Mental Health Commission

Approved Centre Inspection Report

(Mental Health Act 2001)

APPROVED CENTRE NAME:	St Gabriel's Ward, St Canice's Hospital
IDENTIFICATION NUMBER:	AC0017
APPROVED CENTRE TYPE:	Psychiatry of Old Age, Rehabilitation
REGISTERED PROPRIETOR:	Health Service Executive (HSE)
REGISTERED PROPRIETOR NOMINEE:	Ms Anna Marie Lanigan
MOST RECENT REGISTRATION DATE:	1 March 2014
NUMBER OF RESIDENTS REGISTERED FOR:	24
INSPECTION TYPE:	Unannounced
INSPECTION DATE:	27 and 28 July 2015
PREVIOUS INSPECTION DATE:	6 March 2014
CONDITIONS ATTACHED:	None
LEAD INSPECTOR:	Mr. Liam Hennessy
INSPECTION TEAM:	Dr. Susan Finnerty, MCN 009711
THE INSPECTOR OF MENTAL HEALTH SERVICES:	Dr. Fionnuala O'Loughlin MCN 08108 (Acting)

Contents

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 and rules, 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 and rules 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 actions, and ongoing preventative actions must be clearly identified. These actions are required to be specific, measurable, achievable and timely. 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 approved centre was a 24-bed facility, although only 13 beds were occupied at the time of inspection. The centre accommodated residents under the Psychiatry of Later Life (POLL) and Rehabilitation and Recovery teams. Discussions were taking place about a possible change in the formal role of the centre to that of a dementia specific assessment unit which could have implications for the number of beds required for the unit.
The unit was a modern single storey brick facade building erected in the 1980s and annexed to an older prefabricated structure on the grounds of the former St Canice's hospital on the outskirts of the medieval city of Kilkenny. However, the approved centre was still characterized as a "ward" in St Canice's Hospital. External signage was poor or non-existent.
The centre comprised a number of corridors of moderate length branching out from a central hub. Sleeping accommodation was in two or three bedded rooms with toilet and shower facilities en suite although none of the rooms were fully occupied at the time of the inspection.
The approved centre was quiet, reasonably well lit, warm and well ventilated. Cleanliness was of a very high standard. There was good, picture based signage on most doors.
At the time of inspection, the quality of care was evidently of a very high standard. Staff interacted with residents in a noticeably caring, dignified, empathic and highly professional manner. This was entirely consistent with the declared philosophy of the approved centre which aimed "to provide a patient centred approach to care with emphasis on individuality and autonomy".
The age range of residents varied from early 60s to early 90s. There were eight residents under the care of the POLL team - four acute and four long stay – and five residents were under the care of the Rehabilitation and Recovery team. There was one Ward of Court.
While on inspection, the inspection team noted the range of activities being carried out in the centre which was led, for the most part, by the activities nurse. The range included attending Mass while accompanied at an external location, *Sonas* groups, cards and board games, outings "1:1 time" and others. Moreover, there was a Snoezellan room.

2.2 Governance

The inspection team reviewed the minutes of the monthly meetings of the Senior Management Team (SMT) which had been held since the last inspection. The meetings covered the whole of the Carlow/Kilkenny/South Tipperary Mental Health Services area and were not dedicated solely to governance at the approved centre.
The Senior Management Team comprised the Acting Executive Clinical Director, relevant consultants, senior members of the administration of the wider Carlow/Kilkenny/South Tipperary service, Director of Nursing (DON), heads of allied health professionals and consumer panel representatives. Other senior nursing and allied health professionals attended as required.
The monthly reports indicated a thoughtful and considered overview of the service as well as a focus on specific items of concern by the members of the SMT.

2.3 Inspection scope

This was an unannounced annual inspection. All aspects of the Regulations, Rules and Codes of Practice were inspected against.

The inspection was undertaken onsite in the approved centre on

- 27 July 2015 from 0930h to 1700h
- 28 July 2015 from 0900h to 1700h.

2.4 Outstanding issues from previous inspection

Three Regulations and two Rules were identified as having outstanding issues arising from the previous onsite inspection. These issues included:

- Individual Care Plans were incomplete
- Therapeutic Programmes and Activities were not clearly linked to Care Plans
- The Register of Residents was incomplete.

These were considered in the evaluation of the related Regulations and Rules, and the findings are documented within part 3 of this report.

2.5 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 15: Individual Care Plan	Low
Regulation 18: Transfer of Residents	Moderate
Regulation 28: Register of Residents	Moderate
Regulation 31: Complaints Procedure	Moderate

The approved centre has been requested to provide 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 6: Food Safety
Regulation 14: Care of the Dying
Regulation 33: Insurance
Regulation 34: Certificate of Registration
Code of Practice on Notification of Deaths and Incident Reporting

2.7 Reporting on the National Clinical Guidelines

There was one case of MRSA recorded in the approved centre since the last inspection. As the resident concerned was very elderly, the decision was taken not to move the resident to an isolation facility on another site. In consequence, the resident was nursed on the ward.

There was an infection control nurse for the Carlow/Kilkenny/South Tipperary Mental Health Services area.

2.8 Areas of good practice identified on this inspection

The inspection team became aware of five activities that indicated innovative thinking in the care of residents.

- The activities nurse used an evidence based group programme to offer cognitive stimulation therapy (CST) to people with dementia called "Making a Difference". Implementation of this programme did not require staff to have special qualifications or training.
- The Clinical Nurse Specialist in Dementia Care introduced documentation to improve communication of residents' needs between the community (including home and external care facilities) and St Gabriel's Ward. This documentation includes admission and discharge forms.
- The Clinical Nurse Specialist in Dementia Care in conjunction with ward staff encourages families and carers to complete a "Getting to know you" form.
- The occupational therapist, who attended on a sessional basis, was piloting a "Timeslips" programme in conjunction with the Butler gallery which supplied the imagery to serve as a focus for the therapy. "Timeslips"(which requires some training in relevant facilitation although not professional training as such) has as its objectives to improve the lives of people with memory loss through creative engagement and to lead to a situation where creative engagement is a standard practice of care for the profile of residents in the approved centre and elsewhere.
- Finally, the Clinical Nurse Specialist in Dementia Care had reached out to local primary schools whose pupils have participated in a programme of painting very attractive, large and colourful butterfly motifs on one wall of the centre. This small initiative, which it is hoped will resume in the new school year, was consistent with a focus on intergenerational contact which the approved centre wishes to develop.

2.9 Resident Interviews

While conscious of the communication difficulties facing residents at the approved centre, the inspection team conversed with a number of residents all of whom indicated their satisfaction with the care they received in the approved centre.

2.10 Feedback Meeting

A feedback meeting was held on Friday 28 August 2015 involving the inspection team and local service management.

This meeting was attended by the following –

Liam Hennessy, Assistant Inspector of Mental Health Services,
Dr Susan Finnerty, Assistant Inspector of Mental Health Services.
Clinical Director,
Area Mental Health Services Manager,

Assistant Manager, Area Mental Health Services,
Risk Manager,
Area Director of Nursing,
Area Assistant Director of Nursing,
Area Acting Assistant Director of Nursing,
Acting Clinical Nurse Manager 2,
Occupational Therapist, Psychiatry of Later Life (POLL),
Acting Clinical Placement Manager.

This meeting provided an opportunity for the inspection team to give initial feedback about the findings of the inspection which are outlined in further detail throughout this report and a facility for representatives of the service who attended to clarify any perceived omissions or oversights by the inspection team.
A number of clarifications were provided regarding aspects of the inspection process, particularly in relation to the implementation of the operation of the key worker requirement, together with an indication of progress to date on the development of a dementia assessment unit.

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 Resident

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

Inspection Findings

Processes: There was a policy with regard to identification of residents that was up to date. The processes for identification of residents were outlined in the policy. This included the use of two unique identifiers and a process for same name resident identification. Training requirements for the process of identifying residents was not in the policy. Monitoring requirements for non-compliance were also not in the policy.

Training: There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection. Staff were aware of the policy and the process contained within it.

Monitoring of Compliance: No annual audit was undertaken to determine compliance with the processes and analysis was not completed to identify opportunities for improvement in the processes. Incident reports were not completed for any non-compliance.

Evidence of Implementation: There was photographic identification for each resident in the clinical files and medication prescription and administration records. Date of birth was also used on records.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 with regard to food and nutrition available in the approved centre which was up to date. The policy outlined roles and responsibilities and the process of food management. The policy did not refer to staff training in food and nutrition processes nor did it refer to monitoring of the processes.

Training: The nursing staff had trained in nutrition as part of their professional training. No other training in food and nutrition was documented. There was no evidence available that the staff had signed as having read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: No annual audit was undertaken to determine compliance with the processes and analysis was not completed to identify opportunities for improvement in the processes. Incident reports were not completed for any non-compliance.

Evidence of Implementation: A Speech and Language Therapy service was available to residents in the approved centre on a sessional basis from the Community Care programme. Assessments included swallow and communication assessments. Appropriate dietary requirements were provided by the local catering department of the service. Food preference diaries were completed for all residents. There was a menu with a choice of meals while meals were also provided outside of designated meal times to meet residents' requirements. Finally, a Dietary Needs and Preference form was completed for each resident and reviewed as needs and preferences changed.

There was a water dispenser in the day area, which was regularly checked. Hot and cold drinks were offered at regular times during the day.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 with regard to food safety in the approved centre and it was up to date. The policy referred to Hazard Analysis and Critical Control Points (HACCP) processes. The policy also referred to relevant legislation with regard to food safety. The policy contained training requirements but did not contain monitoring of processes in relation to food safety. However, catering staff were fully aware of defined processes in relation to food safety and were able to articulate these.

Training: Catering staff had received training in HACCP. There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: The catering officer monitored and audited compliance with food safety processes.

Evidence of Implementation: There was a kitchen in the approved centre. Meals came from the nearby main kitchen in trolleys that were sealed and maintained at a safe consistent temperature. The food temperature log book was inspected and found to be in order. Hand wash facilities were available. Staff were observed to wear personal protective clothing while serving the meals. The kitchen was very clean. There was adequate storage and refrigeration. There was sufficient cutlery and crockery for all the residents.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There was a policy with regard to clothing in the approved centre, which was up to date. It did not contain reference to the residents' responsibility for their own clothes or the approved centre's responsibility to manage their clothing, which was relevant to the resident group in this approved centre. It did, however, refer to the responsibility of the approved centre to provide clothing for residents, should it be required. The policy contained the process for implementing night and day clothes changes.

Training: There was no evidence available that the staff had signed as having read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection. Staff were aware of the process with regard to clothing.

Monitoring of Compliance: No annual audit was undertaken to determine compliance with the processes and analysis was not completed to identify opportunities for improvement in the processes. Incident reports were not completed for any non-compliance.

Evidence of Implementation: Each resident had a wardrobe that contained his or her clothing. All residents were wearing clean appropriate clothing. Laundry services were available for residents. Clothes were labelled and each resident had their own individualised clothes. No residents were in their night clothes. A supply of emergency clothing was available.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There was an up-to-date policy with regard to personal property and possessions. The policy outlined the process for managing residents' personal property and possessions. This included restrictions for residents in keeping hazardous or valuable items, the requirement for a property list to be maintained and the process of return of property and possessions at the time of discharge. Monitoring of the processes was not contained in the policy.

Training: There was no evidence available that the staff had signed as having read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection. There was no documented training in the processes in regard to personal property and possessions.

Monitoring of Compliance: No annual audit was undertaken to determine compliance with the processes and analysis was not completed to identify opportunities for improvement in the processes. Incident reports were not completed for any non-compliance.

Evidence of Implementation: A property list was maintained for each resident. Each resident had a locker but it was not possible for these to be lockable due to severity of the residents' illnesses. There was a safe for valuables. Each resident had a financial account in the main office. Two staff recorded and signed for any financial transaction on behalf of a resident. No resident was capable of managing their own finances.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 no written policy on recreational activities in the approved centre. Although not a written policy as such, there was a folder labelled *Activities We Enjoy* available at the nurses' station which served as a general guide to the kind of activities that residents found meaningful.

The primary responsibility for the establishment and ongoing provision of recreational activities rested with the activities nurse who provided a programme of such activities throughout the working week. The activities nurse post was not a dedicated post and, as a consequence, the nurse could be allocated to other duties on the ward and elsewhere in certain circumstances. In those cases, the recreational programmes were curtailed although the inspection team were informed that the activities nurse did try voluntarily to give some extra time to keeping some activities going.

There was involvement by the occupational therapist in some special programmes.

Training: Other than the activities nurse and the occupational therapist, no other staff member had received specific training about the provision of recreational activities.

Monitoring of Compliance: While the participation of residents in recreational programmes was recorded in some detail and while residents' needs in this regard were all reviewed in the six months leading up to the date of the inspection, there was no process in place to monitor the overall provision of recreational activities.

Evidence of Implementation: The inspection team was provided with a schedule of the weekly programme of activities which ranged from attending Mass at an external location, attending Sonas groups to playing cards and board games. The timetable could be changed depending on residents' needs or preferences on the day. Moreover, seasonal activities and birthdays were recognised and took precedence over some planned activities to maximise orientation and enjoyment from life.

Aromatherapy was provided by one member of the nursing staff who had been trained in this therapy.

The day room had an attractive and colourful activities/orientation board on which was inscribed a theme for the day for group discussion purposes. There were board games and a television with a DVD player and appropriate DVDs in the day room. Residents found a number of these DVDs – (in particular, *Ciunas, Favourite Hymns and Prayers*) which had a relaxing quality - to be very enjoyable and they were replayed regularly.

There was an extensive enclosed garden area which was relatively underdeveloped and underused although plans were in train to redress this and to make it an attractive, user friendly, therapeutic and recreational environment.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There was an extensive policy on religion and cultural diversity.

Religious affiliation was recorded in residents' clinical files and residents were facilitated in the practice of their religion. At the time of inspection, all residents were of the Roman Catholic persuasion although contact points for ministers/officials of other religions were retained in the event that a resident might require the services of such ministers/officials.

Training: All staff were aware of the religious affiliation and needs of residents which resulted in active efforts to meet those needs.

Monitoring of Compliance: The policy on religion and cultural diversity was reviewed every three years.

Evidence of Implementation: There was a Roman Catholic chaplaincy service and Mass was celebrated on the ward once a fortnight. Staff informed the inspection team that, in the intervening week and, sometimes more often, those residents who were physically able to and who wished to do so were accompanied to Mass at an external location by the activities nurse and/or a health care assistant (HCA).

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There were processes in place to facilitate visitors to the approved centre. There were particular arrangements for facilitating children visiting a resident. Children were not permitted in all areas of the approved centre, but when accompanied by a responsible adult could be facilitated in one of two visiting areas in the centre. This was important as it enabled some residents to have contact with grandchildren in a service that had some focus on intergenerational communication. The service had a policy on visiting.

Training: Staff were aware of the arrangements relating to visiting and the attention of new staff members was drawn to these by the clinical nurse manager (CNM) in charge on induction at the point of taking up duty. The inspection team was informed that not all staff had been trained in the *Children First* guidelines.

Monitoring of Compliance: There was no evidence available to the inspection team that audits of the visiting arrangements were carried out although the policy on visiting was subject to review every three years.

Evidence of Implementation: There was an attractive and succinct *Patient and Family Information* leaflet which, as regards visiting times, indicated that relatives were free to visit the unit at any time except meal times and after 2100h. In fact, the inspection team was informed that, on occasion and when suitable, relatives did attend and help at meal times.

There was a single A4 sheet posted on the door at the entrance to the approved centre - which was locked at all times - kindly requesting visitors “to refrain from visiting during meal times and after 9pm”. The modest size of this notice was consistent with the absence of relevant external signage in the approved centre.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There was a policy on communication. The policy was last reviewed in January 2014 and was due for review in January 2017. As with all other policies seen by the inspection team, this policy was generic relating to all approved centre services in the Carlow/Kilkenny/South Tipperary area and was not specifically dedicated to the approved centre subject to inspection. Being generic, it met all the requirements of the regulation even if, given the health needs of the residents in the approved centre, not all the elements of the policy could apply in practice.

Training: Staff were aware of the policy on communication although it was not clear to the inspection team that the policy had been studied in detail by members of staff.

Monitoring of Compliance: There was no evidence available to the inspection team that formal audits of the specific communication experience of residents in the approved centre had been audited notwithstanding the commitment in the generic policy to review that policy every three years.

Evidence of Implementation: Some residents had their own mobile phones and could use these freely other than to apply the camera facility on those phones with such a capability. Sending and receiving mail was not a feature in the approved centre although, when this did occur, it was sent and received unopened by staff. For residents who did not have mobile phones or who chose not to use them, calls could be made or received at the nurses' station or at the night nurse station (which was at a separate location). Despite a number of requests, a cordless phone which residents could take away from the stations was not available.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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

As the resident population was elderly and long-stay in the approved centre, searches were not carried out. Therefore, this Regulation was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There was a policy on care of the dying which applied throughout the Carlow/Kilkenny/South Tipperary Mental Health Services area which was up to date and reviewable every three years. The policy emphasised the requirement for respect for privacy and dignity and urged staff to have cultural awareness.

Training: There was no dedicated training for staff in relation to end of life care. However, staff were aware of the policy and the usual practice in the approved centre was to bring the palliative care team from the local hospice as end of life approached. By definition, the palliative care team had appropriate training in end of life care.

Monitoring of Compliance: There was no audit of the processes involved in end of life care and no analysis of care of the dying to improve the processes.

Evidence of Implementation: The only single bedroom in the approved centre was used exclusively for care of the dying. It had a separate patio entrance which enabled the relatives and supporters of residents who were dying to come and go discreetly. Another room was made available to relatives if they wished to stay overnight and it had tea and coffee making facilities. The final stage of life nursing care was provided by a palliative care team from the local hospice.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: The approved centre had the generic *Care and Recovery Plan* policy which applied to all approved centres in the Carlow/Kilkenny/South Tipperary Mental Health Services Area. Since the last inspection visit to the approved centre in March 2014, the Carlow/Kilkenny/South Tipperary service had introduced a new *Care and Recovery Plan* template incorporating a column dealing with "Goals". This had been one of the concerns expressed following the March 2014 inspection and, indeed, an earlier inspection in 2013. In fact, the template now incorporates clearly identified needs – including the use of the Camberwell Assessment of need (*sic*) Short Appraisal Schedule – goals, planned interventions and clinical responsibility for delivery of assessed needs.

Training: The inspection team were informed that staff members had been trained in the *Multi Disciplinary Team Approach to Care-Planning* in what was described as "An Integrated System: Assessment to Discharge and Beyond" and a copy of a comprehensive Power Point presentation to that effect prepared and presented by a Clinical Placement Coordinator (CPC) was provided to the team.

The inspectors were also informed that there were proposals to have a dedicated staff member with responsibility for training on care planning, amongst other things, put in place at an early date.

Monitoring of Compliance: As the recently developed template has only been in use for just over a year, it has not been formally reviewed to date. However, the training presentation on care planning recognised that audit and research in relation to care planning are "essential components for achieving an Effective Quality Care System".

Evidence of Implementation: The inspection team inspected the clinical files of all residents to establish that each had a care plan articulated in the new template format. This was the case. However, a further closer examination of more than half of the residents' files revealed some weaknesses in the care planning process and documentation to the inspectors.

The weaknesses noted by inspectors in their examination of the care plans related to the following areas: delineation of goals, outlining of the clinical responsibility with regard to actions set out in the plan to address needs and nomination of a key worker. There were also instances on plans where review date documentation provided for on the template were not signed by relevant members of the multidisciplinary team (MDT).

As regards the delineation of goals, these were quite often referred to in very broad terms along the lines of “Maintain good mental health”, for example, with a correspondingly broad statement in relation to the actions to be carried out to achieve the relevant goal. The nominated person responsible for carrying out the action was generally referred to in a generic fashion such as “Medical staff”, “nursing staff” or “all staff”. While it is accepted that, given the nature of the needs of the residents, there would be a focus on medical and nursing care, this should not be exclusive. And while there was indication of other MDT member involvement on some of the plans, especially of the activities nurse, occupational therapy and social work, this was a relatively minor feature and may not have fully reflected the work done by those disciplines in the approved centre. Finally, in the clinical files examined, there was a complete absence of any reference to a keyworker for the resident concerned. As the key worker principle is the fulcrum of the care planning and implementation process, it is a matter of some concern that this feature appeared to be entirely absent from the process in the approved centre. This was surprising as the importance of this feature is specifically referenced at paragraphs 6.3 and 12.3 of the service’s own policy on care planning.

The approved centre was deemed not to be compliant with this regulation as the care plans reviewed by the inspection team were deficient in a number of critical elements.

Compliance Rating:

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

Risk Rating

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
X				

3.15 Regulation 15: Individual Care Plan				
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	**18th 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*
1. The team had recognised before the summer that there were deficits in the care planning documentation. Training had already been organised for the 28th September. Training will focus specifically on the weaknesses outlined in the draft report. This is a *corrective action* Post-Holder(s): Training Sheila Hanly A/ADON, Yvonne Murphy CNM3 Audit: Dr McLaughlin Consultant Psychiatrist, Dr Nadeem NCHD	Delineation of goals. Identifying clinical responsibility for actions set out in the care plan. Ensuring that relevant members of the multidisciplinary team (MDT) are recorded in the care plan review section.	A Care Plan audit cycle will commence in October 2015 to ensure compliance with the regulation and areas of weakness identified in the draft report.	These actions are achievable and realistic	28th September 2015- Training October 2015 –March 2016 Auditing

3.16 Regulation 16: Therapeutic Services and Programmes

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

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

Inspection Findings

Processes: The approved centre did not have a dedicated policy on therapeutic services and programmes. However, there was a document called the "Observation and Therapeutic Engagement Policy" which covered some of the relevant ground. There was also an "Activities We Enjoy" folder in the nurses' station which acted as a guide to staff when engaging with residents. The activities nurse provided a broad range of therapeutic services and these were outlined in a timetable every week.

Training: Other than formal discipline specific training, for example, in relation to occupational therapy, there was no locally based training on therapeutic services and programmes.

Monitoring of Compliance: There was no evidence available to the inspection team to indicate that any formal review or audit of therapeutic services and programmes had taken place at the approved centre. However, in documenting the progress of residents in the context of the "Observation and Therapeutic Engagement Policy", there was a level of ongoing review by the activities nurse amongst others.

Evidence of Implementation: There was a range of appropriate services and programmes available for residents and these were referred to in the individual care plans, although sometimes expressed in somewhat general terms such as "participate in ward activities". A schedule of activities was posted every week and offered a broad range of possibilities for residents to engage with. These ranged from attending a religious service while accompanied at an external location, attending Sonas groups, playing cards and board games to outings and "1:1 time".

The approved centre did not have a dedicated room for therapeutic services and programmes and the day room was used for group work as well as eating meals. This the inspection team were told could cause some difficulty as, on occasion, residents who might not be part of a group activity could disturb that activity with challenging behaviour. There was also a Snoezellan room for multi-sensory therapy. Reports of residents' involvement with some of the services were recorded in logs dedicated to that particular service.

The activities nurse used an evidence based group programme to offer cognitive stimulation therapy (CST) to people with dementia called "Making a difference". Implementation of this programme did not require staff to have special qualifications or training.

The occupational therapist who attended on a sessional basis was piloting a "Timeslips" programme in conjunction with the Butler gallery which supplied the imagery to serve as a focus for the therapy. "Timeslips"(which requires some training in relevant facilitation

although not professional training as such) has as its objectives to improve the lives of people with memory loss through creative engagement and to lead to a situation where creative engagement is a standard practice of care for the resident profile in the approved centre and elsewhere.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 children were not admitted to the approved centre, this regulation was not relevant.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 with regard to transfer of residents, which was up to date. The processes for planning and managing transfers were outlined in the policy, as were the criteria for transfer. Communication between the transferring and receiving centres was included, as was the requirement for risk assessment prior to transfer. The process for managing the transferred resident's property was not included in the policy. Staff training requirements and the requirement for monitoring the processes were not included in the policy. Other processes not included in the policy were: ensuring residents' privacy and confidentiality during the transfer, emergency transfers and the process for managing the residents' medication.

Training: There was no documented training with regard to transferring residents. There was no evidence available that the staff had signed as having read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: No annual audit was undertaken to determine compliance with the processes and analysis was not completed to identify opportunities for improvement in the processes. Incident reports were not completed for any non-compliance.

Evidence of Implementation: One resident had been transferred to another approved centre since the previous inspection and their clinical file was inspected. The decision to transfer and the transfer itself was documented in the clinical file. The clinical file and the medication prescription and administration record went with the resident to the other approved centre and a nurse accompanied the resident to hand over care and impart information to the receiving team. There was no record of communication with the receiving approved centre prior to transfer. Risk assessment prior to transfer was not completed. The resident did not have capacity to consent to transfer and the transfer was deemed to be urgent.

The approved centre was judged to be non-compliant due to the gaps in the defined processes, the lack of training for staff, the lack of monitoring of processes and the absence of risk assessment prior to transfer.

Compliance Rating:

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

Risk Rating

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

3.18 Regulation 18: Transfer of Residents				
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	**18th 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*
1. Transfer of Residents policy will be amended to reflect the residents' privacy and confidentiality during transfer, the transfer of the residents' private property, emergency transfer and the process for managing the residents' medication. This is a corrective action Post-Holder(s): Irene Ryan CPC	Residents' privacy and confidentiality during transfer, the transfer of the residents' private property, emergency transfer and the process for managing the residents' medication was not included in the Transfer policy	The policy will be reviewed by the MDT policy review team to reflect changes in practice or at least every three years.	This is achievable and realistic	October 2015
2. Communication has been circulated to all staff regarding updating risk assessments and management plans prior to transferring a resident. This is a *corrective action* Post-Holder(s): Sheila Hanly A/ADON.	There was an absence of risk assessment prior to transfer.	Audit of the DOP and St Gabriel's Unit MDT Care Plans	This is achievable and realistic	Completed

3.19 Regulation 19: General Health

(1) The registered proprietor shall ensure that:

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

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

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

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

Inspection Findings

Processes: There was a policy in the approved centre with regard to general health of residents. It outlined the roles and responsibilities of staff, the process for medical emergencies, training in cardio-pulmonary resuscitation and use of the Automated External Defibrillator (AED), the process for regular physical examinations, at least every six months, resource implications for equipment and the incorporation of individual health needs into the individual care plan. Monitoring of the processes with regard to general health was not included in the policy. The requirement for staff training was not included in the policy.

Training: Staff involved in general health and screening were medical and nursing staff and had received relevant training during their professional training. There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: Monitoring of the processes was not carried out. Annual audits and analysis were not completed to monitor and improve processes. As only one resident was age-eligible for screening, monitoring of take-up of screening was not applicable. Incident reports were not completed for any non-compliance.

Evidence of Implementation: All residents who had been in the approved centre for six months or more had a physical examination in that period. This included blood tests and measuring weight. There was a schedule displayed which indicated when a resident was due a routine physical examination. Examinations were carried out in private and recorded in the clinical file. The AED was located in the nurses' office and was clearly signed. There was also an emergency tray which was checked regularly. Physical needs were documented in the individual care plan.

Only one resident was eligible for screening and this had been completed and was documented in the clinical file.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: The approved centre used the generic Carlow/Kilkenny/South Tipperary policy on communication which was up to date and subject to review every three years. Being generic, as is the case with other policies used in the approved centre, it was of the "one size fits all" variety and did not recognise the particular challenges as regards the provision of information to the residents – with their particular needs – in the centre. However, it may not be possible to address those challenges fully and the policy, although generic, was appropriate for the provision of information to relatives/supporters.

Training: The inspection team was not presented with any evidence to the effect that staff had received dedicated training in the communication needs of, or difficulties in the provision of information to, residents with dementia and other issues relating to the Psychiatry of Later Life (POLL). However, staff, who could adduce their specific professional training, were aware of the policy.

Monitoring of Compliance: There was no annual audit undertaken to determine compliance with the process and analysis to improve the performance of the processes was not completed.

Evidence of Implementation: There was an attractively laid out and succinct *Patient and Family Information* leaflet which included housekeeping arrangements, visiting times and complaints procedures. There was a folder which contained leaflets on various conditions relating to the POLL. Families were involved as far as is possible in the provision of information for residents. Information on medications was available, if sought, and there were a number of leaflet racks on walls around the centre providing information on various relevant physical and mental health conditions and social care options. However, at the time of inspection, the inspection team noted that the contents of these racks were not well maintained and were, in some cases, misfiled.

Information regarding health and safety was not displayed.

Compliance Rating

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There was a policy on privacy in the approved centre. The policy was up to date and subject to review after three years of operation. It outlined the roles and responsibilities of staff and the requirement for privacy and dignity for residents was included in the policy. However, the following were not outlined in the policy: the requirement for appropriate layout and furnishing of the approved centre; training requirements for staff with regard to ensuring privacy and dignity; and the monitoring of compliance with the processes relating to privacy and dignity.

Training: Staff were aware of the policy on privacy.

Monitoring of Compliance: There was neither evidence of an annual audit on compliance with privacy requirements nor of any analysis to identify opportunities for improvement of processes relating to the privacy and dignity of residents.

Evidence of Implementation: As this was an approved centre which cared for residents with severe dementia and other psychiatric conditions found in later life requiring extensive nursing and other care relating to activities of daily living (ADL), there were limitations to the level of privacy that could be afforded to residents. However, it was abundantly clear to the inspection team during the inspection that, as far as was possible, residents' privacy and dignity were respected. Staff interacted in a very caring, dignified, empathic and highly professional manner with residents. This was entirely consistent with the declared philosophy of the approved centre which aimed "to provide a patient centred approach to care with emphasis on individuality and autonomy".

There was only one single bedroom available which was used for care of the dying; residents slept in two or three bedded rooms with attached bathrooms, although not all beds in those rooms were occupied. Two of the larger bedrooms - which were at some distance away from the hub of activity around or near the nursing station - had a single occupant. The rationale for this practice was explained to the inspection team as being a response to the fact that the occupants had particularly challenging behaviour - which could be disturbing for other residents - who benefited from the "quieter" environment of the rooms in which they slept alone. All beds had surrounding curtains, although the inspection team noted that the curtain around one of the beds in one of the rooms which had only a single occupant did not surround the bed completely. As that room had only one occupant, it might not be a matter of great concern particularly as the sight lines from the doorway did not permit viewing when the surround curtain was drawn to its fullest extent. There was no facility by which the residents could receive phone calls in private as there was no portable phone meaning that calls had to be taken in the nursing office or the night nurses' station. Records relating to residents were maintained securely in the locked nursing office.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 generic policy of the Carlow/Kilkenny/South Tipperary on premises was made available to the inspection team. It was up to date and subject to review every three years. As with other policies shown to the inspectors, this policy was written to cover all approved centres within in the Carlow/Kilkenny/South Tipperary service area.

The policy outlined the roles and responsibilities of staff with regard to the premises. However, the following issues were not covered by the policy: the dedication of rooms in the approved centre, the design of approved centre to meet residents' needs, infection control, utility controls and requirements, change control processes, staff training requirements and monitoring and continuous improvement processes.

Training: Staff were aware of the policy on premises.

Monitoring of Compliance: There was no audit for compliance with the premises process. Incident reports were completed if faults or problems constituted a risk. Cleaning schedules were carefully documented and copies of these were shown to the inspection team. No analysis was carried out to identify opportunities for improvement to the process.

Evidence of Implementation: On a walkaround inspection of the approved centre and in conversation with staff, the inspection team paid particular attention to the fabric, décor and suitability of the premises and its furnishings for the treatment and care of residents with dementia and other issues of mental health associated with later life.

The approved centre was a 24-bed facility although only 13 beds were occupied at the time of inspection. Discussions were taking place about a possible change in the formal role of the centre to that of a dementia specific assessment unit which could have implications for the number of beds required for the unit.

The unit was a modern brick facade building annexed to an older prefabricated structure on the grounds of the former St Canice's hospital on the outskirts of the medieval city of Kilkenny. In fact, the approved centre is still characterized as a "ward" in St Canice's hospital. External signage was poor or non-existent and, on the first day of inspection, the inspection team had an initial difficulty locating the entrance to the approved centre. Inspectors were informed that staff were aware of this problem and had alerted the relevant authorities to it. Various proposals had been considered in this regard including a possible renaming – with associated appropriate signage – of the approved centre.

The approved centre was quiet, reasonably well lit, warm and well ventilated. Cleanliness was of a very high standard. There was good, picture based signage on most doors and bathrooms were gradually being retrofitted with uniform plasticised wall covering – colour contrasted and easy clean - to replace tiles which, because of the construction of the building, were inclined to become detached.

There had been contact with, and involvement by, local primary school children in the painting of colourful and very attractive butterfly motifs on a wall in the centre with the intention of taking this further. The project was in keeping with a focus on intergenerational contact which the centre is attempting to foster.

The lino floor covering gave rise to some concerns particularly as there were inlays in the surface which the inspection team were informed could confuse residents into thinking they were, in fact, steps thereby giving rise to the possibility of falls. The floor at the return to the main area of the centre from the night nurses' station was sloped creating another fall hazard.

Rails on all walls in the corridors of the approved centre mitigated the fall hazards to some extent. However, as they were a uniform grey in colour, they did not always stand out against their background suggesting a somewhat limited usefulness for the residents of the centre especially in the light of their particular needs. The inspection team was informed that there were proposals to have the rails repainted in more prominent colours.

The large day room served a number of purposes, some of which might be regarded as mutually exclusive. For example, the room was used for group activities as well as just a place to linger, relax or watch television. It was also used as a dining room. The inspection team was informed that, sometimes during group work, residents who were not attached to the relevant group and who might be resting in the day room could be disruptive of the group work. Some thought might be given to an appropriate partitioning of the day room assuming that health and safety considerations would allow for this.

There was a large and potentially very attractive enclosed garden to the rear of the building, part of which had recently been paved to provide a bright courtyard space. The garden itself was underdeveloped from a therapeutic perspective but there were thoughtful plans in place to remedy this. Some funds had been received from the Friends of St Gabriel's – the

charity associated with the approved centre – to help with this and more was being sought from official sources.

Compliance Rating:

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

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

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

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

Inspection Findings

Processes: There was a policy with regard to medication management which was up to date. It outlined the roles and responsibilities of staff and the legislative frameworks were referred to in the policy. The processes for ordering, prescribing, storage and administration of medication were included. The process for crushing medication or withholding medication was not in the policy. The process for review of medication, training of staff and monitoring of the medication processes were also not included.

Training: Medication management in the approved centre was limited to nurses, doctors and pharmacists. As such, they were trained in ordering, prescribing, storage and administration of medication. There was no other formal training in medication management. There was no documented training on medication errors and near misses. There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: Medication management was monitored and audited by the pharmacists. A medication audit had been completed and was available for inspection.

Evidence of Implementation: The medication prescription and administration records of the residents were available for inspection. All medication was written in generic form, signed and dated. In a small number of cases (three), the doctor's Medical Council Registration Number was not recorded. Administration records were in order and medication had been discontinued correctly. All medication was prescribed.

Staff were observed using hand wash facilities before the medication rounds.

Medication was stored in locked cabinets and controlled drugs were locked in a separate cupboard. There was also a fridge for cold storage of medication. The amount of controlled drugs and the controlled drug register were correct. There were no out-of-date or unused medication stored in the approved centre.

Compliance Rating:

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

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a policy with regard to Health and Safety in the approved centre which was up to date. The policy referred to the Health and Safety Statement which contained the processes for Health and Safety. These included the fire management plan, evacuation plan and training requirements for staff. It did not include infection control measures and first aid response requirements. Falls prevention was not included in the Health and Safety Statement but a falls prevention process was operational in the approved centre.

Training: There was training for staff in manual handling, managing sharps, hand hygiene, and infection control, but not all staff had been trained in these processes. Only two staff had been trained in health and safety awareness. Training was documented. Fire safety training was overdue. (The inspection team were subsequently informed that fire safety training is scheduled for 9 October 2015).

Monitoring of Compliance: There was no monitoring of take-up of staff of vaccinations and immunisations in the approved centre. There was no record of an annual audit to determine compliance to health and safety procedures and no analysis to identify opportunities for improvement in the approved centre. Incident reports were completed if there was non-compliance with the processes of Health and Safety.

Evidence of Implementation: The staff demonstrated good understanding of health and safety processes and were aware of the Health and Safety Statement. Three staff had signed the statement as having read and understood it. There was a risk register available. Risk assessments were completed for each resident. Fire drills were held in the approved centre regularly. Environmental Health Officer reports, fire reports and health and safety reports were maintained in the approved centre. Staff used personal protective equipment in the kitchen and when changing residents. Waste was segregated and a sharps box was used. There were changing facilities for staff. Health and safety incidents were recorded on incident forms.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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

There was no CCTV in the approved centre apart from the entrance door. Therefore, this Regulation was not applicable.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There was a policy with regard to staffing and training. This referred to recruitment, selection and appointment of staff. The organisational structure, including lines of responsibility, was not in the policy and neither were available in the approved centre. Terms and conditions of employment and job descriptions were referred to in the policy. Agreed staff numbers and the requirement for a rota were also included in the policy. Induction of staff and staff training processes were outlined, as were checks on qualifications. The process for evaluation of staff training and staff performance evaluations were not included in the policy. The policy did not contain staff record content and the assignment and reassignment of staff to specific roles in the approved centre. The process for using agency staff was outlined in the policy.

Training: There was no training documented in staffing policies, procedures and processes.

Monitoring of Compliance: The central office monitored staffing plans, the implementation of training plans and the effectiveness of internal and external training but these were not documented. There was no annual audit to determine compliance to the processes and analysis was not completed to determine opportunities for improvement to the processes. Incident reports were not completed for non-compliance in the processes.

Evidence of Implementation: The staffing policy was available in the approved centre and staff showed awareness of the policy although there were no signatures to state that they had read and understood the policy. There was no organisational chart available to the inspection team in the approved centre to outline leadership and management and the lines of authority and accountability in the approved centre. There was a record of the rota of staff. Personnel files showed that staff had been vetted by An Garda Síochána. Staff evaluations of performance were not included in the personnel files. Each staff member received a job description and terms and conditions of employment. There was a written induction for student nurses and new staff were orientated to the approved centre by the clinical nurse manager.

There were sufficient nursing staff for the approved centre. However, if a one-to-one nurse or health care assistant was required, this was taken from the unit complement. The approved centre was not self-staffing so the clinical nurse manager was not aware of which staff would be rostered to the unit. However, every effort was made to have consistency in staffing for continuity of care.

There was a psychiatry of later life team, which included a consultant psychiatrist, social worker, occupational therapist, speech and language therapist, a clinical nurse specialist and a non-consultant hospital doctor (NCHD). The team also has access to a clinical speech and language therapist. This team had clinical responsibility for the approved centre. There was an activities nurse who worked 39 hours a week in the approved centre but was not replaced when on leave.

There were training records maintained for staff. Most staff had not received up to date training in control and restraint but had received training in diffusion of aggression specifically for residents with dementia. Children First training had not been available for most staff. Staff were trained in basic life support, care planning and manual handling. A training coordinator had been appointed and will focus on training for staff.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 with regard to record keeping and maintenance. This policy was up to date. It included creation, storage and destruction of records. This policy also referred to HSE Standards and Recommended Practices for Healthcare Records which contained processes for managing records, including creation, storage, training, content, confidentiality and legislative framework.

Training: There was no documented training in policies, procedures and process relating to maintenance of records. The HSE Standards and Recommended Practices for Healthcare Records outlines training in healthcare record management. There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: The residents' clinical files were reviewed and updated regularly. The nursing staff were responsible for maintaining clinical files. There was no annual audit of the processes and no analysis to identify opportunities for improvement in the process. As there had not been non-compliance with the process, no incident reports had been completed.

Evidence of Implementation: All clinical files were located in the nursing office which was locked. The files were generally in good order, chronological and up to date. A number of clinical files had loose pages. Each clinical file had unique identifiers including a medical record number and a photo. Only the multidisciplinary team recorded progress in the clinical files. The Environmental Health Officer's report and the Fire Officer's report were available to the inspection team.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There were no written processes with regard to the Register of Residents. However, there was a process for entering residents' details in the register and the updating of the register.

A register of residents was not available to the inspection team on the days of inspection.

Training: Staff were not fully aware of the requirements for the Register of Residents.

Monitoring of Compliance: The register of records was not monitored for compliance with the defined processes. The Register of Residents was not available to the inspection team.

Evidence of Implementation: It was unclear who was responsible for maintaining the Register of Residents. A record of admissions and discharges, proffered by staff, was not a Register of Residents as required by the Regulations.

The approved centre was not compliant with this Regulation as there was no Register of Residents as outlined in Schedule 1 to the Regulations.

Compliance Rating:

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

Risk Rating

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

3.28 Regulation 28: Register of Residents				
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 submitted	**18th 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*
1. The approved centre maintains a Register of Residents in an electronic format as outline in schedule 1. This is maintained by the ward clerk in the Department of Psychiatry. A hard copy of the Register of Residents will be kept on St Gabriel's ward. This is a *corrective action* Post-Holder(s): Annette Byrne CNM2	The approved centre was not compliant with the Regulation as there was no Register of Residents as outlined in Scheduled 1 of the Regulations.	By completing a walk through review (the tool is currently being developed).	This action is achievable and realistic	Register - September 2015 Walk through review – March 16

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 senior management team had charge of preparing and approving all policies in the Carlow/Kilkenny/South Tipperary Mental Health Services area. The team comprises the Executive Clinical Director, Director of Nursing and other senior nursing personnel, local heads of allied health professionals, local senior administrators and local consumer panel representatives. The policies produced have, for the most part, application in all approved centres in the services area. The team overseeing the policy making process not only has the task of having all policies prepared and then approving them, but they also set a review date which must occur within three years of the date of first preparation of the policies.

Training: Newly arrived staff were informed about the policies on induction.

Monitoring of Compliance: The triennial review process has a built in review mechanism which ensures that policies are examined and interrogated at regular intervals. However, there was no evidence available to the inspection team that there was a process in place for formal audit to determine compliance with the operating policies and procedures.

Evidence of Implementation: The policies and procedures operating in the approved centre were examined by the inspection team who spoke with staff about their implementation in practice. The staff spoken to indicated that they were informed about the policies on their induction into the Carlow/Kilkenny/South Tipperary Mental Health Services. Policies were retained in a folder in the acting Assistant Director of Nursing's office and could be perused there by staff.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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

Detained patients were not admitted to the approved centre and there were no detained patients since the previous inspection.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 used the Carlow/Kilkenny/South Tipperary generic complaints policy. Moreover, there was the Health Service Executive (HSE) complaints policy, *Your Service Your Say*. The residents of the approved centre also had access to the advocacy service officer provided by the Irish Advocacy Service for the South East. All of these avenues for complaints and related matters were highlighted in the approved centre's *Patient and Family Information* leaflet.

Training: Staff were not specifically trained on the complaints process. However, it became apparent to the inspection team from conversations with staff members that they were familiar with the process.

Monitoring of Compliance: The approved centre did not maintain a local complaints log, rather complaints were forwarded to the central complaints officer who was not located in the approved centre. The central complaints officer for the service was responsible for analysing complaints forwarded to him. The inspectors pointed out to staff that this represented a lost learning opportunity at local level notwithstanding the fact that many complaints were handled locally although not recorded.

Evidence of Implementation: There was an undated notice posted on the wall of the approved centre entitled "Carlow/Kilkenny Mental Health Services: Complaints Handling Procedure" (The inspection team noted that South Tipperary was not included in this notice). Its size was small, the language used and the processes outlined were cumbersome and the signature provided by the complaints officer was illegible and unsupported by a printed

subscript. The inspection team formed the opinion that, because of its deficiencies, it was not fit for purpose.

The Carlow/Kilkenny/South Tipperary generic complaints policy was applied in the centre although there was no reference to this on the posted notice. Minor complaints were dealt with locally and informally.

As the processes by which formal complaints could be made were poorly relayed and cumbersome, as minor complaints were handled locally and not formally recorded in a log – thereby ensuring that learning opportunities were lost – and as the designated complaints officer was offsite and not clearly identified, the approved centre was not compliant with this Regulation and rated it as a moderate risk factor.

Compliance Rating:

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

Risk Rating

Low	**Moderate**	**High**	**Critical**	**Not - Applicable**
	X			

3.31 Regulation 31: Complaints Procedure				
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	**16th October 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*
1. The notice on Complaints Handling Procedure is updated to address the weaknesses outlined in the draft report (see appendix). Mr. Paul Meehan is the nominated person in the approved centre to deal with all complaints. This is a corrective action Post-Holder(s):Irene Ryan CPC and Annette Byrne CNM2	The designated complaints officer was off site and not clearly identified.	By completing a walk through review (the tool is currently being developed).	Completed	Notice Update is Completed Walk through review – March 16
2 In an effort to learn from feedback from our service users and family members a complements/ complaints/comments log is now maintained locally to capture the nature of feedback received. This log contains: the date, nature of feedback, date passed the complaints officer, and the outcome (see appendix) This is a *corrective action.*	The approved centre did not maintain a local complaints log.	By completing a walk through review (the tool is currently being developed).	Completed	Log -Completed Walk through review – March 16

Post-Holder(s): Annette Byrne CNM2				

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: There was a risk management policy in the approved centre which was up to date. It contained processes for addressing suicide and self-harm, resident absence without leave, assault, and accidental injury to residents or staff. It did not reference the person with responsibility for risk management, the responsibilities of the Registered Proprietor and the multidisciplinary team or the individual responsible for completion of six-monthly incident summary reports. The policy covered organisational risks, individual risk, risk assessment and risk management. Incident reporting was also included in the Health and Safety statement as was risk rating. The policy included the process for responding to emergencies. It did not contain the process required for protection of children and vulnerable adults. There was a risk register available for inspection.

Training: Staff were qualified to assess and manage risk through their professional training. There was training for staff in manual handling, managing sharps, hand hygiene, and infection control, but not all staff had been trained in these processes. Only two staff had been trained in health and safety awareness. Training was documented. Staff were not trained in incident reporting and documentation. There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: Incidents were recorded where there were identified risks. There were no annual reports on compliance with the processes or analysis for identifying

opportunities for improvement in the approved centre. However, a new risk manager had been appointed and would be auditing and analysing risk.

Evidence of Implementation: Staff were aware that there was a risk manager with responsibility for overseeing risk. Each resident had an individual risk assessment on admission and this formed part of the individual care plan. Individual risk assessments and management plans were discussed at the multidisciplinary team meeting. There was no formal risk assessment completed on transfer or discharge. Health and safety risks were documented in the risk register. The legislative framework was outlined in the Health and Safety Statement. Incident reports were completed where risks were identified and six-monthly summary reports were forwarded to the Mental Health Commission. Staff were unaware of the requirements for the protection of children and vulnerable adults and this was not included in the policy.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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's insurance was managed by the HSE Corporate Services.

Training: Staff were aware of the insurance arrangements.

Monitoring of Compliance: HSE Corporate Services monitored the insurance status of the approved centre.

Evidence of Implementation: The Clinical Indemnity Scheme statement was available to the inspection team.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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: There were no written processes to ensure that the certificate of registration was displayed but staff were able to articulate the process.

Training: Staff were aware of the requirements in relation to the certificate of registration.

Monitoring of Compliance: The scope of the approved centre's certificate of registration was reviewed and any changes were communicated to the Mental Health Commission.

Evidence of Implementation: The Certificate of Registration was prominently displayed in the approved centre, near the entrance.

Compliance Rating:

Non – Compliant – Negligible Achievement (1)	Non – Compliant – Poor Achievement (2)	Compliant – Good Achievement (3)	Complaint – 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 administered in the approved centre and no resident was receiving ECT elsewhere.

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 and there were no seclusion facilities.

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

Two residents were restrained with either a lap belt or a groin belt under Part 5 of the Rules on the Governing the Use of Mechanical Restraint. The use of the restraints was for enduring risk of harm to resident, to prevent falling.

Processes: There was a policy with regard to mechanical restraint which was up to date. It included the roles and responsibilities for mechanical restraint. The assessment requirements and alternative options for consideration prior to the use of mechanical restraint were not included.

Training: Relevant staff had received training in mechanical restraint as part of their Mental Health Act 2001 training. There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: The policy with regard to mechanical restraint was reviewed annually. There was no annual audit of the processes of mechanical restraint. As there had been no non-compliance with Part 5 of the Rules Governing the Use of Mechanical Restraint, there were no incident reports completed. No analysis had been completed to identify opportunities for improvement.

Evidence of Implementation: The lap belt and groin belt in use were inspected. They fitted comfortably, were clean and easily released by staff. There was a prescription for the use of the belts in the clinical file, signed by the consultant psychiatrist. The rationale for restraint, the restraint type, date of review of the prescription and the duration of the order were included. The duration of the restraint was not included.

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 There were no detained patients in the approved centre since the previous inspection, therefore, Part 4 of the Mental Health Act 2001 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

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

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

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

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

6.1 The Use of Physical Restraint

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

Inspection Findings

Physical restraint was not used in the approved centre. There were no entries in the physical restraint Clinical Practice Forms.

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

Children were not admitted to the approved centre. Therefore this Code of Practice 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

6.3 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: There were processes in place to ensure that deaths in the approved centre were notified to the Mental Health Commission and that a summary of incidents was forwarded to the Mental Health Commission every six months. Staff were able to articulate this process.

Training: Staff were aware of the processes with regard to notification of deaths and incident reporting.

Monitoring of Compliance: Incidents were monitored and audited by the risk manager.

Evidence of Implementation: The approved centre notified all deaths to the Mental Health Commission within 48 hours and the notifications were available. There was an incident reporting book and six-monthly reports of incidents were sent to the Mental Health Commission.

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

There were no residents with an intellectual disability in the approved centre since the previous inspection.

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

Inspection Findings

ECT was not administered in the approved centre and no resident was receiving ECT elsewhere.

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

The following were inspected:

Two clinical files of residents recently admitted;

One clinical file of a resident who had been transferred to another approved centre; and

One clinical file of a resident who had been discharged.

Processes: There were admission, transfer and discharge policies that were up to date. These contained processes for the admission, transfer and discharge of residents and also included the processes for involuntary patients. Follow-up for discharged residents was outlined, as was the process for homeless residents and elderly residents. The admission policy included criteria for admission and the procedure for the admission process.

Training: Staff had not received specific training for admission, transfer and discharge. However, they were aware of the processes and able to articulate them. There was no evidence available that the staff had signed that they had read and understood the policy, although the inspection team were told that these signatures had been made and were not accessible at the time of the inspection.

Monitoring of Compliance: Admissions and discharges were monitored by the HSE through review and audit. Information was sent to the Health Research Board which produces published reports on in-patient activity.

Evidence of Implementation: Admission: All admissions to the approved centres were planned. Referrals were made through the multidisciplinary team and discussed at the team meeting. A home visit was carried out to complete an initial assessment and meet with families or nursing home staff. On admission the resident was assessed. The documentation of this assessment was sparse and contained very little information in most cases. A risk assessment and management plan was completed. An initial care plan was compiled. There was no key worker system in place. The approved centre was compliant with Regulations 7 and 8 on Clothing and Personal Property and Possessions; Regulation 15 Individual Care Plan; Regulation 20 Provision of Information to Residents; and Regulation 27 Maintenance of Records.

Transfer: The decision to transfer was documented in the clinical file. The clinical file and the medication prescription and administration record went with the resident to the other approved centre and a nurse accompanied the resident to hand over care and impart information to the receiving team. There was no record of communication with the receiving approved centre prior to transfer. Risk assessment prior to transfer was not completed. The resident did not have capacity to consent to transfer and the transfer was deemed to be

urgent. There was no key worker. The approved centre was not compliant with Regulation 20 Transfer of Residents.

Discharge: There was an assessment of the resident prior to discharge. No risk assessment was completed. The decision to discharge was documented in the clinical file. Discharges were discussed at the multidisciplinary team meetings and with the family and/or staff of the nursing home. The plans for follow-up were documented in the clinical file. A comprehensive discharge summary was completed by the consultant psychiatrist.

Compliance Rating:

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