspection team spoke with medical, nursing, OT and clinical psychology staff and with a number of residents. There were 43 in-patients in the Jonathan Swift Clinic on the first day of inspection and all of the clinical files were inspected.

Those residents admitted within the previous couple of days had initial care plans in place. All other residents had an ICP recorded in their clinical file. A pro forma ICP document was used and made provision for the recording of assessed needs, goals, interventions, who was responsible, review and outcome. The ICP template was landscape style and so provided sufficient space for adequate elucidation of the ICP. The standard of recording was good in all but a couple of instances. In these instances the specification of the resource or person responsible for delivering interventions was vague and was recorded as "team" with no clear assignment or timeframe for delivery. Likewise, the signature of the author recording the ICPs was poorly recorded and consisted of an illegible squiggle. Residents in the majority of cases signed their ICP document.

There was clear evidence of regular ICP reviews. In Beckett and Fownes units the weekly MDT review of an ICP was recorded on a sticky-backed sheet and this was completed and pasted into the clinical progress notes. The records clearly showed who attended the MDT meeting, the updated issues and targeted interventions and who was responsible. It was easy to both locate the ICPs in the clinical files and to track issues, progress and outcomes. The records showed evident interdisciplinary collaboration. The ICPs showed regular consultation with family and carers. The ICPs in Conolly Norman were also reviewed regularly and the standard of recording was good. Each resident in the Jonathan Swift Clinic was risk reviewed at the weekly MDT meeting as part of the ICP process.

Each resident was provided with a pro forma document to record their expectations, goals and concerns at the end of each week. These forms were placed in the clinical file and provided a clear account of a resident's views and expectations at that time. Where a resident declined to complete or did not wish to attend their weekly multi-disciplinary ICP review meeting, this was recorded. Nursing staff reported that some residents considered the MDT setting as intimidating. On enquiry by the inspection team about the process for providing a resident with a copy of their ICP if they so wished, staff stated that there was no defined process for doing so. The inspection team spoke with some residents about the ICP process. While aware in general terms of the goals and progress required for discharge, none had a copy of their ICP and goals within a weekly timeframe were less clear.

Each resident had an ICP and the scope, MDT input, review and clarity of recording merited a rating of compliant – excellent achievement.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: There was a policy on therapeutic services and programmes. The policy was aspirational and vague. It stated that the approved centre was committed to providing therapeutic services and programmes as required by this regulation. It stated that each sector team “will strive to have a fully staffed” MDT and that each resident would have access to an appropriate range of therapeutic interventions. The policy did not address the processes and procedures required to deliver such interventions. Nonetheless, it was evident that nursing and health and social care professionals within the approved centre collaborated to provide therapeutic services and programmes and this was timetabled. The policy needed to be updated to reflect practice.

Training: All staff providing therapeutic services and programmes were professionally trained and supervised.

Monitoring of Compliance: Records of attendance, engagement and outcomes were maintained in relation to therapeutic services and programmes in Beckett and Fownes units. There was a discharge planning committee comprising nursing and health and social care staff. The minutes of this committee showed that they effectively reviewed and monitored many aspects of the therapeutic services provided and recommended improvements. There was no structured forum for the overall review and strategic planning of therapeutic services and programmes within the approved centre.

Evidence of Implementation: The inspection team visited Fownes, Beckett and Conolly Norman units and the OT department. The team spoke with nursing and health and social care professionals and an art teacher. Individual clinical files were inspected to identify the provision of therapies and services to meet assessed needs.

Each unit had a timetable of therapeutic programmes clearly posted. The services and programmes provided addressed physical and psychosocial health and wellbeing. Individual and group interventions were provided and these were well recorded in the individual clinical files. The culture in the Jonathan Swift Clinic was recovery oriented and outward looking. The unit information posters about therapeutic activities included offerings in sector day centres and local voluntary groups such as community centres, AWARE and Mental Health Reform. Some residents attended programmes in the day hospitals. There was a core therapeutic day provided for in-patients in the approved centre. Clinical psychology provided three groups per week which were process groups aimed at providing an opportunity to express and reflect on individual experiences. Clinical psychology also provided an eight week programme which dealt with metacognitions and psychosis. Occupational therapy provided a range of creative, directive and recovery oriented

occupational groups in addition to individual OT assessment and therapies. Social work provided individual assistance with accessing welfare and accommodation, family work and a discharge group. Nursing staff provided a number of recovery oriented groups.

The OT department contained a pottery room, an activities of daily living room, a kitchen and a large multiactivity group room. The OT department had previously provided outdoor activity and gardening activities. The newly built seven storey unit located some feet away from Jonathan Swift Centre severely limited natural light on one side of the OT department and had eliminated gardening as an option for residents. The art teachers were also ceramicists and residents' creative works were plentiful throughout the OT department.

Inspection of individual clinical files showed that residents had access to therapeutic services and programmes in accordance with their ICPs. Each discipline recorded therapeutic interventions and progress in the clinical files. A pro forma sticky-backed report form was used for some groups and succinctly captured key aspects of a resident's participation and progress.

The range of service provision, the clear linkage to ICPs and risk assessment and the quality of recording in individual clinical files merited a rating of compliant- excellent achievement.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.17 Regulation 17: Children's Education

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

Inspection Findings

As no children had been admitted or were resident within the approved centre during this inspection, this Regulation was not inspected.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

3.18 Regulation 18: Transfer of Residents

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

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

Inspection Findings

Processes: There was a policy on the transfer of residents both internally within the approved centre and external transfer to another healthcare facility, including the transfer of a detained patient. Roles and responsibilities were clearly stated. The policy required the treating doctor to complete a transfer letter with a copy retained in the clinical file. The reasons for transfer were documented in the clinical file. The responsible consultant or nominated member of the treating team were required to liaise with the other hospital and arrange the transfer, preferably during business hours. Nursing staff were required to complete a nursing transfer letter. The MDT team was required to update the risk assessment prior to transfer. A copy of the residents' MDT notes including risk assessment were copied and forwarded to the receiving facility or accompanied the resident on transfer. The policy required all statutory forms to be faxed, checked and signed off by the treating consultant.

Training: It was the responsibility of discipline heads to ensure medical and nursing staff were informed about the protocols and procedures in relation to the transfer of residents and the transfer of relevant clinical data, having regard for consent and privacy. The induction programme addressed the transfer of residents.

Monitoring of Compliance: There was no evident process for the monitoring or audit of information transfer when a resident was being transferred to another ward or healthcare facility.

Evidence of Implementation: The inspection team discussed with nursing staff the process and procedures for transferring information when a resident was being transferred. Two individual clinical files were inspected. Both related to residents transferred to a Psychiatric Intensive Care Unit. The relevant policies and procedures were inspected.

Nursing staff provided a clear account of the processes and procedures relating to the transfer of information where a resident is being transferred. The nursing transfer form was in the process of being updated and a new transfer form which is being introduced was inspected. The two clinical files inspected provided a clear account of the decision to transfer, the risk assessment completed prior to transfer and the clinical documentation provided to the receiving facility in advance. Both transfers were planned and agreed in advance with the receiving facility. Copies of the medical referral letters and reports were retained in the clinical files. A record of the faxes sent were retained in the clinical files along with a record of the receiving facilities requirements in relation to accepting the referral. The transfers were facilitated by an assisted admission service and details were retained in the clinical file. A copy of the medication prescription form accompanied the resident on transfer.

There was no copy of the nursing transfer form in the clinical files or a property checklist for the residents being transferred.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.19 Regulation 19: General Health

(1) *The registered proprietor shall ensure that:*

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

(2) *The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.*

Inspection Findings

Processes: The centre had a clear policy covering the provision of general health services including screening services. A separate documented policy covered procedure for addressing medical emergencies. These policies included provision for the safeguarding of resident privacy and dignity and procedure and documentation to ensure that required physical examinations were undertaken.

Training: Staff interviewed were familiar with requirements in relation to general health provision. Training had been provided to staff in relation to basic life support (BLS) and emergency response and this was documented.

Monitoring of Compliance: An audit process was in place dealing specifically with six-monthly physical reviews. Physical reviews and screening processes were documented and recorded.

Evidence of Implementation: Review of clinical files and interview of staff indicated that appropriate physical assessment on admission and as required thereafter was undertaken. Adequate provision for safeguarding privacy and dignity was available. Specific general health interventions were documented in the ICP. All resident stays over six months had an up-to-date physical review documented. Where appropriate residents were referred to the general hospital for specialist services. An emergency trolley was available and this was checked weekly. Information regarding recommended national screening was provided to residents and they were encouraged to avail of this.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.20 Regulation 20: Provision of Information to Residents

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

- (a) details of the resident's multi-disciplinary team;*
- (b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;*
- (c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;*
- (d) details of relevant advocacy and voluntary agencies;*
- (e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.*

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

Inspection Findings

Processes: There was a comprehensive policy on the provision of information to residents and families. On admission, the policy required staff to provide all residents with clear and easily understood oral and, where practical, written information about the facility, diagnosis and treatments (including medications) unless instructed otherwise by the consultant psychiatrist responsible for their care. The admitting nurse was charged with providing a resident with information about the admission processes, the treating team, and housekeeping arrangements such as visiting and meal times. There was a patient treatment contract provided to each resident on admission. This outlined information about smoking, illicit use of alcohol and drugs and use of mobile phones. Patients were provided with written information about their rights under the Mental Health Act 2001.

It was the responsibility of all staff administering medication to ensure that all residents were aware of the nature, purpose and likely effects of prescribed medication. Staff had access to the Choice and Medication and the Royal College of Psychiatrists websites on behalf of the residents on each ward. Information could be visually displayed and supplied in written format.

The policy charged each member of the multidisciplinary team with professional responsibility to actively participate in information giving and exchange. This was done through engaging with each resident to ensure they had full comprehension of the information given, answering any questions they had and encouraging them to seek further information or clarification where required. The policy promoted a culture of information giving.

Training: Each head of discipline was responsible for informing staff about the policy and procedure. The induction programme addressed the information provided to residents at the time of admission.

Monitoring of Compliance: There was an audit of the information publicly displayed within each unit. There was an admission checklist of the information provided to a resident on admission and this was audited.

Evidence of Implementation: The inspection team spoke with nursing staff, the pharmacist, health and social care professionals and residents. The team inspected the information booklet, the information posted throughout the approved centre and the information leaflets on diagnoses, medicines and side effects of medicines provided at the nurses' station.

It was evident that residents had been informed of their diagnosis, the contract for care and the information booklet. A discharge group was provided three times per week and this forum provided residents with information about follow up and community services.

The quality of the content of the information leaflets was very good. The pharmacist provided the information leaflets on medicines and on side effects. The pharmacist met with individual residents to discuss medication and to answer questions. The nursing staff provided the information leaflets about diagnoses. Nursing and OT staff oversaw the information publicly posted within the approved centre.

Compliance Rating

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: The Centre had a comprehensive policy dealing with requirements in relation to safeguarding the dignity and privacy of residents, their information and their property. Staff interviewed were familiar with the requirements on this policy and their own role in safeguarding privacy of residents.

Training: As part of their induction training, all staff were educated regarding the requirements in the approved centre to ensure privacy to residents.

Monitoring of Compliance: There was no formal audit process documented to review issues relating to privacy. Incident reports did not identify any incidents or complaints relating to failure to safeguard privacy.

Evidence of Implementation: Subject to the overall physical limitations of the approved centre (and particularly of Fownes ward) it was apparent from documentation, observation and interview with staff that all possible steps were taken to maintain the dignity and privacy of residents. Residents could wear their own clothing and limited facilities were available for private engagement with clinical staff and other visitors. Staff were respectful of the rights of residents in this regard. The residents had access to personal phones and other means of communication.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.22 Regulation 22: Premises

(1) The registered proprietor shall ensure that:

- (a) premises are clean and maintained in good structural and decorative condition;*
- (b) premises are adequately lit, heated and ventilated;*
- (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.*

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

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

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

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

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

Inspection Findings

Processes: The centre had a policy covering general aspects relating to the suitability of the premises. Previous inspection reports have negatively commented on the lighting and space available, particularly access to outside space. This applied particularly to Fownes ward which had a claustrophobic feel with poor sight lines and limited recreational and therapeutic facilities for residents. These long-standing difficulties have now been exacerbated by the building of a seven-floor building within metres of the centre. Privacy and access to natural sunlight will be seriously impeded, particularly in winter. Current physical design is unsuitable to adequately meet mental health needs with respect for privacy and dignity. Bathroom facilities on Fownes ward had been partially renovated but remained inadequate. The layout of Becket ward remains inefficient. Staff interviewed indicated that negotiation had commenced with the hospital management seeking the provision of a suitable alternative premises but that this was at an early stage.

Training: Staff interviewed confirmed the inadequacy of the physical premises. Documentary evidence was available that the staff had been trained in various processes relating to the safe operation of the unit.

Monitoring of Compliance: A number of audits relating to the premises were ongoing (Health & Safety, Hygiene). Where necessary, the centre had access to infection control oversight

within the main hospital. Routine maintenance was undertaken and records observed confirmed this.

Evidence of Implementation: As noted above, the physical suitability of the centre to provide adequate opportunity for the maintenance and improvement of mental health was seriously in doubt. Personal space was limited and access to outdoor space was limited due to design and security limitations. Access to natural light was significantly impaired in various areas of the centre and this issue is likely to be exacerbated on a seasonal basis. Availability of suitable therapeutic and recreational space was limited, particularly on Fownes ward. While there was a daily cleaning schedule the design and relative overcrowding of the acute unit presented difficulties in maintaining an adequate standard of hygiene.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
	X			

Risk Rating

Low	Moderate	High	Critical	Not - Applicable
X				

3.22 Regulation 22: Premises

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

Date received	16 th September 2015			
CAPAs	Specific	Measureable	Achievable & Realistic	Time-bound
Define the action <u>and</u> state if it is corrective or preventative <u>and</u> state post-holder(s) responsible	Define the area of non-compliance addressed by this CAPA	State method of evaluation and monitoring of outcome	State feasibility of action	State time-frame for completion of action
<p>1.Preventative Action</p> <p>The Registered Proprietor will write to the CEO of St. James's Hospital with a view to progressing discussions regarding the future opportunities for a major capital development on site. Representatives from the HSE Estates Department will also be involved in such discussions.</p> <p>Post-Holder(s): Registered Proprietor Mr Kevin Brady, General Manager</p> <p>Executive Clinical Director Dr Brendan McCormack</p>	Inadequacy of the physical premises	The executive management team will review the outcome of the meetings in three months.	This action is both achievable and feasible within the specified timeframe. The ECD has already made contact with the CEO of St James's and following that meeting the General Manager will write to the CEO of ST James's to set up	3 Months. (December 2015)

			meeting with HSE Estates.	
<p>2. Corrective Action</p> <p>Engagement will take place locally with both HSE Estates and Maintenance Department at St. James's to look at improving the wards with minor capital works. It is envisaged that an options appraisal will be carried out within the next 3 months with a view to securing funding in the short term that will assist in enhancing the physical environment.</p> <p>Post-Holder(s): General Manager Mr Kevin Brady Executive Clinical Director Dr Brendan McCormack</p>	Inadequacy of the physical premises		This action is both achievable and feasible within the specified timeframe.	3 Months. (December 2015)

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

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

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

Inspection Findings

Processes: The approved centre had extensive documented policy, derived in significant part from the general hospital, covering various aspects pertaining to the ordering, prescribing, storing and administration of medicines. A separate policy covered the requirements for response to mishaps in the medication process. It appeared that the policy did not document procedure to be followed in the event of medication refusal. The centre had the services of a full-time pharmacist to oversee and advise in relation to procedure and practice.

Training: Staff were trained in the required procedures involved in the safe and legal administration of medicines. Documentation and observation confirmed that medication administration was overseen by two appropriately qualified staff. At least two resident identifiers were utilised in the administration process. Medications, including requirements under the Misuse of Drugs Act (MDA), were appropriately stored and accounted for.

Monitoring of Compliance: Both medication kardexes and MDA stock were audited on a regular basis. An ongoing process of review of procedures was undertaken to improve practice.

Evidence of Implementation: The ordering and storing of medication was in accordance with legal and professional requirements. Records were kept documenting the administration of medicines to individual residents. Review of medication kardexes indicated a number of instances where there was a failure by the prescriber to record the Medical Council Registration Number as required by law. Documentary evidence of such practice was taken. In one case it was noted that medication was administered to a resident crushed in yogurt. While this was undertaken with the knowledge of the resident, review of the relevant clinical files did not record any formal review or authorisation by the registered medical practitioner or document consultation with a pharmacist in relation to this unlicensed administration. The pharmacist was interviewed and did recollect offering advice but this matter had not been documented. Such failure would appear to be contrary to hospital policy in relation to Medication Management (6.29 – page 18 of 34).

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
	X			

Risk Rating

Low	Moderate	High	Critical	Not - Applicable
X				

3.23 Regulation 23: Ordering, Storing, Prescribing and Administering Medicine

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

Date received	16 th September 2015			
CAPAs	Specific	Measureable	Achievable & Realistic	Time-bound
Define the action <u>and</u> state if it is corrective or preventative <u>and</u> state post-holder(s) responsible	Define the area of non-compliance addressed by this CAPA	State method of evaluation and monitoring of outcome	State feasibility of action	State time-frame for completion of action
<p>1. Corrective Action</p> <p>The approved centre will amend the existing medication management policy to incorporate a refusal of medication, within 3 months. A working group will be established at the policy meeting on 2nd September 2015 to draft an amendment within 4 weeks. The draft amendment will come back to the policy committee for approval and distribution to Heads of Discipline and Clinical Director for final approval.</p>	<p>The refusal of medication is not addressed in the current Medication Policy.</p>	<p>There is a clear method and practice of policy development in St James's.</p> <p>Policies once appropriately ratified, are reviewed every 2 years unless a change in practice or</p>	<p>This action is achievable and realistic and has already commenced. First draft is available.</p>	<p>04/11/2015</p>

Post-Holder(s): Ollie Mernagh, ADON Siobhan Ni Bhrian, Clinical Director		legislation requires an update in between.		
2. Corrective and Preventative Actions The Pharmacist and Clinical Director will remind the medical staff of their legal obligation to complete the appropriate section of the medicine kardex which details their Medical Council Registration Number (MCRN). In addition to the annual audit of Medication Kardexes, a monthly audit of Medication Kardexes to specifically look at MCRN documentation will be administered by the pharmacist and nurse management (10 Kardexes per month) to ensure compliance. Medical staff will be contacted directly and the consultant psychiatrist will be informed of episodes of noncompliance. The Clinical Director and Senior Nurse Management will be appraised of the results of the audit on a monthly basis. Post-Holder(s): Ollie Mernagh, ADON Siobhan Ni Bhrian, Clinical Director Aisling Hickey, Clinical Pharmacist.	Failure of prescriber to document MCRN	Monthly audit of 10 drug prescription sheets from the 3 wards of the approved centre. All medical staff to be contacted directly if non complaint. 3 month appraisal of results of audits by clinical director and senior nurse management.	Reminders have been sent by the CD and pharmacist. The audits and actions from the audits are feasible and realistic.	The monthly audit will commence Tuesday 29th September and be carried out every last Tuesday of the month. The annual audit will be carried out in February 2016.

<p>3. Preventative Action</p> <p>The service failed to adhere to section 6.29 of its medication management policy in relation to crushed medications. In the event of a patient receiving crushed medication, consultation will take place between the prescriber, pharmacist and nurse. This will be documented in the patient's care plan and endorsed by the medical prescriber on the medicine kardex. A safety and learning notice will go out to all relevant staff to this effect. The policy will be included in the induction programme for all nursing and medical staff.</p> <p>Post-Holder(s): Ollie Mernagh, ADON</p> <p>Siobhan Ni Bhrian, Clinical Director</p> <p>Aisling Hickey, Clinical Pharmacist</p>	<p>Failure to adhere to the services' medication management policy (Section 6.29) in relation to documentation of the communication between the team and pharmacist about the crushing of medication.</p>	<p>As part of the monthly MCRN audit, the pharmacist will check on each ward whether a patient is receiving crushed medications and if so check is the appropriate documentation completed on the care plan and kardex.</p>	<p>These actions are feasible and realistic. The nursing staff are updated and reminded of the policy through the daily "safety pause" on the wards.</p> <p>The nurse managers of the three wards have been informed and will liaise directly with the staff nurses.</p>	<p>All new nursing staff will be informed of this practice on induction and the NCHDs will be informed on induction every January and July.</p> <p>A safety and learning notice will go to all staff in September 2015.</p> <p>The monthly check will commence September 29th, 2015</p>
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3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a comprehensive Health and Safety statement specific to the Jonathan Swift Clinic. The statement clearly identified the persons responsible for both overall responsibility for Health and Safety and those with responsibility for specific aspects. Identified hazards were risk rated and controls put in place. There was an emergency plan in place. The Deputy Chief Operations Officer in St. James's Hospital had designated responsibility for overseeing Health and safety. There was an occupational health and Safety employee assistance programme in place.

Training: Staff were appropriately trained commensurate with their roles in relation to Health and Safety. The training record showed that staff were trained in manual handling, handwashing, infection control, fire safety, the prevention and management of violence and aggression, the management of sharps, the use of personal alarms and the prevention of slips, trips and falls.

Monitoring of Compliance: The Health and Safety statement was reviewed and updated annually. There were a number of Health and Safety audits conducted on a monthly basis within the approved centre. The take up of vaccinations was audited. The fire safety equipment was tested on a regular basis.

Evidence of Implementation: The inspection team walked through the approved centre, talked with nursing staff and read the Health and Safety documentation.

Each unit had a copy of the Safety Statement, but this was not displayed in the approved centre. Staff were aware of the Health and Safety structures and roles, including the identity of the Health and Safety officer and the Health and Safety representatives. The service had a Risk Register, which was viewed by the inspector. There was a clear and detailed fire management plan in place of which staff were aware. Information about what to do in the event of a fire was posted in a user friendly format in each unit. The fire safety inspection report was inspected. Handwashing facilities were provided in prominent positions throughout the units and were well signposted. The Safety Statement contained an Emergency Planning section. Responsibility for infection control was managed by the infection control nurse located in the general hospital. Staff had separate shower and changing facilities. Nursing management conducted a monthly Health and Safety checklist in each unit.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
			X	

3.25 Regulation 25: Use of Close Circuit Television (CCTV)

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

- (a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;*
- (b) it shall be clearly labelled and be evident;*
- (c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;*
- (d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;*
- (e) it must not be used if a resident starts to act in a way which compromises his or her dignity.*

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

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

Inspection Findings

CCTV was not used in the approved centre and there was a policy to this effect. This Regulation was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

3.26 Regulation 26: Staffing

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

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

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

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

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

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

Inspection Findings

Processes: The approved centre had a written policy relating to the recruitment, selection and vetting of staff. The policy covered supervision, staff mix, induction and training issues.

Training: Staff interviewed were aware of the policy and its implications for their own situation. Staff at management level were trained in review and evaluation processes.

Monitoring of Compliance: Staffing needs and any deficits occurring were kept under continuous monitoring by management. Efforts to improve staffing ratios were complicated by recruitment and retention bottle-necks.

Evidence of Implementation: There was an organisational chart identifying management and supervisory roles and staff interviewed were familiar with this. Personnel files of two staff were reviewed and these incorporated recruitment processes, evidence of Garda vetting, reference processes, evidence of qualification and experience, copy of terms and conditions applying to the particular post, evidence of training and performance evaluation. Evidence of induction training was also available. Staff training records were provided which indicated an ongoing process of training in both mandatory and elective areas. Mandatory training requirements were up to date. Staff interviewed outlined the processes in place to supervise and evaluate new staff. Observation and review of documentation confirmed that there was an appropriately qualified member of staff in charge of each of the wards within the centre at all times.

Discussion with management indicated that progress had been made in addressing previously identified critical vacancies, e.g. OT. Short-term nursing vacancies were covered either on an overtime basis or, where necessary, through the use of agency nurses. Management outlined difficulties and frustration at delays in nursing recruitment due to the necessity to process vacancies through the HSE National Recruitment Service process. Concern was expressed by management of various disciplines within the centre at the loss of experienced staff and their eventual replacement by relatively inexperienced staff.

Management of health and social care disciplines complained of the significant service disruption associated with inability to replace staff on maternity leave.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
			X	

3.27 Regulation 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

Note: Actual assessment of food safety, health and safety and fire risk records is outside the scope of this Regulation which refers only to maintenance of records pertaining to these areas.

Inspection Findings

Processes: There was a policy on the maintenance of records. The scope of the policy addressed the setting up, maintenance, access to, retention and destruction of records. The ward clerk and the admitting nurse had responsibility to make up the admission clinical files. Each clinical file contained a standardised contents list and dividers. All MDT members were charged with responsibility to maintain records according to the policy. There was a staff signature log. The policy addressed resident confidentiality and secure storage of records.

Training: The induction programme for staff included record management.

Monitoring of Compliance: There were monthly audits of nursing records. There was a weekly audit completed on the admission records and the ICP records. An annual audit was completed on the discharge records and the medicine prescription and administration record.

Evidence of Implementation: The inspection team reviewed the records for food safety and hygiene, fire safety and the clinical files.

The most recent Environmental Health Officer's report and the fire inspection reports were available for inspection. The clinical files were well maintained. The contents were well ordered and information was readily accessible. The entries from all disciplines were clearly identifiable and records were in chronological order. The frequency and quality of clinical progress notes were good and provided a clear account of care and treatment. This included telephone discussions or meetings with families and carers, and weekly accounts of each resident's own views and expectations.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.28 Regulation 28: Register of Residents

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

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

Inspection Findings

Processes: The centre maintained a register consistent with the requirements of this Regulation. An edited extract of the daily register was provided to the inspectors in documentary form and access to the full register in electronic form was made available.

Training: Relevant staff were trained and familiar with the requirements of this regulation.

Monitoring of Compliance: The Mental Health Act Administrator undertook a regular review of the Register to ensure compliance with the requirements for Schedule 1.

Evidence of Implementation: An up-to-date register was maintained and access to this was controlled.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.29 Regulation 29: Operating Policies and Procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

Inspection Findings

Processes: A comprehensive set of operating policies and procedures were made available to the inspectors. These defined the responsibilities and review process, including frequency of review. All relevant policies were up to date.

Training: Staff interviewed were aware of the policies and the various processes associated with them. Training was provided as part of induction training.

Monitoring of Compliance: A process was in place to monitor and review relevant policies and to make them more user-friendly through the use of simpler language.

Evidence of Implementation: Policies had been developed and reviewed by a multi-disciplinary team within the centre and had been approved by management. Policies took account of relevant legislation. Staff were familiar with the policies and the policies were available in both hard-copy and electronically.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

3.30 Regulation 30: Mental Health Tribunals

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

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

Inspection Findings

Processes: There was a policy on Mental Health Tribunals. This policy clearly outlined the roles and responsibilities of staff in relation to the provision of information to residents, the support an information regarding Tribunal process and attendance.

Training: Staff were trained in relation to the tribunal process, patient rights under the Mental Health Act 2001 and facilitating patients in attending hearings. Training was documented.

Monitoring of Compliance: Policy and procedures were monitored by the designated Mental Health Act Administrator and any improvements deemed necessary were implemented.

Evidence of Implementation: The inspection team visited the room assigned for Mental Health Tribunals, spoke with nursing staff and the Mental Health Act Administrator. The team observed a resident being facilitated to attend their tribunal.

Tribunals were held in a room designated for the purpose, and were convenient for the patient to attend. All necessary facilities, including the availability of staff to accompany a patient when necessary, were made available.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.31 Regulation 31: Complaints Procedure

(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 complaints policy which identified a nominated person to receive complaints and a process for addressing complaints. Notices advising residents on procedure for making complaints along with timeframe for response were displayed prominently throughout the approved centre in prominent locations. A complaints log was available and was reviewed by the inspection team.

Training: Staff interviewed were familiar with the complaints process. They indicated that all possible efforts were made to address complaints locally and that a process was in place to advise residents regarding the availability of an independent advocate to assist with any complaints process.

Monitoring of Compliance: Review of documented complaints indicated that all complaints were dealt with in a timely manner. Management reviewed complaints on a regular basis and any changes deemed appropriate were put in train.

Evidence of Implementation: Staff were aware of their relative roles and responsibilities in addressing complaints. Review of complaints made indicated a consistent and transparent approach to dealing with complaints. Complaints were appropriately logged and follow-up was documented. Complainants were informed of the outcome of their complaints and options offered to them.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – Excellent Achievement (4)	Not- Applicable
			X	

3.32 Regulation 32: Risk Management Procedure

(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 centre had a clear and extensive policy dealing with various aspects of risk management. Staff interviewed were familiar with the general requirements of the policy. The policy addressed various clinical and operational risks and defined responsibility for managing such risk. A procedure was in place to monitor and review risk assessments and staff were familiar with this. The policy did not specifically address the needs of children admitted to the centre.

Training: Staff interviewed were familiar with the policy and had received specific training as part of the induction process.

Monitoring of Compliance: A process was in place for the monitoring and auditing of all incidents and for implementing recommended changes.

Evidence of Implementation: All residents had regular risk assessments undertaken to assist and guide management. Both frontline and management staff had clear understanding of responsibility in relation to monitoring and addressing risks arising. Health and Safety risks were identified. The incident reporting process was used in tandem with the risk management to stratify risks arising. Clinical risks were regularly reviewed by the MDT. Relevant notification of deaths occurring were made to the MHC (Mental Health Commission) as required.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not- Applicable
		X		

3.33 Regulation 33: Insurance

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

Inspection Findings

Processes: The approved centre was insured by the State Claims Agency.

Training: Management of the centre were aware of the insurance requirements and the necessity to ensure that compliance was up to date.

Monitoring of Compliance: Management kept the scope of insurance under ongoing review to ensure that adequate cover was maintained.

Evidence of Implementation: A copy of the statement of insurance cover was provided.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

3.34 Regulation 34: Certificate of Registration

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

Inspection Findings

Processes: The Registered Proprietor had a process in place to ensure display in a suitable public place of the current Certificate of Registration

Training: Staff were aware of the requirements in relation to this Regulation, including information to be submitted in relation to renewal.

Monitoring of Compliance: The Registered Proprietor undertook review of the Certificate to ensure that it accurately reflected the service being provided.

Evidence of Implementation: The centre had the current Certificate of Registration prominently displayed. There were no conditions currently attached.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 Section 59: The use of Electro Convulsive Therapy Section 59

((1) "A programme of electro-convulsive therapy shall not be administered to a patient unless either –

- (a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
- (b) where the patient is unable or unwilling 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

ECT was not provided within the approved centre and therefore this Rule did not apply.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

4.2 Section 69: The use of Seclusion

Mental Health Act 2001

Bodily restraint and seclusion

Section 69

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section "patient" includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient"

Inspection Findings

Seclusion was not used in the approved centre.

Mechanical Restraint Part 5 was not used in the approved centre.

This rule was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

4.2 Section 69: The use of Mechanical Restraint

Mental Health Act 2001

Bodily restraint and seclusion

Section 69

(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.

(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.

(4) In this section "patient" includes –

(a) a child in respect of whom an order under section 25 is in force, and

(b) a voluntary patient"

Inspection Findings

Mechanical restraint was not used in any situation within the approved centre and this Rule did not apply.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

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

5.1 Part 4: Consent to Treatment

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

- (a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and*
- (b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.*

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

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

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

- (a) the patient gives his or her consent in writing to the continued administration of that medicine, or*
- (b) where the patient is unable or unwilling 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

Processes: The centre had a defined process in place to ensure compliance with this section of the Act. The documented process included consideration of capacity, provision of relevant information (including necessary supports), and a process for obtaining an appropriate second opinion where required.

Training: Staff were aware, and understood the requirements, of this section of the Act. Training in the requirements of the Mental Health Act was documented.

Monitoring of Compliance: Review of incident reports did not indicate any failures to adequately address the requirements of this Rule.

Evidence of Implementation:

One patient had been in the approved centre for longer than three months. A form 17 (second opinion) consent provided within the previous three months was available in the patient's file.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

6.0 Inspection Findings and Required Actions – Codes of Practice

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

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

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

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

6.1 Physical Restraint

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

Inspection Findings

Processes: The service had an up-to-date policy on the use of physical restraint which was reviewed annually. This policy identified the need for all staff to be trained in the use of physical restraint and those who may initiate restraint. The policy stated that where security personnel were involved in restraint this was under the direction of the nurse in charge. The training specified in respect of physical restraint did not make reference to the use of physical restraint of children who may be resident.

Training: Staff were trained in the application of physical restraint and in the therapeutic management of violence and aggression, including de-escalation techniques. Some staff had been trained as trainers.

Monitoring of Compliance: There was no evidence of audit or analysis of the use of physical restraint. Incident forms were completed where appropriate.

Evidence of Implementation: The inspection team reviewed two Clinical Practice Form Books for physical restraint, the clinical files of five residents who had been restrained, the staff training record and also spoke with nursing staff.

Physical restraint had been used on 40 occasions in 2015 to date. Physical restraint had only been used in the acute Fownes unit. Overall, the standard of completing the orders for physical restraint in the Clinical Practice Form Book was good. In two instances, the responsible consultant psychiatrist had not signed the form within the required timeframe. In

one instance the signature of the responsible consultant psychiatrist was illegible and no MCN was used.

Each of the clinical files inspected showed that physical restraint had been used for the safety of the resident or others. Only nursing staff had been involved in applying physical restraint. The clinical files indicated that de-escalation attempts had been used where appropriate prior to restraint. In each of the instances the residents were acutely unwell. Physical restraint had been used for a brief period of minutes. The episode of restraint was subsequently discussed with the residents except for two instances where the residents were not well enough to do so. Next of kin were informed, and where this was not done the reason was stated. Four residents were medically reviewed within three hours and one resident refused an examination. The responsible consultant psychiatrist was informed of the use of physical restraint. A copy of the physical restraint form was placed in each of the individual clinical files.

The staff training in physical restraint was up to date.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

6.2 Admission of Children

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

Inspection Findings

The clinical files of two children admitted to the approved centre since the last inspection were examined. One admission was an overnight crisis admission which led to early discharge. The other admission had reached 18 years and was in receipt of ongoing treatment elsewhere.

Processes: The approved centre had a number of policies dealing with the admission, welfare, leave arrangements and education arrangements for those under eighteen. These policies were up to date. The policy covered such areas as the admission process, risk assessment, communication with families, and the requirements in relation to both voluntary and involuntary admission of children. Staff interviewed were familiar with the requirements of the policy.

Training: Training records indicated that a number of staff of the approved centre had received training in the Children First National Guidelines and planning was in train to undertake further staff training.

Monitoring of Compliance: There was no documented evidence of an annual audit being undertaken and incident reports did not indicate evidence of non-compliance.

Evidence of Implementation: Review of the clinical files of both children admitted indicated that these admissions occurred on an exceptional basis. The centre did not incorporate age-appropriate facilities and programmes for children. In view of the physical constraints of the centre, it was necessary to provide children with a single room. There was no evidence of specific educational planning being undertaken. Age appropriate advocacy services were not routinely available. There was no input from a Child and Adolescent Mental Health Service (CAMHS) to the approved centre. Required notifications were forwarded to the MHC. Appropriate consents were obtained.

Because of the lack of age appropriate facilities and programmes (4.2.2 of the Judgement Support Framework) the approved centre was considered to be non-compliant with this Code of Practice.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
	X			

Risk Rating

Low	Moderate	High	Critical	Not - Applicable
	X			

6.2 Admission of Children

The following Corrective and Preventative Actions (CAPAs) were provided by the Registered Proprietor or nominee and are subject to ongoing review by the Mental Health Commission. All actions should be Specific, Measurable, Achievable, Realistic and Time-bound with defined responsibilities for implementation:

Date received	16 th September 2015			
CAPAs	Specific	Measureable	Achievable & Realistic	Time-bound
Define the action and state if it is corrective or preventative and state post-holder(s) responsible	Define the area of non-compliance addressed by this CAPA	State method of evaluation and monitoring of outcome	State feasibility of action	State time-frame for completion of action
<p>1. Preventative Action</p> <p>The service will engage with the Child and Adolescent Mental Health Service to cease the practice of admitting children to the adult unit in emergency situations. This will be facilitated by the opening of the new CAMHS building in Ballyfermot which is due to handed over from the developer to the HSE at the end of September 2015</p>	Lack of age appropriate facilities and programmes for children.	The ECD, Clinical Director for Adult Mental Health Services and the Clinical Director for CAMHS have regular meetings to monitor and review progress	<p>Protocols are currently being agreed regarding the assessment of children in the Emergency Department and referral for admission to the CAMHS unit.</p> <p>If no CAMHS beds are available</p>	Currently implemented.

Post-Holder(s): Executive Clinical Director Dr Brendan McCormack, Clinical Director Dr Brendan Doody, Clinical Director Dr Siobhan Ni Bhriain			admission to the adult unit may occur.	
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6.3 Notification of Deaths and Incident Reporting

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

Inspection Findings

Processes: A process was defined and in place within the centre to notify the MHC of all deaths occurring. Staff interviewed were aware of the process and a management process was in place to ensure that notification was made in a timely manner. Six-monthly incident summary reports were also submitted.

Training: Staff interviewed were aware and understood the requirements of this Code.

Monitoring of Compliance: There was no documentary evidence presented of current audit of the requirements of this Code.

Evidence of Implementation: Since the last inspection two deaths had occurred. Both incidents had been notified to the MHC within 48 hours. The centre had a number of policies concerning the management of incidents occurring, including specific policies relating to Risk Management. A detailed log of all incidents was provided and summary reports were provided to the MHC.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

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

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

Inspection Findings

Processes: There was a policy on the care and management of persons with a mental illness and an intellectual disability (ID).

Training: Staff had completed an online approved training programme addressing communication and the care and treatment of individuals with an intellectual disability. A half day training session had also been provided by a specialist in intellectual disability and mental health.

Monitoring of Compliance: Individual care plans were audited weekly. There was no evidence presented of any formal audit of processes relating to working with people with ID.

Evidence of Implementation: The inspection team read the relevant policy and training documents, spoke with nursing staff and inspected clinical files.

There were three residents with an intellectual disability and a mental illness. Three individual clinical files were inspected and there was a care plan in place for each resident.

Review of the clinical files of the specific residents indicated that a specific and comprehensive assessment focussed on issues pertinent to ID had been undertaken on admission. This assessment led to the generation of an ICP which included consideration of issues relevant to the particular residents. Treatment was provided on a least restrictive basis and a functional approach was taken to assessing the residents' capacity to make choices. Advocacy support was available to the residents. Family involvement was supported by nursing staff. One resident was a Ward of Court. One resident required appropriate step down facilities and the MDT had made strenuous efforts to identify and secure an appropriate facility in the community. An acute psychiatric unit was not a suitable environment for the medium to long-term care of the resident. The lack of suitable high support facilities had significant implications for the discharge care pathway and quality of life of the young resident.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
		X		

6.5 Electroconvulsive Therapy (ECT) for voluntary patients

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

Inspection Findings

ECT was not provided within the approved centre and no resident was currently receiving ECT elsewhere. This rule was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
				X

6.6 Admissions, Transfer and Discharge

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

Inspection Findings

Processes: The service had policies on admission, transfer and discharge of residents to and from the approved centre. The policies addressed issues including admission of involuntary patients, urgent referrals, admissions from a GP and admission of persons with an intellectual disability, of persons with no fixed abode and of older persons. There was a policy on transfer and discharge which addressed discharge of a homeless person, after-care following discharge and discharge against medical advice. The policy also addressed the care co-ordinator system in place.

Training: Staff were aware of the policies and procedures relating to admissions, transfers and discharges. The staff induction programme addressed these issues and discipline heads were responsible for ensuring staff had knowledge of these specific to their role.

Monitoring of Compliance: There was a weekly audit of admissions and of discharge summaries. There was a weekly audit of ICPs and these included a heading of discharge planning. There was a discharge planning committee which identified and reviewed issues related to discharge and implemented quality initiatives related to discharge.

Evidence of Implementation: The inspection team looked at the relevant policies and procedures, spoke with medical and nursing staff and with residents, and inspected individual clinical files.

The admission process was supported through the use of admission pro forma templates. Admission assessment was completed by a doctor and a nurse. The risk assessment completed at admission was jointly undertaken by the admitting doctor and nurse and counter signed. The admission documents contained a good account of the assessment process, case formulation and initial diagnosis and initial care plan. The admission assessments included a physical examination and a mental state examination. The physical, medical, psychosocial, educational and occupational histories were all adequately completed. There was evidence of family involvement and consultation where appropriate. Each resident was provided with adequate and appropriate information about their admission process and planned care and treatment. Residents were provided with a care contract to sign. An admission checklist was used to ensure a resident was appropriately supported and settled in to the unit.

There was one resident out on transfer to another approved centre. The clinical file showed that the transfer was made to secure appropriate care and treatment for the individual. The reasons for transfer had been explained to the individual and their family. The transfer was pre-planned and all relevant clinical data had been forwarded to the receiving facility. The resident was transferred on a Form 10 and this was sent in a secure fax message. A copy of the medical report, referral and correspondence with the receiving facility was retained in the clinical file. Follow up liaison between the responsible consultant psychiatrist and the

treating team in the other approved centre was recorded in the clinical file. There was no evidence of an updated property checklist or a nursing transfer form in the clinical file.

The service was compliant with Regulation 7 Clothing; Regulation 8 Personal Property and Possessions; Regulation 15 Individual Care Plan; Regulation 20 Provision of Information to Residents; and Regulation 27 Maintenance of Records.

The clinical file of one resident previously discharged and re-admitted was inspected. The resident was assessed by the consultant psychiatrist prior to discharge and the discharge plan was developed by the MDT. The discharge plan was addressed in the individual's ICP. There was evidence of discussion with the resident and family about the discharge, and a discharge summary was sent promptly to the GP. This documented details of the resident's condition, medications and follow-up plans by the treating team. The resident had been provided with a follow up appointment before being discharged from the approved centre. The plans for discharge were documented in the resident's clinical file.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Compliant – Excellent Achievement (4)	Not-Applicable
			X	