Department of Psychiatry, Letterkenny General Hospital

ID Number: AC0086

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry
Letterkenny General Hospital
Circular Road
Letterkenny
Co. Donegal

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Care for People with
Intellectual Disability
Child & Adolescent Mental Health Care

Most Recent Registration Date:
14 September 2014

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Teresa Dykes, Operations
Manager, Mental Health, CHO 1

Inspection Team:
Dr Ann Marie Murray, Lead Inspector
Dr Enda Dooley
Orla O’Neill
David McGuinness

Inspection Date:
27 – 30 June 2017

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
11 – 14 October 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
14 September 2017

2017 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

Compliant

Non-compliant

Not applicable
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

Chart 2 – Comparison of overall risk ratings 2015 – 2017
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1.0 Introduction to the Inspection Process

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

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

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

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.

b) See every patient the propriety of whose detention he or she has reason to doubt.

c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.

d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.
The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, realistic, achievable and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre’s plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an
2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

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

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

Safety in the approved centre

The approved centre had a written policy in relation to health and safety, a safety statement and an infection control manual dated 2004. There was a series of risk management policies. However, the policies did not include a process for learning from, reviewing, and monitoring incidents and there were no policy arrangements for responding to emergencies. Training records indicated that not all health care professionals had up-to-date mandatory training in fire safety, Basic Life Support (BLS), the management of violence and aggression, and the Mental Health Act 2001. At least one staff member was trained in Children First. At least two person-specific resident identifiers were in use in the approved centre. The identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of health care services and therapeutic services and programmes.

No food safety audits had been carried out. Housekeeping and catering staff shared a toilet and cleaning facilities with other staff and national infection control guidelines were not being followed. In four of the residents’ bathrooms there was no hand soap. Although doctors did not always use their Medical Council Registration numbers, the ordering, prescribing, storage and administration was satisfactory.

There was a blind spot in one corner of the seclusion room which meant that it was not possible to maintain direct observation of a resident in seclusion, and the mattress in the seclusion area did not ensure patient safety. There was no named consultant anaesthetist with overall responsibility for anaesthesia in ECT and four staff members involved in ECT did not have up-to-date Basic Life Support training.

AREAS REFERRED TO

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

Staff had received training in manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, recovery-centred approaches to mental health care and treatment and the protection of children and vulnerable adults.

There was no key worker system in place to ensure continuity in the implementation of the individual care plan (ICP). The psychologist only attended multi-disciplinary team (MDT) meetings by arrangement when a particular issue arose. The occupational therapist and social worker assigned to the approved centre did not regularly attend MDT meetings. Residents had access to their ICPs and were offered copies of them. However, when interviewed, not all residents were aware of their ICP or felt they had enough time to read their ICP before signing it. This was the sixth successive year that the approved centre was non-compliant with this regulation. Despite this, ICPs had not been audited on a quarterly basis to assess compliance with the regulation. The approved centre had completed the first cycle of an audit of ICPs. Not all MDT members had received training in individual care planning. The non-compliance with the regulation for ICPs was rated critical.

There was a schedule of therapeutic services and programmes provided by therapy recovery programme nurses, the occupational therapist (OT), and the social worker, which met the assessed needs of residents as outlined in their individual care plans. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. Residents’ records were secure, up to date, and in good order.

Although the approved centre was attached to Letterkenny General Hospital, the medical emergency team from Letterkenny General did not provide a medical emergency response team as they did in the rest of the hospital, and the approved centre had to call an ambulance when a medical emergency occurred. This did not provide adequate access for residents to a medical emergency response team and was discriminatory to the mentally ill residents of Letterkenny General Hospital.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment. There were documentation inadequacies with regard to physical restraint. The approved centre did not provide age-appropriate facilities and a programme of activities appropriate to the age and ability of the child resident, and there was no access to an age-appropriate advocacy service for children. The approved centre did not comply with 13 of the provisions of the code of practice on admission, transfer and discharge. One resident was transferred to a 24-hour supervised residence because of a bed crisis in the approved centre and this was not done in the best interests of the resident.

**AREAS REFERRED TO**

Respect for residents’ privacy and dignity

Residents wore their personal clothing, which was observed to be clean and appropriate to their needs. They could bring personal possessions into the approved centre and were supported to manage their own property. There was secure storage for valuables and monies. Searches were implemented with due regard to the residents’ dignity, privacy, and gender. Residents were informed by those implementing the search of what was happening and why. A minimum of two clinical staff were in attendance when searches were conducted. In two shared bedrooms, bed screening was inadequate and did not ensure resident privacy. A blind was missing from the observation panel of one resident bedroom. The same room did not have a curtain on the window, therefore it was possible to view the room from the garden area.

Areas referred to

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

Responsiveness to residents’ needs

Menus were reviewed regularly by the dietitian and catering manager and residents were provided with a range of wholesome and nutritious food choices. Food, including modified consistency diets, was presented in an appealing manner.

The approved centre provided access to recreational activities appropriate to the residents’ profile on weekdays and at the weekend. There was a weekly meeting at which residents could express their views and preferences in relation to recreation. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Residents were facilitated in observing or abstaining from religious practice in line with their wishes. Visiting times were appropriate and reasonable and there was a dedicated visitors’ room. There was a visiting room which was suitable for visiting children. Residents had access to mail, fax, e-mail, Internet, and telephone. Required information was given to residents and their representatives at admission in an information booklet, which included an outline of patients’ rights. There was access to evidence-based written information about diagnosis and medication. Residents had access to personal space, including suitable accommodation. There were a number of unsatisfactory environmental issues: information holders in two of the bedrooms were broken and posed a safety risk, there were ligature points throughout the approved centre, including ligature points in the new High Dependency Unit, there was a leak in the wall of one of the resident’s bedrooms which resulted in damp and paint chipping, and in two of the female bathrooms, the flush panel was missing. The greenery was overgrown at the external entrance to the approved centre. Even though a cleaning schedule was in place, there was a strong smell of urine in two toilets.

All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy. The approved centre was unable to provide the correct name of the nominated complaints officer.

Areas referred to

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

With the establishment of the Community Healthcare Organisation (CHO) 1, Donegal, Sligo, Leitrim, West Cavan, Cavan, and Monaghan mental health services were amalgamated. Meetings of the Donegal Area Mental Health management team had been held sporadically but more recently were occurring monthly. The quality and risk management committee fed into the area management team meetings with a standing agenda item for risk on the agenda; however, this was frequently recorded in minutes as not discussed for various reasons. An advocate representative was a member of the Donegal area management mental health meetings and the quality and risk management meetings and was chairperson of the policy, protocols, and guidelines group.

Some of the heads of discipline worked cross divisionally between mental health services, primary care, disability, and social care. This meant that a number of them had limited contact with residents of the approved centre and limited resource to provide governance to the approved centre. Each discipline had clear reporting and line management systems in place. Not all the heads of discipline had clear strategic aims for their departments. In the absence of sufficient staffing levels, the heads of discipline reported that it was challenging to engage in quality development. Not all disciplines had performance appraisals or used key performance indicators for the staff of their departments as it relates to the approved centre. All of the disciplines had clear structures around supervision of staff and peer review, with some of the heads of disciplines having written policies in relation to supervision. The approved centre’s operating policies and procedures were not developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, were not communicated to all relevant staff, and had not been appropriately approved before being implemented. Policies and procedures did not specify the document owners or reviewers and did not include the date at which the policy became effective. Not all policies and procedures required by the regulations had been reviewed within three years.

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

The following quality initiatives were identified on this inspection:

- The introduction of the HSE’s national “Safety Pause”. This strategy aims to improve communication among the team in relation to risks to the quality of patient care.
- There was a daily “clinical walkabout” where the senior nurse walked around the approved centre to identify any issues.
- Funding by the Donegal Sports Partnership Community Coaching Programme for a “Body & Mind” exercise programme each week for residents.
- There was a weekly art programme delivered by a skilled local artist and part-funded by the Donegal Training and Education Board Community Education Programme.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Department of Psychiatry, Letterkenny, was the in-patient service for Donegal Mental Health Services. It was situated on the grounds of Letterkenny General Hospital and was connected to the General Hospital via a corridor. The unit was well signposted within the main hospital. There was a reception and a waiting area at the entrance of the approved centre. The unit provided accommodation for 34 residents in a combination of four- and two-bed rooms and single rooms.

A new high dependency unit had been completed. This refurbishment included one high dependency bedroom with a separate toilet, a seclusion room with a separate toilet, a sitting area, and a small external courtyard. An attractive mural had been created on the boundary of the courtyard. The approved centre had not yet used the high dependency bedroom as the facilities for observing a resident in this bedroom were not adequate. There had been no clinical need identified by the approved centre to use the seclusion room since it was opened in May 2017.

Support, training, education, employment, and research (STEER) specialists in advocacy and recovery services were available to represent residents in the approved centre.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>34</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>30</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>7</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>1</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

The governance of the approved centre had undergone a period of change since the last inspection with the establishment of the Community Healthcare Organisation (CHO) 1. This change involved the amalgamation of Donegal with Sligo, Leitrim, West Cavan, Cavan, and Monaghan mental health services. Minutes of eight meetings of the Donegal Area Mental Health management team were provided. These had been held sporadically but more recently were occurring monthly. The minutes of these meetings centred around the CHO 1 Mental Health Operational Plan 2017 and focused on Donegal’s mental health services, including the approved centre and community mental health services. The quality and risk management committee fed into the area management team meetings with a standing agenda item for risk on the agenda; however, this was frequently recorded as not discussed for various reasons. There was no forum for the different staff disciplines working in the approved centre to meet together to discuss specific governance matters.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 11 – 14 October 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Complaints</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice Relating to the Admission of Children under the Mental Health Act 2001</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
5.2 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas in 2016 and 2015:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Relating to the Admission of Children under the Mental Health Act 2001</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

5.3 Areas of compliance rated Excellent on this inspection

No areas of compliance were rated excellent on this inspection.
6.0 Service-user Experience

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

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

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

Two residents chose to speak with the inspection team. Eleven leaflets were returned either partially or completely filled in. Residents complimented the approved centre’s food and activities. Not all residents were aware of their individual care plan (ICP) or felt they had enough time to read their ICP before signing it.
7.0 Interviews with Heads of Discipline

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

- Clinical Director
- Occupational Therapy Manager
- Principal Psychologist
- Acting Director of Nursing

The following were unable to meet the inspection team:

- Principal Social Worker. The acting principal social worker spoke to the lead inspector over the phone.

Some of the heads of discipline worked cross divisionally between mental health services, primary care, disability, and social care. This meant that a number of them had limited contact with residents of the approved centre and limited resources to provide governance to the approved centre. Each discipline had clear reporting and line management systems in place. Not all the heads of discipline had clear strategic aims for their departments. For many of them, the biggest challenge was to provide adequate staffing levels to the approved centre. In the absence of sufficient staffing levels, the heads of discipline reported that it was challenging to engage in quality development. They also noted that it was very challenging to attract and recruit staff to the approved centre and cited the remote geographical location of Letterkenny as a possible reason for this. Recruitment campaigns were ongoing and there was evidence that the heads of discipline were continuing efforts to recruit staff.

Not all disciplines had performance appraisals or used key performance indicators for the staff of their departments as it relates to the approved centre. All of the disciplines had clear structures around supervision of staff and peer review, with some of the heads of discipline having written policies in relation to supervision. An advocate representative was a member of the Donegal area management mental health meetings and the quality and risk management meetings and was chairperson of the policy, protocols, and guidelines group.
8.0 Feedback Meeting

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

- Executive Clinical Director
- Acting Director of Nursing
- Senior Occupational Therapist on behalf of Occupational Therapy Manager
- Registered Proprietor
- Clinical Nurse Manager 1
- Clinical Nurse Manager 2

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

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions
Regulation 4: Identification of Residents

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

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Processes:</strong> The approved centre had a written policy in relation to the identification of residents, which was last reviewed in April 2015. It included all of the requirements of the Judgement Support Framework.</td>
</tr>
<tr>
<td><strong>Training and Education:</strong> Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents, as set out in the policy.</td>
</tr>
<tr>
<td><strong>Monitoring:</strong> An annual audit had not been undertaken to ensure that clinical files contained appropriate resident identifiers. Documented analysis had been completed to identify opportunities for improving the resident identification process.</td>
</tr>
<tr>
<td><strong>Evidence of Implementation:</strong> At least two person-specific resident identifiers were in use in the approved centre. The identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of health care services and therapeutic services and programmes. A sticker system was in place to alert staff to the presence of residents with the same or a similar name.</td>
</tr>
</tbody>
</table>

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and monitoring pillars.
**Regulation 5: Food and Nutrition**

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the provision of appropriate food and nutrition to residents, which was last reviewed in June 2016. It included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

**Monitoring:** A systematic review of menu plans had been completed to ensure that residents received wholesome and nutritious food in accordance with their needs. Analysis had been completed to identify opportunities for improving the processes for food and nutrition.

**Evidence of Implementation:** Menus were reviewed regularly by the dietitian and catering manager to ensure nutritional adequacy in line with residents’ needs. Residents were provided with a range of wholesome and nutritious food choices. Hot meals were served on a daily basis. Residents had regular access to hot and cold drinks and to a source of safe, fresh drinking water. Food, including modified consistency diets, was presented in an appealing manner.

The needs of residents identified as having special nutritional requirements were regularly reviewed by the dietitian. The approved centre used the Malnutrition Universal Screening Tool to assess residents with special dietary needs. The nutritional and dietary requirements of residents were assessed, where necessary, and addressed in their individual care plans. Weight charts were implemented, monitored, and acted upon, where required. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate.

**The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education pillar.**
Regulation 6: Food Safety

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

(2) This regulation is without prejudice to:
   (a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
   (b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
   (c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in July 2014. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for food safety, as set out in the policy. Training records indicated that all staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP).

Monitoring: Food safety audits had not been undertaken. There was no evidence provided to verify that analysis had been completed to identify opportunities for improving food safety processes. Food temperatures were recorded in line with food safety recommendations, and a temperature log sheet was maintained and monitored.

Evidence of Implementation: Food was prepared and cooked in the kitchen in Letterkenny General Hospital and delivered to the approved centre. Appropriate hand-washing areas were provided for catering services, and there was suitable catering equipment as well as appropriate facilities for the management of food. Catering areas and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

An environmental health officer (EHO) report of April 2016 noted that housekeeping and catering staff shared a toilet and cleaning facilities with other staff. The EHO had sought the implementation of clear, documented infection control procedures on account of the risk of infection being introduced into the kitchen because of the shared bathroom. This had not been completed and the catering staff continued to share the same bathroom. This practice did not ensure a high standard of hygiene in relation to the preparation of food.
The approved centre was not compliant with this regulation because the practice of catering staff sharing a bathroom with other staff did not ensure a high standard of hygiene in relation to the preparation of food, 6(1)(c).
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to clothing, which was last reviewed in June 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes in relation to residents’ clothing, as set out in the policy.

Monitoring: An emergency supply of clothing for residents was maintained and monitored. During the inspection, no resident was observed wearing nightclothes during the day.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, and residents’ clothing was observed to be clean and appropriate to their needs.

An emergency supply of clothing was available for residents, which took account of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day. All residents had an adequate supply of individualised clothing and wardrobes in which to store it.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ personal property and possessions, which was last reviewed in April 2015. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to residents’ property and possessions, as set out in the policy.

Monitoring: The approved centre regularly monitored personal property logs and residents’ money logs. Analysis had not been completed to identify opportunities to improve the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their individual care plans (ICPs). Residents’ personal property and possessions were secured when the approved centre assumed responsibility for them. There were secure facilities on the ward for the safeguarding of small amounts of residents’ monies.

Families were encouraged to take custody of valuables. A checklist detailing each resident’s property and possession was maintained in the clinical files, separately to ICPs.

The process of accessing and using resident monies was overseen by two members of staff and the resident or their representative. Transactions were signed by two staff and, if possible, countersigned by the resident.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the training and education and monitoring pillars.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in April 2016. The policy included requirements of the Judgement Support Framework, with the exception of the process used to develop recreational activity programmes.

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

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident attendance and a list of the activities provided. Documented analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and at the weekend. Posters were displayed throughout the approved centre containing colourful, accessible information about activities and programmes. The activities provided included outdoor table tennis, word wheels, beauty care, baking, furniture restoration, knitting, art, gardening, puzzles, reading, trips out to the cinema and for shopping, music and singing, crosswords, table games, light exercise, and relaxation.

Activities were developed, maintained, and implemented with resident involvement. There was a weekly meeting at which residents could express their views and preferences in relation to recreation. Where appropriate, individual risk assessments were completed for residents in relation to the selection of appropriate activities.

Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. There were suitable indoor areas for recreation, and residents had access to an internal garden. Residents’ decisions on whether or not to participate in activities were respected. Records of resident attendance/involvement in activities were retained in the clinical files.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in June 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: An audit of the policy’s implementation had been completed in June 2016 to ensure that residents’ identified religious needs were met.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. Mass was held in the group room every Saturday for those who wished to attend. Residents had access to multi-faith chaplains, where required. Residents could also attend religious services outside the approved centre, if it was deemed appropriate following a risk assessment. Residents, accompanied by staff, attended mass on Sundays in St. Conal’s Hospital.

The care and services provided within the approved centre were respectful of residents’ religious beliefs and values. Residents were facilitated in observing or abstaining from religious practice in line with their wishes. Provision was also made for specific religious requirements relating to the provision of services, care, and treatment, including dietary requirements.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 11: Visits

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<td>(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive</td>
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<td>visitors having regard to the nature and purpose of the visit and the needs of the resident.</td>
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<td>(2) The registered proprietor shall ensure that reasonable times are identified during which a resident</td>
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<td>may receive visits.</td>
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<td>(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and</td>
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<td>visitors.</td>
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<td>(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the</td>
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<td>privacy of a resident during visits are respected, in so far as is practicable, unless indicated</td>
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<td>otherwise in the resident’s individual care plan.</td>
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<td>(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for</td>
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<td>children visiting a resident.</td>
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<td>(6) The registered proprietor shall ensure that an approved centre has written operational policies and</td>
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<td>procedures for visits.</td>
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**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to visits, which was last reviewed in April 2015. It addressed criteria of the *Judgement Support Framework*, with the exception of the required visitor identification methods.

**Training and Education:** Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to visits, as set out in the policy.

**Monitoring:** Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. At the time of the inspection, no residents were subject to visiting restrictions. Analysis had been completed to identify opportunities for improving visiting processes.

**Evidence of Implementation:** Visiting times, which were appropriate and reasonable, were publicly displayed in the reception area. There was a dedicated visitors’ room, and the relaxation room was also used for visits. Residents were facilitated in meeting visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits. Children were welcome in the approved centre when accompanied by an adult and supervised at all times to ensure their safety. The visiting room adjacent to the nurses’ station was suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and training and education pillars.
Regulation 12: Communication

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in June 2015. It included requirements of the Judgement Support Framework, with the exception of processes for assessing resident communication needs and for risk-assessing residents in relation to their communication activities.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating residents’ communication needs, as set out in the policy.

Monitoring: Residents’ communications needs and restrictions on communication were monitored on an ongoing basis. Documented analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, e-mail, Internet, and telephone. Where appropriate, individual assessments were completed for residents in relation to risks associated with their external communication. At the time of the inspection, no resident was subject to restrictions on their communications.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
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 a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in July 2015. It addressed the criteria of the Judgement Support Framework, including requirements relating to the following:

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

The policy did not address the application of individual risk assessment in relation to resident searches.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for undertaking a search, as set out in the policy.

Monitoring: The approved centre maintained a log of searches, which had been introduced since the last inspection. Analysis had been completed to identify opportunities for improving search processes.

Evidence of Implementation: Two clinical files were inspected in relation to environmental searches. In each case, a risk assessment was completed in advance of the search and resident consent was sought and received. The searches were implemented with due regard to the residents’ dignity, privacy, and...
gender. Residents were informed by those implementing the search of what was happening and why. A minimum of two clinical staff were in attendance when searches were conducted.

There was a written record of each resident search, which detailed the reasons for the search, recorded the names of the staff members who undertook the search, and indicated who was in attendance. The policy and processes relating to searches were communicated to all residents in the approved centre. Where illicit substances were uncovered during a search, policy requirements were implemented.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 14: Care of the Dying

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

(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to care of the dying, which was last reviewed in May 2014. It included requirements of the Judgement Support Framework, with the following exceptions:

- Protocols in relation to advance directives and Do Not Attempt Resuscitation orders.
- The support available to other residents and staff following the death of a resident.
- The process for notifying the Mental Health Commission (MHC) of deaths of residents within 48 hours.
- The process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred to another facility.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policy.

As no resident of the approved centre had required end of life care or had passed away since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this regulation.
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 a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in June 2016. It included requirements of the Judgement Support Framework, with the exception of processes for ensuring resident involvement in individual care planning and for providing residents with access to their ICPs.

Training and Education: Not all clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes relating to individual care planning. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: ICPs had not been audited on a quarterly basis to assess compliance with the regulation. The approved centre had completed the first cycle of an audit of ICPs. Analysis had been completed to identify opportunities for improving the individual care planning process.

Evidence of Implementation: A review of 11 clinical files found that the ICPs were not a composite set of documents. The ICPs were filed separately to ICP review sheets, which were chronologically filed within progress notes. There was no key worker system in place to ensure continuity in the implementation of the ICP. Nine ICPs did not detail the resources required to meet residents’ identified needs, with resources recorded as “MDT,” “nursing,” and “nursing and MDT”. Goals were identified in all 11 ICPs, but these lacked specificity with the use of generic and overly broad terminology.

The ICPs were reviewed weekly in consultation with the resident. The psychologist only attended MDT meetings by arrangement when a particular issue arose. None of the community mental team or community social care professionals attended MDT meetings. The occupational therapist and social worker assigned to the approved centre attempted to attend MDT meetings insofar as was practicable. The MDT did not develop seven of the ICPs inspected.

Residents had access to their ICPs and were offered copies of them. The ICPs were discussed, agreed where practicable, and developed with the involvement of the resident and their family. Each included an individual risk management plan and a preliminary discharge plan.

There had been one child admission since the last inspection, but educational requirements did not apply.
This was the sixth successive year that the approved centre was non-compliant with this regulation.

The approved centre was not compliant with this regulation for the following reasons:

a) The 11 ICPs reviewed did not comprise a composite set of documents.
b) Nine ICPs did not adequately specify the resources required to meet assessed resident needs.
c) Seven ICPs were not developed by the MDT.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was dated September 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents’ assessed needs were met. Analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: There was a schedule of therapeutic services and programmes provided by therapy recovery programme nurses, the occupational therapist (OT), and the social worker. The programmes consisted mainly of open groups, and the staff advertised them well with colourful posters and catchy programme titles. Among the group programmes provided were cookery and baking, peer discussion and support, Cognitive Behavioural Therapy, and “dance, voice, and movement”. There was also a weekly art programme delivered by a skilled local artist and part-funded by the Donegal Training and Education Board Community Education Programme.

The range of available, evidence-based programmes was appropriate to the assessed needs of residents, as outlined in their individual care plans. Therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. The OT delivered individual and group interventions, including functional assessments, leisure exploration and engagement, independent living skills, socialisation, discharge planning, community access, vocational assessments and exploration, and psychoeducation relating to sleep, relaxation, and occupational balance. Residents could also take part in an eight-week physical exercise programme organised in conjunction with the Donegal Sports Partnership.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. The facilities included a therapy kitchen, interview rooms, group rooms, and an activity room. There was an internal courtyard garden with raised planters, which were tended by residents. The
approved centre had a minibus for resident use, and community outings were a regular element of the recovery-oriented programme. Residents were risk-assessed in relation to outings.

A log was maintained of residents’ participation and engagement in therapeutic services and programmes, and outcomes achieved were documented. Where residents required a service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

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

There was one child admission since the last inspection. As the resident did not have educational requirements, this regulation was not applicable.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in July 2015. It included requirements of the Judgement Support Framework, with the following exceptions:

- The pre-transfer resident assessment requirements, including individual risk assessment.
- The process for ensuring resident privacy and confidentiality during a transfer, specifically in relation to the transfer of personal information.
- The process for managing resident property during a transfer.
- The process for emergency transfers.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy.

Monitoring: The approved centre did not maintain a transfer log. Analysis had been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who had been transferred to a 24-hour residence because of a bed shortage in the approved centre was examined. The resident’s consent to the transfer was recorded. There was no documentary evidence that the decision to transfer was agreed with the receiving facility. Nursing staff from the receiving facility attended the approved centre and completed a clinical risk assessment and management form with the approved centre’s nursing staff. There was no record made in the clinical file about how the resident was transported and how their belongings were managed. A copy of the Medication Prescription and Administration Record accompanied the resident on transfer, and the resident’s medication needs during the transfer were documented. The clinical file indicated that an assessment of the resident was undertaken in advance of the transfer.

A letter of referral or a resident transfer form were not issued as part of the transfer. No checklist had been completed to ensure comprehensive resident records were transferred to the receiving facility, and not all copies of relevant records were retained in the clinical file.

The approved centre was not compliant with this regulation as not all relevant information was provided to the receiving facility, 18(1).
Regulation 19: General Health

(1) The registered proprietor shall ensure that:
   (a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
   (b) each resident’s general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
   (c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of general health care, which was due for review in June 2017. There was also a medical emergencies policy, dated June 2015. The policies included requirements of the Judgement Support Framework, with the following exceptions:

- The staff training requirements in relation to Basic Life Support.
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The referral process for the general health needs of residents.

Training and Education: Not all clinical staff had signed a log indicating that they had read and understood the policies. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policies.

Monitoring: Residents’ take-up of national screening programmes was not recorded or monitored. A systematic review had not been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had a resuscitation trolley and an Automated External Defibrillator, stored in the clinical room. These were checked weekly. All medical emergencies were documented using the National Incident Management System.

Residents’ general health needs were assessed by a registered medical practitioner at admission and on an ongoing basis. Residents received general health care in line with their individual care plans, and their general health needs were monitored and assessed at least every six months. Records of residents’ completed health checks and the associated results were maintained in the clinical files. Residents had access to age- and gender-appropriate national screening programmes, and information was provided in relation to the programmes available through the approved centre.
The approved centre was attached to Letterkenny General Hospital via a corridor. However, if there was a medical emergency in the approved centre, the medical emergency team from Letterkenny General did not provide a response team. The approved centre had to call an ambulance. This did not provide adequate access for residents to a medical emergency response team.

The approved centre was not compliant with this regulation because residents did not have adequate access to general health services, specifically an emergency medical response team, 19(1)(a).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to the provision of information to residents, which was last reviewed in April 2015. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for identifying residents’ preferred ways of receiving and giving information.
- The methods for providing information to residents on an ongoing basis.
- The interpreter and translation services available in the approved centre.
- The process for managing the provision of information to residents’ representatives, family, and next of kin.

Training and Education: Not all staff had had signed a log indicating that they had read and understood the policy. Staff interviewed could articulate the processes for providing information to residents, as set out in the policy.

Monitoring: The provision of information to residents was reviewed on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had not been completed to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: Required information was given to residents and their representatives at admission in an information booklet. Details were provided of housekeeping arrangements including, personal property, mealtimes, visiting times and arrangements. Residents were provided with details of relevant advocacy and voluntary agencies, and residents’ rights. Residents were also informed about their multi-disciplinary team.

Residents had access to evidence-based written information about diagnosis and medication, including potential side-effects and risks. Verbal information was provided by clinical staff, as required. Written and
verbal information was appropriate to residents’ needs, and the content of medication sheets included information on indications for use of all medications administered to the resident.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in June 2016. It included requirements of the Judgement Support Framework, with the exception of the process for identifying residents’ privacy and dignity expectations and preferences.

Training and Education: Not all staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: An annual review had been undertaken to determine whether the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a polite, helpful, and respectful manner at all times. Staff conducted all conversations relating to residents’ clinical and therapeutic needs with discretion. Residents were observed to be wearing clothing that respected their privacy and dignity.

Bathrooms, showers, toilets, and single rooms had locks on the inside of the doors, and these had an override facility.

In two shared rooms, bed screening was inadequate and did not ensure resident privacy. On the first day of the inspection, a blind was missing from the observation panel of one resident bedroom. The same room did not have a curtain on the window, therefore it was possible to view the room from the garden area. Staff rectified this during the inspection.

Noticeboards in the approved centre did not display identifiable resident information, and residents were facilitated in making private phone calls.

The approved centre was not compliant with this regulation because the lack of appropriate screening in three rooms did not ensure that residents’ privacy and dignity were respected at all times.
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.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the premises, which was last reviewed in June 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed ligature and hygiene audits. Analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space, including suitable accommodation. Communal rooms were appropriately sized and adequately lit. Rooms were comfortably heated and ventilated. Appropriate signage was in place to support resident orientation needs. Residents had access to and used a courtyard garden.

Perspex information holders in two of the bedrooms were broken and posed a safety risk. Maintenance staff gave a commitment to remove these when alerted to them. There were ligature points throughout the approved centre including ligature points in the new High Dependency Unit. The ligature audit had identified a number of ligature points, and an action plan was in place to minimise these.

There was a leak in the wall of one of the resident’s bedrooms which resulted in damp and paint chipping. In two of the female bathrooms, the flush panel was missing. One of these was fixed during the inspection.
The greenery was overgrown at the external entrance to the approved centre. A cleaning schedule was in place however, there was a strong smell of urine in two toilets. National infection control guidelines were not being followed. According to the 2016 environmental health officer report, the sharing of a toilet by cleaning, catering, and other staff increased the risk of importing infection into the kitchen. The report recommended the implementation of robust infection control procedures, but this had not been done at the time of the inspection. In four of the residents’ bathrooms there was no hand soap. Residents were provided with handtowels to dry their hands in en suite bathrooms but there was no place for them to hang their towel.

There were designated sluice, cleaning, laundry, and examination rooms. Bedrooms were appropriately sized to address resident needs. Furnishings throughout the approved centre supported resident independence and comfort.

The approved centre was not compliant with this regulation for the following reasons:

a) There was a leak in the wall of one of the residents’ bedrooms, which resulted in damp and paint chipping. In two of the female bathrooms, the flush panel was missing, 22(1)(a).

b) There was a strong smell of urine in two toilets, 22(1)(a).

c) Hazards and ligature points were not minimised. This did not show due regard to the safety and well-being of residents, 22(3).
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.


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in July 2015. It included requirements of the Judgement Support Framework, with the exception of the process for medication reconciliation.

Training and Education: Not all medical staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to comprehensive up-to-date information on all aspects of medication management. All clinical staff had received documented training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were undertaken to determine compliance with the policy and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents using the National Incident Management System. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: An MPAR was maintained for each resident, and 26 of these were inspected. Two appropriate resident identifiers were used when medication was being administered. Names of medications were written in full, and the generic names of medication were recorded. The frequency of administration, the dosage, and the administration route for medications were documented.

In one of the MPARs inspected, the resident’s allergy status was not documented. In six MPARs, the date of discontinuation for medication was not clearly recorded. The Medical Council Registration Number of every medical practitioner prescribing medication to residents was not recorded on six MPARs.

MPARs were reviewed monthly. Where there were alterations in the medication order, the medical practitioner rewrote the prescription. Medication, including scheduled controlled drugs, was administered by two registered nurses in accordance with the directions of the prescriber, and good hygiene and cross-infection control techniques were implemented during the dispensing of medications. The expiration date of the medication was checked prior to administration.
Where a resident’s medication was withheld, the justification was noted in the MPAR and documented in the respective clinical file. Where a resident refused medication, this was documented in the MPAR and clinical file and communicated to medical staff. No resident was receiving crushed medication.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Medication storage areas were clean and tidy, and food and drink were not kept in areas used to store medication. Where medication required refrigeration, a log of fridge temperatures was maintained on a daily basis. The medication trolley and fridge were locked and secured in a locked room. A system of stock rotation was in place, and all medication was reviewed weekly to prioritise returns to the pharmacy.

The approved centre was not compliant with 23(1) of this regulation because the Irish Medical Council Registration Number of every medical practitioner prescribing medication to residents was not recorded on six MPARs.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety, dated April 2015, a safety statement dated January 2017, and an infection control manual dated 2004. Together, these documents included requirements of the Judgement Support Framework, with the exception of the following:

- Measures for raising awareness of residents and visitors to infection control measures.
- Infection control measures relating to linen handling and the covering of cuts and abrasions.
- Details of the support provided to staff following exposure to infectious diseases.
- First aid response requirements.

Training and Education: Not all staff had signed a log indicating that they had read and understood the policy and safety statement. Staff interviewed were able to articulate the processes relating to health and safety, as set out in the documents.

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

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

The approved centre was compliant with this regulation.
Regulation 25: Use of Closed Circuit Television

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of CCTV, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of the provisions relating to the maintenance of CCTV cameras.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the use of CCTV.

CCTV cameras were located in the foyer of the main entrance to the Department of Psychiatry but were not used within the approved centre to observe residents. There was CCTV in the seclusion room; however, this had not yet been used to observe a resident. As the CCTV in the seclusion room had not been in use, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this regulation.
### Regulation 26: Staffing

1. The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
2. The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
3. The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
4. The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
5. The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
6. The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to staffing, which was last reviewed in June 2016. It addressed requirements of the *Judgement Support Framework*, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment of staff.
- The approved centre’s recruitment, selection, and appointment process, including Garda vetting requirements.

It did not reference the following:

- The staff planning requirements to address the number and skill mix of staff appropriate to the assessed needs of residents and the size and layout of the approved centre.
- The use of agency staff.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- The ongoing staff training requirements and frequency of training required to provide safe and effective care and treatment.
- The required qualifications of training personnel.
- The evaluation of training programmes.

**Training and Education:** Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to staffing, as set out in the policy.

**Monitoring:** The implementation and effectiveness of the staff training plan had not been subject to an annual review. The number and skill mix of staff had been assessed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities for improving staffing processes.
Evidence of Implementation: The approved centre had an organisational chart to identify the leadership and management structure and lines of authority and accountability. Planned and actual staff rotas were in place. Staff were recruited, selected, and vetted in line with the approved centre’s policy and procedures. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times, as evidenced by the rosters. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency.

A full-time psychology post was unfilled at the time of the inspection. There was a psychologist who attended the approved centre two days’ a week. The psychology department identified a need for a senior full-time psychology post in addition to the current psychology input. There was no psychology input into developing and reviewing residents’ individual care plans.

The approved centre did not have a staffing plan, and annual staffing plans had not been completed for all staff. Training records indicated that not all health care professionals had up-to-date mandatory training in fire safety, Basic Life Support (BLS), the management of violence and aggression, and the Mental Health Act 2001.

At least one staff member was trained in Children First. Staff had received training in manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, recovery-centred approaches to mental health care and treatment and the protection of children and vulnerable adults. Staff training was documented, and staff training logs were maintained. Resources were available to staff for further training and education, and in-house trainers were appropriately qualified. The Mental Health Act 2001, the associated regulations, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in the approved centre.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CNM1/CNM2</td>
<td>1-2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Department of Psychiatry, Letterkenny General Hospital</td>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>Two days’ per week</td>
<td></td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)

The approved centre was not compliant with this regulation for the following reasons:

a) The number of psychology staff was not appropriate to the assessed needs of the residents, 26(2).
b) Not all staff had up-to-date mandatory training in fire safety, BLS, the management of aggression and violence, and the Mental Health Act 2001, 26(4) and (5).
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.


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in June 2016. The policy addressed requirements of the Judgement Support Framework, including policies and procedures relating to the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- The required resident record creation.
- Those authorised to access and make entries in residents’ records.
- Record retention periods.
- The destruction of records.

The policy did not reference the retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed a log indicating that they had read and understood the policy. Clinical staff and other relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records in the approved centre. All clinical staff had received training in best-practice record keeping.

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

Evidence of Implementation: Residents’ records were secure, up to date, and in good order, and they were constructed, maintained, and used in accordance with the Data Protection Act (1988) and (2003), the Freedom of Information Act (1997) and (2003), and national guidelines and legislative requirements.
Resident records were physically stored together. Records were initiated for every resident and were reflective of residents’ current status and the care and treatment being provided.

Resident records were maintained using an appropriate resident identifier, a patient chart number, and they were developed and maintained in a logical sequence. They could be accessed by authorised clinical staff only, and only authorised staff made entries in them.

Resident records were maintained appropriately in terms of completeness, accuracy, and ease of retrieval. Documentation relating to food safety, health and safety, and fire inspections was maintained. Records were retained or destroyed in accordance with legislative requirements and the approved centre’s policy and procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date register of residents. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, the register did not consistently record diagnosis at admission or diagnosis at discharge.

The approved centre was not compliant with this regulation because residents' diagnosis at admission and diagnosis at discharge were not consistently recorded.
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 draft policy in relation to operating policies and procedures was provided to the inspection team. As the policy was in draft form this was not considered by the inspection team to be an operational policy.

Training and Education: There was no operational policy for staff to read and understand. Relevant staff had not been trained on approved operational policies and procedures. Relevant staff interviewed were able to articulate the approved centre’s processes for developing and reviewing operational policies.

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the process of developing and reviewing policies.

Evidence of Implementation: The approved centre’s operating policies and procedures were not developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. Policies and procedures were not communicated to all relevant staff, as evidence by the fact that the approved centre’s medication policy was not available to staff. Many of the operating policies and procedures had not been appropriately approved before being implemented.

Policies and procedures did not specify the document owners or reviewers and did not include the date at which the policy became effective. Not all policies and procedures required by the regulations had been reviewed within three years, specifically the policy relating to Regulation 14: Care of the Dying. Where generic policies such as Children First and national safeguarding guidelines were used to satisfy compliance with Regulation 32, the approved centre did not have a written statement adopting the policies in question. Generic policies in use were appropriate to the approved centre and the resident group profile.

The approved centre was not compliant with this regulation for the following reasons:

a) The care of the dying policy had not been reviewed within three years.

b) There was no statement adopting two generic policies for Regulation 32.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of Mental Health Tribunals. It was a draft policy, which was not approved or dated. The policy included all of the requirements of the Judgement Support Framework but was not accepted by the inspection team as an operational policy.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the process for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: To support the tribunals process, the approved centre provided a private room. There was a dedicated Mental Health Act administrator with responsibility for the organisation and coordination of tribunal processes. Staff assisted and supported residents to attend and participate in Mental Health Tribunals, where necessary.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in March 2015. It addressed requirements of the Judgement Support Framework, with the exception of the following:

- The confidentiality requirements in relation to complaints.
- The documentation of complaints.
- The communication with the complainant during the complaint process.

Training and Education: Not all relevant staff had received training on complaints management processes, and not all staff had signed a log indicating that they had read and understood the policy. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data had been analysed for the purpose of identifying and implementing required actions to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There were posters displaying the name of a nominated complaints officer in the approved centre; however, this name was incorrect. The approved centre did not subsequently provide the inspection team with the correct name of the nominated complaints officer.

The approved centre’s management of complaints processes was explained in the resident information booklet and on posters displayed throughout the approved centre.
The approved centre was not compliant with this regulation because the approved centre did not provide information to determine compliance with 31(4) and 31(6) of the regulation.
Regulation 32: Risk Management Procedures

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
   (a) The identification and assessment of risks throughout the approved centre;
   (b) The precautions in place to control the risks identified;
   (c) The precautions in place to control the following specified risks:
      (i) resident absent without leave,
      (ii) suicide and self harm,
      (iii) assault,
      (iv) accidental injury to residents or staff;
   (d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   (e) Arrangements for responding to emergencies;
   (f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies in relation to risk management: a non-clinical risk management policy dated June 2016, a clinical risk management policy, a safety statement, an absence without official leave policy dated November 2012, and a policy on managing aggression and violence in the workplace dated July 2017. Together, the policies and safety statement included the requirements of the Judgement Support Framework, including processes for the following:

- Identification, assessment, treatment, reporting, and monitoring of health and safety risks to the residents, staff, and visitors.
- Identification, assessment, treatment, reporting, and monitoring of risks to the resident group and to individuals during the provision of care and services.
- Rating identified risks.
- Controlling risks such as resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Managing incidents involving residents of the approved centre.
- Protecting children and vulnerable adults in the care of the approved centre.

The policies and safety statement did not reference the following:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The individual responsible for completing six-monthly incident summary reports.
The process for the identification, assessment, treatment, reporting, and monitoring of organisational risks, structural risks including ligature points, and capacity risks relating to the number of residents in the approved centre.

The process for maintaining and reviewing the risk register.

The record keeping requirement for risk management.

The process for reviewing and monitoring incidents.

The process for learning from incidents.

The process for notifying the Mental Health Commission (MHC) about incidents involving residents.

The process for responding to emergencies.

**Training and Education:** Documentation was not provided to confirm that staff had received training in the identification, assessment, and management of risk or in health and safety risk management. Documentation was not provided to confirm that clinical staff had been trained in individual risk management, and managerial staff were trained in organisational risk management. Documentation was not provided to confirm that all staff had been trained in incident reporting and documentation. Not all staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.

**Monitoring:** The risk register had not been audited at least quarterly to determine compliance with the approved centre’s risk management policies. The approved centre had documented a review of the risks on the risk register. All incidents in the approved centre were documented and risk-rated. No analysis of incident reports had been completed to identify opportunities for improving risk management processes.

**Evidence of Implementation:** The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management. Risk management procedures actively sought to reduce identified risks to the lowest practical level of risk. Perspex information holders in two of the bedrooms were broken and posed a safety risk. Staff of the approved centre had not identified this as a risk. When staff were alerted they gave a commitment to remove these. Corporate risks were identified, assessed, treated, reported, and monitored.

Ligature risks had been identified and assessed in a ligature audit but these were not documented in the risk register. Ligature points, had not been removed or effectively mitigated.

The approved centre implemented a plan to reduce risks to residents while any renovation works to the premises were ongoing.

The approved centre completed resident risk assessments at admission to identify individual risk factors. Assessments were also completed before and during the use of physical restraint, seclusion, and specialised treatments; prior to resident transfer and discharge; and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of individual risk management processes, as did residents and/or their representatives. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.
Incidents were recorded and risk-rated using the National Incident Management System. Six-monthly summary reports of all incidents were forwarded to the MHC.

Clinical incidents were regularly reviewed by senior nursing staff, but not by the entire MDT. The approved centre did not have an emergency plan that specified responses of staff in relation to possible emergencies or incorporated evacuation procedures.

The approved centre was not compliant with this regulation for the following reasons:

a) The policies did not include a process for learning from, reviewing and monitoring incidents, 32(2)(d).

b) There were no policy arrangements for responding to emergencies, 32(2)(e).
Regulation 33: Insurance

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

INSPECTION FINDINGS

The approved centre’s insurance certificate was provided to the inspection team. It confirmed that the approved centre was insured under the State Claims Agency for public liability, employer’s liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.
Regulation 34: Certificate of Registration

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was prominently displayed.

The approved centre was compliant with this regulation.
10.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001
SECTION 52 (d)
Section 59: The Use of Electro-Convulsive Therapy

Section 59

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

(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or

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

(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT), which had been reviewed in May 2017 but not yet approved. It met all of the criteria of this rule, including provisions in relation to the following:

- Storage of Dantrolene.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.
- Obtaining consent for maintenance/continuation of ECT.

Training and Education: Four nurses involved in delivering ECT were trained in line with best international practice. Four staff members involved in ECT did not have up-to-date Basic Life Support training.

Evidence of Implementation: Residents of the approved centre attended Letterkenny General Hospital for ECT treatment, which was delivered in the main operating theatre. There was documentary evidence that ECT machines were regularly maintained.

A named consultant psychiatrist had responsibility for ECT. The designated ECT nurse was responsible for checking emergency equipment and drugs. There was no named consultant anaesthetist with overall responsibility for anaesthesia in ECT. The on-call anaesthetist provided the service.

At the time of the inspection, no patient of the approved centre was receiving ECT treatment.

The approved centre was not compliant with this rule for the following reasons:

a) There was no named consultant anaesthetist with overall responsibility for anaesthesia in ECT, 11.3.

b) Four staff members involved in ECT did not have up-to-date Basic Life Support training, 10.7.
Section 69: The Use of Seclusion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of seclusion, dated April 2017. It included the following elements of this rule:

- Those authorised to initiate seclusion.
- The provision of information to the patient.
- The policy regarding the use of CCTV.

It did not reference the following:

- Ways of reducing seclusion rates.
- Staff training requirements in relation to the use of seclusion.

Training and Education: Staff had signed a log indicating that they had read and understood the policy. Records were maintained of staff attendance at training. A total of 77 staff had been trained in the use of seclusion throughout April and May 2017.

Evidence of Implementation: The seclusion room and bathroom were developed as part of the new high dependency unit. Residents accommodated in the seclusion area had access to adequate toilet and washing facilities. There was a large, high unsuitable mattress in the seclusion room which did not ensure the safety of a resident in seclusion. Staff of the approved centre had identified this as an issue and had ordered a more suitable mattress. There was a blind spot in one corner of the room, which meant that it was not possible to maintain direct observation of a resident in seclusion. Seclusion had not been used in the approved centre since the 2016 inspection.
The approved centre was not compliant with this rule for the following reasons:

a) The policy did not address ways of reducing seclusion rates, 10.2(a).
b) The approved centre did not have policies and procedures for training staff in relation to the use of seclusion, 11.1.
c) The mattress in the seclusion area did not ensure patient safety, 8.3.
Section 69: The Use of Mechanical Restraint

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

(4) In this section “patient” includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

INSPECTION FINDINGS

As mechanical means of bodily restraint were not in use in the approved centre, this rule was not applicable.
11.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001
Part 4 Consent to Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one resident who had been in the approved centre for over three months and in continued receipt of medication was examined. The patient was assessed by the responsible consultant psychiatrist as being unable to consent. A Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed, and a copy was placed in the clinical file. It detailed the following:

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

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint, which was dated May 2017. This was a draft policy and not yet approved. It addressed the provision of information to residents and the training requirements in relation to the use of physical restraint. It also provided information on staff training requirements, including details of those who could initiate restraint, those who should receive training, areas to be addressed in training, the mandatory of training, and alternatives to the use of physical restraint.

Training and Education: Not all staff involved in physical restraint had signed a log indicating that they had read and understood the policy. A record of staff attendance at training on the use of physical restraint was maintained. Restraint was never used to ameliorate staff shortages.

Monitoring: An annual report on the use of physical restraint in the approved centre was submitted to the Mental Health Commission.

Evidence of Implementation: The files of three residents who had been physically restrained were examined. In each case, the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others and following a risk assessment.

Each episode was initiated by an appropriate staff member, and a designated staff member was the lead. The episodes of physical restraint were not prolonged beyond the period necessary. The consultant psychiatrist was notified as soon as was practicable. A registered medical practitioner completed a medical examination of the residents within three hours of the start of physical restraint. In each episode, the use of physical restraint was reviewed by the multi-disciplinary team. The use of physical restraint was not clearly recorded in the clinical file in one episode.

There was no documentary evidence that the residents were informed of the reasons, likely duration, and circumstances leading to the discontinuation of physical restraint. In two episodes, next of kin were not informed of the use of physical restraint as soon as was practicable and no explanation for this was recorded.

The approved centre was not compliant with this code of practice for the following reasons:

a) Not all staff had signed the physical restraint policy, indicating that they had read and understood it, 9.2(b).

b) The use of physical restraint was not clearly recorded in the clinical file in one episode, 8.1.
c) In three episodes, there was no documentary evidence that residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, 5.8.

d) In two episodes, it was not documented that next of kin were informed of the use of physical restraint as soon as was practicable, 5.9(a).
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

Processes: The approved centre had a written policy in relation to the admission of children, which was dated April 2015. It addressed the requirement for each child to be individually risk assessed and the procedures for identifying the person responsible for notifying the Mental Health Commission (MHC) of the child admission. The policy also referenced procedures in relation to family liaison, parental consent, and confidentiality.

Training and Education: Staff had received training in relation to care of children.

Evidence of Implementation: The clinical file of one child resident of the approved centre was examined. Provisions were in place to ensure the safety of the child, to respond to the child’s special needs as a young person in an adult setting, and to ensure the right of the child to have their views heard.

Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided by the approved centre. The resident did not have access to an age-appropriate advocacy service.

Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. All staff having contact with the child had undergone Garda vetting. Appropriate accommodation was provided for the resident, and gender awareness was displayed. Advice and input was received from the Child and Adolescent Mental Health Service. Consent for treatment was obtained from the resident’s main guardian and carer. The MHC was notified of the admission of a child to the approved centre within the required 24-hour time frame.

The approved centre was not compliant with this code of practice for the following reasons:

(a) It did not provide age-appropriate facilities and a programme of activities appropriate to the age and ability of the child resident, 2.5(b).
(b) The resident did not have access to an age-appropriate advocacy service, 2.5(g).
INSPECTION FINDINGS

Processes: The approved centre had a clinical risk management policy and a non-clinical risk management policy that addressed incident reporting. The approved centre had a care of the dying policy and an in the event of an unexpected death policy which outlined the notification of deaths to the Mental Health Commission (MHC). The clinical risk management policy identified the risk manager. Combined these four policies did not specify the roles and responsibilities of staff in relation to the following:

- Reporting deaths and incidents.
- Completing death notification forms.
- Submitting forms to the MHC.
- Completing six-monthly incident summary reports.

Monitoring: There had been no deaths in the approved centre since the 2016 inspection.

Evidence of Implementation: The approved centre was not compliant with Regulation 32: Risk Management Procedures. The approved centre used the National Incident Management System to report incidents, and the standardised incident report form was available to the inspection team. A six-monthly summary of all incidents was sent to the MHC.

No residents of the approved centre had passed away since the last inspection.

The approved centre was not compliant with this code of practice for the following reasons:

a) It did not comply with Regulation 32: Risk Management Procedures, 3.1.

b) The policy did not identify the roles and responsibilities of staff in relation to reporting deaths and incidents, completing death notification forms, submitting forms to the MHC, and completing six-monthly incident summary reports, 4.3.
INSPECTION FINDINGS

Processes: The approved centre had a draft policy in relation to working with people with an intellectual disability, which was dated May 2017. The policy reflected person-centred treatment planning and least restrictive interventions. It contained details of the following:

- The roles and responsibilities of staff.
- The management of problem behaviours.
- The process for ensuring appropriate and relevant communication and liaison with relevant external agencies.

The policy did not reflect presumption of capacity, and its procedures for the training of staff in working with people with an intellectual disability did not identify appropriately qualified people to deliver training.

Training and Education: Staff had received training in support of the principles and guidance of this code of practice, including person-centred approaches and relevant human rights principles. Training had been provided on preventative and responsive approaches to problem behaviours.

Monitoring: The policy had been reviewed within the required three-year time frame. The use of restrictive practices was reviewed periodically.

Evidence of Implementation: The clinical file of one resident in the approved centre who had been diagnosed with an intellectual disability was examined. It indicated that the resident had an appropriate individual care plan, which included details of the following:

- The levels of support and treatment required.
- Assessed needs and available resources and supports.
- Consideration of the environment.

The resident had a comprehensive assessment that included an evaluation of performance capacities and difficulties; communication issues; medication history; medical, psychiatric, and psychosocial history; and social, interpersonal, and physical environment issues. The resident’s preferred way of receiving and giving information was established, and information provided was appropriate and accessible. Opportunities were made available for the resident’s engagement in meaningful activities.
The approved centre was not compliant with this code of practice for the following reasons:

a) The intellectual disability policy did not reflect presumption of capacity, 5.1.
b) The procedures for training staff in working with people with intellectual disability did not identify appropriately qualified people to deliver training, 6.2.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

Processes: The approved centre had a written draft policy in relation to the use of Electro-Convulsive Therapy (ECT), which had been reviewed in May 2017 but not yet approved. It addressed all criteria of this code of practice, including provisions in relation to the following:

- Storage of Dantrolene.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.
- Obtaining consent for maintenance/continuation of ECT.

Training and Education: Four staff members involved in delivering ECT were trained in line with best international practice. Four staff members involved in ECT did not have up-to-date Basic Life Support training.

Evidence of Implementation: Residents of the approved centre attended Letterkenny General Hospital for ECT treatment, which was delivered in the main operating theatre. There was documentary evidence that ECT machines were regularly maintained.

A named consultant had responsibility for ECT. The designated ECT nurse was responsible for checking emergency equipment and drugs. There was no named consultant anaesthetist with overall responsibility for anaesthesia for ECT. The on-call anaesthetist provided the service.

At the time of the inspection, no resident of the approved centre was receiving ECT treatment.

The approved centre was not compliant with this code of practice for the following reasons:

a) There was no named consultant anaesthetist with overall responsibility for anaesthesia for ECT, 11.2.

b) Four staff members involved in ECT did not have up-to-date Basic Life Support training, 11.7.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

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

Admission: The admission policy was dated April 2016. It included a protocol for planned admission with reference to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. It contained protocols for urgent referrals, self-presenting individuals, and timely communication with primary care teams. There was a policy on privacy but not a consent policy.

Transfer: The transfer policy, which was dated July 2015, detailed how a transfer was arranged and included provisions for emergency transfer and the safety of residents and staff during a transfer. It also outlined the roles and responsibilities of staff in relation to the transfer of residents. It did not reference transfers abroad.

Discharge: There were two discharge policies, a general policy dated July 2016 and a policy on the discharge of homeless people dated April 2015. They referenced prescriptions and supply of medication on discharge and included a protocol for discharging homeless people. They also addressed the management of discharge against medical advice. The discharge of people with an intellectual disability was addressed in the policy relating to individuals with intellectual disabilities. The policies did not include a protocol for the discharge of older persons or detail the process for following up and managing missed appointments.

Training and Education: Not all staff had signed a log indicating that they had read and understood the policies on admission, transfer, and discharge.

Monitoring: There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.

Evidence of Implementation:

Admission: Three clinical files were inspected in relation to admission. The entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was taken by the registered medical practitioner (RMP). Residents were admitted to the unit most appropriate to their needs. An admission assessment took place in all three cases, and all assessments and examinations were recorded in the clinical files. The approved centre did not have a key worker system in place therefore a key worker was not assigned to any of the three cases.
The approved centre’s admission process was compliant under Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, Regulation 20: Provision of Information to Residents, and Regulation 27: Maintenance of Records. It was not compliant under Regulation 15: Individual Care Plan.

Transfer: The approved centre was not compliant with Regulation 18: Transfer of Residents. One resident had been transferred since the 2016 inspection, and the relevant clinical file was reviewed. The resident was transferred to a 24-hour supervised residence because of a bed crisis in the approved centre. This was not done in the best interests of the resident. The decision to transfer was made by the RMP. An effort was made to respect the resident’s wishes and obtain consent, and a family member was involved in the transfer process.

There was no documentary evidence that the decision to transfer was agreed with the receiving facility. Nursing staff from the receiving facility attended the approved centre and completed a clinical risk assessment and management form with the approved centre’s nursing staff. An assessment of the resident was completed prior to the transfer. A letter of referral or a resident transfer form were not issued as part of the transfer.

Discharge: The clinical files of three recently discharged residents were inspected. In each case, the decision to discharge was made by the RMP and a discharge plan was in place as part of the residents’ individual care plans. A discharge-planning meeting took place, and residents underwent a comprehensive assessment prior to discharge.

A preliminary discharge summary was sent to the relevant primary care/community mental health teams within three days. Comprehensive discharge summaries followed within 14 days in two cases. As the third discharge had taken place the day before the inspection, the comprehensive discharge summary had not yet been completed.

The admission, transfer, and discharge processes were non-compliant because the approved centre did not comply with Regulation 32: Risk Management Procedures.

The approved centre was not complaint with this code of practice for the following reasons:

a) There was no consent policy, 4.18.
b) The transfer policy did not include provisions for transfer abroad, 4.13.
c) The discharge policy did not include a method for following up and managing missed appointments, 4.14.
d) The discharge policy did not include a protocol for the discharge of older person, 4.17.
e) There was no documentary evidence that staff had read and understood the admission, transfer, or discharge policies, 9.1.
f) There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission and discharge policies, 4.19.
g) The admission process was non-compliant because the approved centre did not comply with Regulation 15: Individual Care Plan, 17.1.
h) The approved centre did not have a key worker system in place. Therefore, a key worker was not assigned to any of the three cases, 20.1 and 20.2.

i) The approved centre did not comply with Regulation 18: Transfer of Residents, 30.1.

j) The transfer of a resident to sleep out in a 24-hour residence due to a bed crisis was not done in the best interest of the resident, 25.1(a).

k) There was no documentary evidence that the decision to transfer was agreed with the receiving facility, 26.2.

l) There was no copy of the referral letter in the clinical file inspected in relation to transfer, 31.2.

m) The approved centre did not comply with Regulation 32: Risk Management Procedures, 7.1.
Appendix 1 – Corrective and Preventative Action Plan

Regulation 6: Food Safety

Report reference: Page 22-23

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring(^1) or New(^2) area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>1. The practice of catering staff sharing a bathroom with other staff did not ensure a high standard of hygiene in relation to the preparation of food.</td>
<td>New</td>
<td>Corrective Action(s): Single toilet in AC foyer to be allocated for Catering staff only Maintenance contacted re changing lock on door and make it accessible by key only Post-Holder(s) responsible: CNM3 Approved Centre; Domestic Supervisor; Maintenance manager</td>
<td>Memo to be issued by Domestic supervisor</td>
<td>No barriers to implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Sign erected on door to inform public and other staff that it is designated to catering staff only Memo to be issued to inform staff of changes Post-Holder(s) responsible: CNM3 Approved Centre Domestic Supervisor</td>
<td>Permanent sign to be fixed by 30/09/17</td>
<td>No barriers to implementation</td>
</tr>
</tbody>
</table>

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\(^1\) Area of non-compliance reoccurring from 2016

\(^2\) Area of non-compliance new in 2017
## Regulation 15: Individual Care Plan

*Report reference: Page 34-35*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
</tbody>
</table>

### 2. The eleven ICPs reviewed did not comprise a composite set of documents.

- **New**

  - **Corrective Action(s):**
    - All inpatient notes amended to become a composite set of notes
    - Post-Holder(s) responsible: Nursing staff
  - **Preventative Action(s):**
    - ICP to be developed into a booklet form
    - ICP training to be developed by CQPS CNM3 for all members of MDT and delivery of training commence September 2017 by CQPS CNM3
    - Post-Holder(s) responsible: ADON/CQPS CNM3

  - **Weekly check by nursing staff and Quartley ICP Audit. Outcomes to be discussed with ECD/ADON of AC**
  - **Achievable and realistic**
  - **Quartely Audit next due Sept 2017; Dec 2017**

### 3. Nine ICPs did not adequately specify the resources required to meet assessed resident needs.

- **Reoccurring since 2015**

  - **Corrective Action(s):**
    - ICP training to be developed by CQPS CNM3 for all members of MDT and commence September 2017
    - Post-Holder(s) responsible: CQPS CNM3 and AC CNM1
  - **Quartely Audit to be discussed with ECD; and Heads of Discipline at Sept Area management team meeting**
  - **Achievable and realistic**
  - **September 2017 to end October 2017**
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
|                           | Preventative Action(s): MDT involvement in the ICP process and audit of same  
Post-Holder(s) responsible: ECD and Heads of Discipline | Each Head of discipline will identify a member of their profession to participate in the ICP audits by 05/09/2017 | Achievable and realistic | 05/09/2017 |
| 4. Seven ICPs were not developed by the MDT.  
Reoccurring since 2015 | Corrective Action(s):  
ICP training to be developed by CQPS CNM3 for all members of MDT and commence September 2017  
Post-Holder(s) responsible: CQPS CNM3 and AC CNM1 | Quartely Audit to be discussed with ECD; and Heads of Discipline at Sept Area management team meeting | Barrier to implementation: WTE SW x1; WTE OT x1 and ½ WTE Psychologist in AC therefor AC MDT not working at full strength. An active recruitment process is currently underway through NRS, and all priority posts have been identified to address deficits in staffing levels | September 2017 to end October 2017 |
|                           | Preventative Action(s):  
All Heads of Discipline to ensure all staff attend training on ICP and become active participants in the ICP process  
Issue to be put on the agenda of the DMHS Quality and Risk meeting  
Post-Holder(s) responsible:  
ECD and Heads of Discipline | Training records | Achievable and realistic | September and October 2017 |
### Regulation 18: Transfer of Residents

*Report reference: Page 39-40*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>5. Not all relevant information was provided to the receiving facility.</td>
<td>New</td>
<td>Corrective Action(s): Transfer form is currently being reviewed and amended to include the requirements of Regulation 18 Transfer of Residents and Code of Practice Post-Holder(s) responsible: AC ADON/ ECD</td>
<td>ADON will produce and implement the new Transfer form by 30/9/17 with the support of ECD Review and Audit</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Staff to be informed of changed Transfer Form Post-Holder(s) responsible: AC ADON/ECD</td>
<td>Review and Audit</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
### Regulation 19: General Health

**Report reference: Page 41-42**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>6. Residents did not have adequate access to general health services, specifically an emergency medical response team.</td>
<td>New</td>
<td>Corrective Action(s): LUH Emergency Response Lead/CNS has confirmed with CNM3 of AC that Emergency Team will respond to medical emergencies in AC. Post-Holder(s) responsible: CNM3</td>
<td>On the event of a medical emergency Email trail available in Nurse manager office</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Letter issued by Registered Proprietor on 26/07/2017 to General Manager and ECD of LUH requesting meeting to discuss medical emergency response team attending the AC. Post-Holder(s) responsible: Registered Proprietor and ECD</td>
<td>ECD to issue Memo to staff to confirm and clarify that LUH Emergency Team to be contacted in the event of a Medical Emergency</td>
<td>Achievable and Realistic</td>
</tr>
</tbody>
</table>
### Area(s) of non-compliance

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<tr>
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<tbody>
<tr>
<td>7. The lack of appropriate screening in three rooms did not ensure that residents' privacy and dignity were respected at all times.</td>
<td>New</td>
<td>Corrective Action(s): Email sent by CQPS CNM3 to CNM’s re privacy in bedrooms</td>
<td>Clinical walkabout</td>
<td>Achievable and realistic</td>
<td>Immediately</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily check of bed curtains, window curtains and blinds on doors to take place in the Clinical walkabout.</td>
<td>Random checks by ADON/CNM3 of Average 3 per week minimum</td>
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<td></td>
<td></td>
<td>Nursing staff to become more vigilant. When noted CNM will contact Domestic Supervisor to replace same ASAP</td>
<td>Checklist will be developed by 30/09/17 to record issues identified and actions taken</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Post-Holder(s) responsible: Nursing staff/ AC CNM’s</td>
<td></td>
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<tr>
<td></td>
<td>Preventative Action(s): Memo to be issued to nursing staff of responsibility of adhering to Privacy Policy</td>
<td></td>
<td>ADON to issue Memo</td>
<td>Achievable and realistic</td>
<td>Immediately</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: AC CNM’s and Domestic Supervisor</td>
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</tbody>
</table>
### Regulation 22: Premises

**Report reference:** Page 46-47

<table>
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<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>8.</strong> There was a leak in the wall of one of the residents’ bedrooms which resulted in damp and paint chipping. In two of the female bathrooms the flush panel was missing.</td>
<td>New</td>
<td>Corrective Action(s): Maintenance contacted to fix same Post-Holder(s) responsible: AC ADON/ Maintenance Manager</td>
<td>Leak fixed</td>
<td>Monies have been identified for this area of concern and a submission has been made to seek the required funding to address this matter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Letter issued by Registered Proprietor on 26/07/2017 to General Manager and ECD of LUH requesting meeting to discuss maintenance with in the AC Post-Holder(s) responsible: Registered Proprietor and ECD</td>
<td>Record of meeting with LUH reflecting issues discussed.</td>
<td></td>
</tr>
<tr>
<td><strong>9.</strong> There was a strong smell of urine in two toilets.</td>
<td>New</td>
<td>Corrective Action(s): Domestic supervisor informed Post-Holder(s) responsible: Domestic supervisor</td>
<td>Clinical walkabout Random checks by ADON/CNM3 and Domestic Supervisor to average 3 per week minimum Checklist will be developed by 30/09/17 to record issues identified and actions taken Daily cleaning schedule of Domestic staff</td>
<td>Achievable and measurable</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
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<td>Achievable / Realistic</td>
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<td></td>
<td>Preventative Action(s): Domestic Supervisor to ensure domestic staff adhere to cleaning schedule</td>
<td>Audit and review of daily cleaning schedule</td>
<td>Achievable and realistic</td>
<td>September 2017</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Domestic Supervisor</td>
<td></td>
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<tr>
<td></td>
<td>Audit and review of daily cleaning schedule</td>
<td>Achievable and realistic</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Preventative Action(s): Results of ligature audit to be put on Risk Register and put on the agenda of the DMHS Quality and Risk group</td>
<td>Record of Q + R meeting will reflect issues discussed</td>
<td>Achievable and realistic</td>
<td>September 2017</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: ADON</td>
<td></td>
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</tr>
<tr>
<td>10. Hazards and ligature points were not minimised. This did not show due regard to the safety and well-being of residents.</td>
<td>New</td>
<td>Corrective Action(s): Letter issued by Registered Proprietor on 26/07/2017 to General Manager and ECD of LUH requesting meeting to discuss maintenance with in the AC</td>
<td>Record of meeting with LUH reflecting issues discussed.</td>
<td>End 4th Quarter 2017</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Registered Proprietor and ECD</td>
<td>Business manager to provide estimates of costs and plan to rectify issues identified in Audits. By 30/09/17</td>
<td></td>
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<td></td>
<td></td>
<td>Awaiting final technical report on the recent Ligature Audit to support submission for the required funding to address this area of concern as highlighted.</td>
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</table>
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
Report reference: Page 48-49

<table>
<thead>
<tr>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>11. The Irish Medical Council Registration Number of every medical practitioner prescribing medication to residents was not recorded on six MPARs.</td>
<td>Reoccurring since 2015</td>
<td>Corrective Action(s): ECD to link with all medical staff to assure compliance with using MCRN on prescriptions Post-Holders responsible: ECD</td>
<td>ECD to issue an urgent memo by 30/08/17 to medical staff to heighten awareness of this statutory requirement</td>
<td>Realistic and achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): ECD to designate Medical staff to audit MPAR’s Post-Holders responsible: ECD</td>
<td>Audit results and action plan to be presented to DMHS AMHMT</td>
<td>Realistic and measurable</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>12. The number of psychology staff was not appropriate to the assessed needs of the residents.</td>
<td>New</td>
<td>Corrective Action(s): Senior Psychology post to be sought for approval and prioritised to meet the assessment and therapeutic needs of the residents within the Approved Centre. Post-Holder(s) responsible: Principal Clinical Psychologist &amp; AMHMT</td>
<td>Psychology Manager to make business case to GM and AMHMT by mid August 2017</td>
<td>Challenge filling previous staff grade post.</td>
</tr>
<tr>
<td>13. Not all staff had up-to-date mandatory training in fire safety, BLS, the management of aggression and violence, and the Mental Health Act 2001.</td>
<td>Reoccurring since 2016</td>
<td>Corrective action(s): Memo from ECD to all staff to ensure mandatory training requirements in all 4 areas are achieved. Training plan to be developed to ensure compliance, taking account of numbers to be trained on each area / availability of training / release of staff and audit Post-holder(s): ECD / ADoN, Department of Psychiatry / Heads of Disciplines</td>
<td>Memo Issued Training Plan developed and implemented by 30/09/17 Training logs to be maintained on each staff member by Head of Discipline.</td>
<td>Availability of staff for training purposes (both trainer and trainee) may prove problematic – e.g. release and backfill</td>
</tr>
<tr>
<td>Preventative action(s):</td>
<td>Training Plan developed and implemente by 30/09/17</td>
<td>Availability of staff for training purposes (both trainer and trainee) may prove problematic – e.g. release and backfill</td>
<td>A schedule of training has been identified for all relevant staff within AC. This schedule is available if required. The schedule names the training subject and the dates they are running etc.</td>
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<tr>
<td>Training plan to be developed to ensure compliance, taking account of numbers to be trained on each area / availability of training / release of staff and audit</td>
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<tr>
<td>Post-holder(s): ADoN, Department of Psychiatry / Heads of Disciplines</td>
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</table>

**Update on the 2016 CAPA Plan:** Training Plans continue to be reviewed and analysed to meet targets. Availability of staff for training purposes (both trainer and trainee) continue to prove problematic due to release and backfill. Where staff attend mandatory training in their own time Time of in Lieu will be offered.
### Regulation 28: Register of Residents

**Report reference:** Page 57

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<tr>
<td>14. Residents’ diagnosis at admission and diagnosis at discharge were not consistently recorded.</td>
<td>New</td>
<td>Corrective Action(s): Memo to be issued by ECD to highlight to medical staff to input diagnosis on admission and discharge. MHA has emailed ICT support to see can an IT programme be written to extract information required to meet this regulation from the PPPM system where it is inputed. Post-Holder(s) responsible: ECD/Mental Health Administrator (MHA)</td>
<td>ECD to issue memo By 30/08/17</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Audit against Admission, Transfer and Discharge Code of Practice</td>
<td>Audit and review Business Manager to organise a meeting to review and improve the administrative processes by 30/09/2017.</td>
<td>Achievable and measurable</td>
<td></td>
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<td>Email sent 01/08/2017</td>
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<td>30/09/2017</td>
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</table>
### Regulation 29: Operating Policies and Procedures

**Report reference: Page 58**

<table>
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</tbody>
</table>
| **15. The care of the dying policy had not been reviewed within three years.** | **New** | **Corrective Action(s):**
The policy will be reviewed and signed off at next PPPG meeting  
Post-Holder(s) responsible:
ECD and PPPG committee | **Review and audit** | **Achievable and realistic** | **August 2017** |

Preventative Action(s):
Policy Audit will identify time frames for review  
Post-Holder(s) responsible:
PPPG committee | Annual Policy Audit and Schedule | **Achievable and realistic** | Annual Policy Audit and review of same as per scheduled date |

| **16. There was no statement adopting two generic policies for Regulation 32.** | **New** | **Corrective Action(s):**
PPPG will devise a local policy statement for all generic policies  
Post-Holder(s) responsible:
PPPG commitee | **Policy Audit and review** | **Lack of Admin support to PPPG group** | **End Sept 2017** |

Preventative Action(s):
This will become standard practice for PPPG group when adopting generic policies  
Post-Holder(s) responsible:
DMHS PPPG group | Chairperson of PPPG group will adopt this into the ongoing agenda of the group from 01/09/17 | | Annual Policy Audit and review of same as per schedule date. |
**Regulation 31: Complaints Procedures**

*Report reference: Page 60-61*

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17. The approved centre did not provide information to determine compliance with 31(4) and 31(6) of the regulation.

- **Corrective Action(s):**
  - (31.4) Complaints Officer has been clarified and identified
  - 31(6) Complaints record initiated 03 July 2017
  - Post-Holder(s) responsible: Complaints Officer/DMHS Business Manager

- **Preventative Action(s):** Registered Proprietor to inform of changes to Complaints Officer
  - Post-Holder(s) responsible: Registered Proprietor

- **Measureable:** The Complaints information on public display has been amended with the correct information since 03/07/2017
- **Achievable / Realistic:** Completed
- **Time-bound:** 03/07/2017

- **Achievable and realistic:** Business manager will issue a memo by 30/08/17 to inform all staff of same.
- **Time-bound:** 30/08/2017
### Regulation 32: Risk Management Procedures (and Code of Practice: Notification of Deaths and Incident Reporting)

Report reference: Page 62-64 and 78

<table>
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<tbody>
<tr>
<td><strong>18.</strong> The policies did not include a process for learning from, reviewing and monitoring incidents.</td>
<td>New Corrective Action(s): The policy to be reviewed and amended to address the areas of non-compliance Post-Holder(s) responsible: PPPG group</td>
<td>Review and audit</td>
<td>Achievable and realistic however there is a lack of Admin support to the PPPG group. This matter for discussion at AMHMT in August.</td>
<td>End August 2017</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Audit of policy against the regulation Post-Holder(s) responsible: PPPG group</td>
<td>Audit</td>
<td>Achievable and realistic</td>
<td>End August 2017</td>
</tr>
<tr>
<td><strong>19.</strong> There were no policy arrangements for responding to emergencies.</td>
<td>New Corrective Action(s): The policy to be reviewed and amended to address the areas of non-compliance Post-Holder(s) responsible: PPPG group</td>
<td>Review and audit</td>
<td>Achievable and realistic</td>
<td>End August 2017</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Audit of policy against the regulation Post-Holder(s) responsible: PPPG group</td>
<td>Review and audit</td>
<td>Achievable and realistic</td>
<td>End August 2017</td>
</tr>
<tr>
<td><strong>20.</strong> The policy did not identify the roles and responsibilities of staff in relation to reporting deaths and incidents, completing</td>
<td>Reoccurring since 2016 Corrective Action(s): The policy had been reviewed and updated from the 2016 MHC visit but was awaiting approval and sign off on the 2017 MHC visit Post-Holder(s) responsible: PPPG group chair</td>
<td>Review and audit</td>
<td>Policy has been amended</td>
<td>PPPG group to meet end August 2017 and edit the policy documentation in adherence with the JSF.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<tr>
<td>death notification forms, submitting forms to the MHC, and completing six-monthly incident summary reports.</td>
<td>Preventative Action(s): Audit of policy against the regulation Post-Holder(s) responsible: PPPG group</td>
<td>Review and audit</td>
<td>Achievable and realistic</td>
<td></td>
</tr>
</tbody>
</table>
### Section 59: The Use of Electro-Convulsive Therapy (and Code of Practice: The Use of Electro-Convulsive Therapy for Voluntary Patients)

*Report reference: Page 68 and 81*

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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>21. There was no named consultant anaesthetist with overall responsibility for anaesthesia in ECT.</td>
<td>New</td>
<td>Corrective Action(s): Letter issued by Registered Proprietor on 26/07/2017 to General Manager and ECD of LUH requesting meeting to discuss named anaesthetist for ECT. Post-Holder(s) responsible: Registered Proprietor and ECD</td>
<td>Record of meeting with LUH reflecting issues discussed.</td>
<td>Requirement to negotiate this with SAOLTA/ LUH Letter has issued to the Senior Management team of LUH for 7th September to meet with the proprietor and the ECD with the purpose of exploring a collective solution to achieve compliance as outlined and guided by the SJF</td>
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<td>Preventative Action(s):</td>
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<td>Post-Holder(s) responsible:</td>
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</tr>
<tr>
<td>22. Four staff members involved in ECT did not have up-to-date Basic Life Support training.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): 3 out of 4 staff have BLS training completed July 2017. 1 staff to complete by end August 2017 Post-Holder(s) responsible: CNM3 AC</td>
<td>Staff training plan</td>
<td>Release and backfill of staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Audit of Training Plan Post-Holder(s) responsible: ADON/Heads of Service</td>
<td>Staff training plan</td>
<td>Release and backfill of staff</td>
</tr>
</tbody>
</table>
## Section 69: The Use of Seclusion

**Report reference: Page 69-70**

<table>
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<tr>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>23. The policy did not meet all the requirements of the rules.</td>
<td>New</td>
<td>Corrective Action(s): Policy to be reviewed and amended to address areas of non-compliance Post-Holder(s) responsible: DMHS PPPG group</td>
<td>Review and audit of policy against the Rules of Seclusion</td>
<td>Achievable and realistic</td>
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<td>Preventative Action(s): Policy Audit against the Rules and Code of Practice Post-Holder(s) responsible: PPPG group</td>
<td>Review and audit</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>24. The mattress in the seclusion area did not ensure patient safety.</td>
<td>New</td>
<td>Corrective Action(s): Mattress has been replaced July 2017 Post-Holder(s) responsible: ADON/CNM3 Approved Centre</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
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<td>Area(s) of non-compliance</td>
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<td>25. Not all staff had signed the physical restraint policy, indicating that they had read and understood it.</td>
<td>New</td>
<td>Corrective Action(s): Memo to all MDT staff to read and sign the policy; Post-Holder(s) responsible: ECD/ PPPG group/ Heads of Discipline</td>
<td>Review of</td>
<td>Achievable and realistic</td>
</tr>
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<td></td>
<td></td>
<td>Preventative Action(s): Heads of Discipline to keep records of staff signage and monitor same; Post-Holder(s) responsible: Heads of Discipline/ECD</td>
<td>Review and audit of policy records</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>26. The use of physical restraint was not clearly recorded in the clinical file in one episode.</td>
<td>New</td>
<td>Corrective Action(s): Training on the Rules and Code of Practice: The use of Physical Restraint to be developed and implemented in September/October 2017 to all MDT staff in AC July 2017; Post-Holder(s) responsible: CNM’s to deliver</td>
<td>Training records</td>
<td>Achievable and realistic</td>
</tr>
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<td></td>
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<td>Preventative Action(s): Staff training to ensure compliance; Post-Holder(s) responsible: All Heads of Discipline</td>
<td>Monitoring of attendance of training</td>
<td>Achievable and realistic</td>
</tr>
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<td>27. In three episodes, there was no documentary evidence that residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): Training on the Rules and Code of Practice: The use of Physical Restraint to be developed and implemented in September/October 2017 to all MDT staff in AC Post-Holder(s) responsible: CNM’s to deliver</td>
<td>Audit and review of documentation against episodes of Restraint Training records</td>
<td>Achievable and realistic</td>
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<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Staff training to ensure compliance Post-Holder(s) responsible: All Heads of Discipline</td>
<td>Training records</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>28. In two episodes, it was not documented that next of kin were informed of the use of physical restraint as soon as was practicable.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): Training on the Code of Practice: The use of Physical Restraint to be developed and implemented in September/October 2017 to all MDT staff in AC Post-Holder(s) responsible: CNM’s to deliver</td>
<td>Audit and review of documentation against episodes of Restraint Training records</td>
<td>Achievable and realistic</td>
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<td>Preventative Action(s): Staff training to ensure compliance Post-Holder(s) responsible: All Heads of Discipline</td>
<td>Audit and review</td>
<td>Achievable and realistic</td>
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<tr>
<td><strong>29. Did not provide age-appropriate facilities and a programme of activities appropriate to the age and ability of the child resident.</strong></td>
<td>Reoccurring since 2016 Corrective action(s): ICP to outline age appropriate programme of activities Individually assessed needs based on CRAM 2017: Inpatient CAMHS team contacted to provide information on same and programme of activities will be devised following consultation with them. Post-holder(s): All members of the MDT / Heads of Disciplines Preventative action(s): On the admission of a child the ICP will identify specific age appropriate programmes/activities 2017: Newly devised programme of activities will be incorporated in Child Admission Policy Post-holder(s): All members of the MDT / Heads of Disciplines</td>
<td>Monitoring of ICP by MDT when a child is admitted CQPS CNM3</td>
<td>Achievable and realistic 2017: Barrier to implementation: AC is an adult mental health facility</td>
<td>As required when child admitted to Dept. of Psychiatry</td>
</tr>
<tr>
<td><strong>30. The resident did not have access to an age-appropriate advocacy service.</strong></td>
<td>New Corrective Action(s): There is no National Mental Health Child advocacy services Preventative Action(s): To be discussed at CHO1 AMMHT meeting Sept 2017 Post-Holder(s) responsible: DON</td>
<td></td>
<td>Unachievable and unrealistic This matter for further discussion at AMHMT. ECD</td>
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<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>31. The policy did not cover all requirements of the Code.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): The policy is currently being reviewed and amended and is awaiting sign</td>
<td>Policy audit and review against the Code of practice</td>
<td>Achievable and realistic however there is a lack of Admin support to the PPPG group</td>
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<td>Post-Holder(s) responsible: DMHS PPPG group</td>
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<td>Preventative Action(s): Audit of Policy against Code of Practice</td>
<td>Review and audit</td>
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<td>32. The admission, transfer and discharge policies did not cover all requirements of the Code.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s):</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The policy is currently being reviewed and amended and is awaiting sign off by PPPG team</td>
<td>Policy audit and review</td>
<td>Lack of Admin support to update policy</td>
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<td></td>
<td></td>
<td>Post-Holder(s) responsible: DMHS PPPG team</td>
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<td>Preventative Action(s):</td>
<td>Policy audit and review</td>
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<td>Audit of Policy against Code of Practice</td>
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<td>Post-Holder(s) responsible: PPPG team</td>
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<tr>
<td>33. There was no documentary evidence that staff had read and understood the admission, transfer, or discharge policies.</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>Review and Record of signatures</td>
<td>Achievable and realistic</td>
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<td></td>
<td>All heads of Discipline to ensure that staff have read and understood the Policy</td>
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<td>Post-Holder(s) responsible: Heads of Discipline/ ECD</td>
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<td></td>
<td>Preventative Action(s):</td>
<td>Review and audit of same</td>
<td>Achievable and realistic</td>
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<td>Signature Log to be kept and reviewed by Heads of Discipline</td>
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<td></td>
<td>Post-Holder(s) responsible: Heads of Discipline</td>
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<td>34. There was no documentary evidence that an audit had been completed on the</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>Review and Audit of Audit schedule</td>
<td>Achievable</td>
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<td>As per Audit schedule 2017 audits not due to Quarter 4 2017</td>
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| implementation of and adherence to the admission and discharge policies.                  | Preventative Action(s): Adherence to Audit schedule for Approved Centre  
Post-Holder(s) responsible: CQPS CNM3                                                                                                       | Review and audit     | Achievable             | Ongoing monitoring and adherence to audit schedule                         |
| 35. The approved centre did not have a key worker system in place. Therefore, a key worker was not assigned to any of the three cases. | New  
Corrective Action(s):  
ICP training to be developed for all members of the MDT and commence September 2017  
ECD to issue a memo to Consultants as MDT leads to identify a key worker  
Post-Holder(s) responsible:  
CQPS CNM3 and Approved Centre CNM1  
ECD  
Preventative Action(s):  
All Heads of Discipline to ensure staff attend ICP training and become more active participants in the ICP process.  
An active recruitment process is currently underway through NRS, and all priority posts have been identified.  
Post-Holder(s) responsible:  
ECD and Heads of Discipline  | ECD to issue memo | Barrier to implementation: WTE SW x1; WTE OT x1 and ½ WTE Psychologist in AC  
However there is an active recruitment campaign underway in DMHS for priority posts to address any shortfalls in supporting the AC. | End October 2017     |
| 36. The transfer of a resident to sleep out in a 24-hour residence due to a bed crisis was not done in the best interest of the resident. | New  
Corrective Action(s):  
When there is a bed crisis resident transfer is determined by Consultant and Nursing mgt and is based on individual Risk Assessment and when all other alternatives have been exhausted  
Post-Holder(s) responsible: ECD/ Treating Consultant/ ADON/ CNM’s  | Memo to be issued by ECD by 30/09/17 | Achievable and realistic | End August 2017   |
<table>
<thead>
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<tr>
<td>Preventative Action(s): Other alternatives to be considered prior to decision to transfer resident to another facility</td>
<td>Preventative Action(s): Transfer log to be updated and Audit of Resident Transfer</td>
<td>Review and Audit</td>
<td>No barriers to implementation</td>
<td>Transfer log to be updated immediately Audit by end of Quarter 4 as per Audit schedule 2017</td>
</tr>
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<td>Post-Holder(s) responsible: ECD/ Treating Consultant/ ADON/ CNM’s</td>
<td>Preventative Action(s): Transfer log to be updated and Audit of Resident Transfer</td>
<td>Review and Audit</td>
<td>No barriers to implementation</td>
<td>End September 2017</td>
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<td>Preventative Action(s): Transfer log to be updated and Audit of Resident Transfer</td>
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<td>No barriers to implementation</td>
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<td>New Corrective Action(s): New transfer form is being developed and will include same. Awaiting review and implementation</td>
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