Coimisiún Meabhair-Shláinte | Mental Health Commission

Rehabilitation and Recovery Mental Health Unit, St. John's Hospital Campus

ID Number: AC0101

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

St. John's Hospital Campus
Ballytivnan
Sligo
Co. Sligo

Approved Centre Type:
Continuing Mental Health Care/Long Stay
Mental Health Rehabilitation

Most Recent Registration Date:
17 November 2016

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Teresa Dykes

Inspection Team:
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Inspection Date:
8 – 11 August 2017

Inspection Type:
Focused Inspection

Previous Inspection Date:
29 November – 1 December 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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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.

On a focused inspection, the Inspector does not assess all regulations, rules, code of practice, and Part 4 of the 2001 Act. The focus of the inspection will be on specific legislative requirements, or parts of legislative requirements where it is determined that there may be a risk to the safety, health and wellbeing of residents and/or staff members.

Following the focused 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 and risk ratings, 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.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.

2.0 Inspector of Mental Health Services – Summary of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

As Inspector of Mental Health Services, I have provided a summary of findings from the focused inspection of the Rehabilitation and Recovery Mental Health Unit.

The Rehabilitation and Recovery Mental Health Unit did not operate as a rehabilitation unit but as a continuing care unit. A number of residents were inappropriately placed there. Care and treatment was provided by the nursing staff and GP only; there was no occupational therapist, psychologist, social worker or consultant psychiatrist. There was no access to speech and language therapy except on a good will basis and no access to physiotherapy. This was despite clear indication that residents urgently required these inputs. The placement of one resident in the approved centre had resulted in an unacceptable risk to the resident because of their physical needs. As there was no consultant psychiatrist and multidisciplinary team (MDT) for the approved centre, the nurses and GP were making decisions that should be made with the support of the MDT and consultant psychiatrist. There was a non-consultant hospital doctor assigned to the unit but in the absence of a supervising consultant psychiatrist, this was not satisfactory. Furthermore, the lack of access to physiotherapy and speech and language therapy on the basis that residents are in a mental health unit is discriminatory, in view of the fact that these services were available in St John's Hospital to all other non-mental health patients.

There were limited recreational activities. There were no therapeutic services and programmes. This was despite an occupational therapy assessment indicating a need for these inputs. The premises was in a poor state of maintenance and decorative order and not suitable for a rehabilitation unit: there was no laundry room, no training kitchen and only three single bedrooms.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Rehabilitation and Recovery Mental Health Unit was located in St John's Hospital in Sligo. There was no signage indicating its location and no name over the door of the approved centre. There were two locked doors at the entrance to the approved centre and darkened glass in the door, giving a custodial appearance. The approved centre was institutionalized in structure and in a poor state of decoration. There were only three single rooms, the remaining six residents shared double rooms. There was access to two courtyards. Residents had complex physical and psychiatric needs and were mostly over 65 years.

Despite its name, the approved centre did not provide any rehabilitation and recovery programmes, therapeutic services and programmes, multi-disciplinary input or a psychiatrist with responsibility for the approved centre. No admissions had taken place to the approved centre in line with Condition 1 to its registration outlined below. Each resident had been assessed by an occupational therapist in line with Condition 2 outlined below. However, while some residents had been placed in appropriate settings, five remained inappropriately placed in the approved centre.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**9**
Number of detained patients	0
Number of Wards of Court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	9

3.2 Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: The Mental Health Commission prohibits the admission or transfer of persons to the Rehab and Recovery Mental Unit, St. John's Hospital Campus.

Condition 2: The Mental Health Commission requires that an assessment of the needs of current residents of the Rehab and Recovery Mental Health Unit, St. John's Hospital Campus is carried out, with residents appropriately placed in accordance with their assessed needs by no later than 21 December 2016.

3.3 Governance

The approved centre was located in Community Health Organisation (CHO 1) and was part of the Sligo/Leitrim Mental Health Services. As there was no consultant psychiatrist or multidisciplinary team for the approved centre decisions were made by the Director of Nursing and nursing staff. There was no clinical

director for the approved centre. The Executive Clinical Director had one meeting with nursing staff in the approved centre in 2017. There had been no progress in appointing a rehabilitation and recovery team and consultant psychiatrist for the approved centre. Governance of the approved centre was entirely inadequate.

4.0 Background

4.1 Reason for focused inspection

The previous inspection of the approved centre on 29 November – 1 December 2016 identified the following areas of concern:

Regulation/Rule/Act/Code	Risk Rating
Regulation 9: Recreational Activities	High
Regulation 15: Individual Care Plan	High
Regulation 16: Therapeutic Services and Programmes	High
Regulation 22: Premises	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	High
Regulation 26: Staffing	High
Regulation 32: Risk Management Procedures	Moderate
Rules Governing the Use of Mechanical Means of Bodily Restraint	High

Ongoing monitoring of the Corrective and Preventative Actions (CAPA) and staff training report updates following the 2016 inspection demonstrated that there were no staff assigned to the approved centre except nursing, domestic attendants and multi-task attendants; there was no consultant psychiatrist assigned to the approved centre; and no multidisciplinary input into the care and treatment of residents. The updates showed little or no progress on actions that were to be completed by 31 December 2016.

It was determined that a focused inspection should be undertaken to gather further information in relation to these areas and to ascertain whether appropriate actions had been taken to address the risks identified.

4.2 Focus of inspection

The focus of the inspection was to assess the following:

- Whether there was an active clinical director for the approved centre.
- The current staffing complement in the approved centre.
- Whether care plans had been developed or reviewed by the MDT.
- Access to therapeutic services.
- Medication practices.
-

Specific legislative requirements, or parts thereof, inspected as part of the focused inspection were as follows:

Regulation/Rule/Act/Code	Part (or full regulation)
Section 71 Mental Health Act 2001	
Regulation 9: Recreational Activities	Full
Regulation 15: Individual Care Plan	Full
Regulation 22: Premises	Full
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	Full
Regulation 26: Staffing	Full
Rules Governing the Use of Mechanical Means of Bodily Restraint	Not Applicable

5.0 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:

- Clinical Director
- Occupational Therapy Manager
- Compliance, Quality, and Safety Officer
- Non-Consultant Hospital Doctor
- Acting Assistant Director of Nursing
- Acting Clinical Nurse Manager 2
- Support Service Supervisor
- Business Manager

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. Serious concern was expressed by the Inspector as to the care and treatment of one resident in particular whose needs were not being met in the approved centre and whose continued placement in the approved centre had resulted in an unacceptable risk to the resident because of their physical needs. The senior management team were asked to address this as a matter of urgency. The business manager undertook to source physiotherapy and speech and language therapy for the residents who had urgent need for these therapies, which were not being provided.

6.0 Focused Inspection Findings

Regulation 9: Recreational Activities

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

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

INSPECTION FOCUS

The full regulation was inspected, including adherence to the *Judgement Support Framework* to ascertain whether appropriate actions have been taken to address the risks identified.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in February 2017. The policy addressed requirements of the *Judgement Support Framework,* with the exception of the facilities available for recreational activities, including the identification of suitable locations.

Training and Education: Not all relevant staff had signed a signature log, to indicate 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 record of resident attendance. Analysis had been completed to identify opportunities for improving the processes relating to recreational activities, and this was documented in the community minutes' book.

Evidence of Implementation: Nursing staff were responsible for all recreational activities, including playing board games and cards, playing CDs, doing manicures, supervising resident walks in the garden, and hosting the newspaper group. Activities were not always available at the weekends. Minutes from the community meetings indicated the importance of outings for residents, but there were not enough staff on duty to facilitate outings at the weekends, which was the only time that residents had access to transport.

An occupational therapist had completed Pool Activity Level assessments, which indicated suitable activities for residents, but these had not been acted upon. A timetable of activities was posted on a noticeboard in the approved centre, but the occurrence of activities was dependent on the availability of nursing staff. Activities were discussed at the resident weekly meetings, and residents' "My Life" books contained information on hobbies and interests. Nursing staff completed risk assessments in relation to residents' selection of appropriate activities, and residents' decisions on whether or not to participate in recreational activities were respected. The inspectors observed few or no personal effects in residents' bedrooms, particularly shared rooms, which were bare and not conducive to rest and relaxation.

Recreational activities were not appropriately resourced. Art therapy had not been provided since the last inspection. A musician attended only once a month, and there was a poor supply of recreational equipment, including colours, draughts, skittles, playing cards, CDs, and DVDs. Where possible, nursing staff took residents for walks outside and did some gentle exercise with them, but there was no structured walking or exercise group. Residents had access to two courtyards, a Snoezelen room, and a garden room in St. John's Hospital. Records of resident attendance at events were maintained.

The approved centre was non-compliant with this regulation because residents were not provided with access to appropriate recreational activities.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Quality Rating	Requires Improvement
Risk Rating	CRITICAL

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 FOCUS

The full regulation was inspected, including adherence to the *Judgement Support Framework* to ascertain whether appropriate actions have been taken to address the risks identified.

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 dated February 2017. It included all of the requirements of the *Judgement Support Framework.*

Training and Education: Not all clinical staff had signed a signature log, indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes relating to individual care planning.

Monitoring: Residents' ICPs were not audited on a quarterly basis to assess compliance with the regulation. Analysis had not been completed to identify opportunities for improving the individual care planning process.

Evidence of Implementation: The ICPs of six residents were inspected. Each was a composite set of documents, stored in the respective clinical files, and they were identifiable, uninterrupted, and kept separately from progress notes. The ICPs specified residents' goals, treatment, and care and included reviews. The resources required to address identified care and treatment for residents were not specified in any of the ICPs reviewed. All of the ICPs inspected included risk assessments and risk management plans. The approved centre had a key worker system in place.

In practice, the ICPs were nursing care plans. They were not developed by a multidisciplinary team and did not receive any MDT or medical input. Residents had ongoing nursing assessments, as well as a recent mental state examination. Evidence-based assessments were used, notably Pool Activity Level assessments. The ICPs were not reviewed by the MDT in consultation with residents every six months. They were updated following a nursing review, as indicated by residents' changing needs, condition, circumstances, and goals.

There was no evidence that ICPs were discussed, agreed where practicable, and developed with the participation of residents and their representatives, family, or next of kin. Residents did not have access to their ICPs and were not informed of any changes, and no justification for this was documented. The ICPs did not include up-to-date preliminary discharge plans.

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

a) **The ICPs were nursing care plans and did not receive MDT or medical input.**
b) **The resources required to address identified care and treatment for residents were not specified in the ICPs inspected.**
c) **There was no evidence that residents, their representatives, family, or next of kin were involved in the care planning process.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Quality Rating	Requires Improvement
Risk Rating	CRITICAL

(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 FOCUS

The full regulation was inspected, including adherence to the *Judgement Support Framework* to ascertain whether appropriate actions have been taken to address the risks identified.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was last reviewed in April 2017. It addressed requirements of the *Judgement Support Framework,* with the exception of processes for the following:

- The planning and provision of therapeutic services and programmes within the approved centre.
- The assessment of residents as to the appropriateness of services and programmes and the resource requirements of the therapeutic services and programmes.

Training and Education: Not all clinical staff had signed a log, to indicate 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 not monitored on an ongoing basis to ensure that residents' assessed needs were met. Analysis had not been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: The range of available therapeutic services and programmes was not appropriate and did not meet the assessed needs of residents. Residents had been assessed in April 2017 by an occupational therapist, using the Pool Activity Level (PAL) assessment. Specific programmes were identified as being of benefit to residents such as cooking and gardening. However, none of the recommendations had been acted upon or incorporated into residents' individual care plans (ICPs).

No therapeutic services or programmes were provided in the approved centre, apart from hand massage, which was not listed in the ICPs. There was no psychology input for residents, including those who exhibited challenging behaviour. The residents did not have input from a dietitian, and there had been no art therapy sessions since the 2016 inspection.

There was no input from occupational therapy (OT) into assessed needs such as falls prevention and seating assessments. The approved centre had no OT-provided groups, despite the identification of group activities that would help to maintain the physical and psychosocial functioning of residents, using the PAL assessment.

Adequate and appropriate resources were not available to provide therapeutic services and programmes. There was no MDT input into residents' Fair Deal applications for nursing home care. Residents did not have regular access to physiotherapy or speech and language therapy and were dependent for these services on the goodwill of staff from St. Johns' Hospital. Residents' ICPs did not specify the resources or interventions required to help them to achieve their goals. Although two residents wanted to live at home, there was no involvement from social work to facilitate this.

A timetable of recreational activities was provided in the approved centre, but the only therapeutic services listed was hand massage. At the time of the inspection, no resident was receiving a therapeutic service or programme outside of the approved centre. Details of the residents' participation in, engagement with, and outcomes achieved in therapeutic services or programmes were not documented in their ICPs or clinical files.

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

a) **Residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their ICPs, 16(1).**
b) **Programmes and services provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).**

Regulation 22: Premises

NON-COMPLIANT

Quality Rating	**Requires Improvement**
Risk Rating	**CRITICAL**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FOCUS

The full regulation was inspected, including adherence to the *Judgement Support Framework* to ascertain whether appropriate actions have been taken to address the risks identified.

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to its premises.

Training and Education: There was no policy for relevant staff to read and understand. Relevant staff interviewed were able to articulate the processes relating to the maintenance of the premises.

Monitoring: The approved centre had completed a hygiene audit. A ligature audit had not been completed. There had been no documented analysis to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space and to appropriately sized communal rooms. Communal rooms were adequately lit to facilitate reading and other activities, and corridor areas were bright. Rooms were comfortably heated, and they were suitably sized and furnished to ensure that noise levels were minimised. There were only three single bedrooms available. The rest of the accommodation consisted of double and four-bed rooms, with privacy screening around the beds. The shared rooms were bare and not personalised.

Sufficient spaces were provided for residents to move about, including two outdoor areas. Hazards such as large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard and rough surfaces had been minimised. Ligature points were mitigated.

Appropriate signage was not in place to identify the approved centre, making it difficult to find. Ventilation was inadequate in bathrooms, which were damp and filled with condensation. The approved centre was not in a good state of repair. The inspectors observed peeling paint, flaking plasterwork, scuffed walls,

stained ceilings, and poor drainage in showers. There was no ongoing maintenance programme in place. Maintenance issues were addressed as they arose. Faults were communicated by phone or e-mail or using requisition orders.

A cleaning schedule was in place, and the approved centre was clean, hygienic, and free from offensive odours. National infection control guidelines were followed. There were adequate toilet and bathroom facilities, including clearly signed assisted needs and wheelchair-accessible facilities. There were designated sluice and cleaning rooms. Assisted devices and/or equipment were available, where required.

There was no laundry room or dedicated examination room and no training kitchen. Not all of the bedrooms were appropriately sized to address residents' needs in that one of the single rooms was very small.

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

a) **The premises were in a poor state of repair, 22(1)(a).**
b) **Bathrooms were damp and poorly ventilated and there was poor drainage in showers, 22(1)(b).**
c) **There was no ongoing programme of maintenance, 22(1)(c).**
d) **There was no laundry room or training kitchen for the rehabilitation needs of residents, 22(3).**

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

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating MODERATE

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

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

INSPECTION FOCUS

The full regulation was inspected, including adherence to the *Judgement Support Framework* to ascertain whether appropriate actions have been taken to address the risks identified.

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 February 2017. It included requirements of the *Judgement Support Framework,* with the exception of processes for reconciling medication and reviewing resident medication.

Training and Education: Not all nursing and medical staff had signed the signature log, to indicate that they had read and understood the policy. Relevant 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. Not all nursing, medical, and pharmacy staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Medication Prescription and Administration Records (MPARs) were audited on a monthly basis to determine compliance with the policies and procedures and the applicable legislation and guidelines. There was a process for recording incident reports for medication issues, but there had been no medication errors or incidents since the last inspection. Analysis had been completed to identify opportunities for improving medication management, and action plans were developed.

Evidence of Implementation: An MPAR was maintained for each resident, and each resident's MPAR was inspected. In the eight MPARs examined, two appropriate resident identifiers were used, including name, date of birth, and photograph. Names of medications were written in full, and the frequency of administration, the dosage, and the administration route for medications were recorded.

The generic name of medication was not recorded in three MPARs, and the allergy section was not completed in one MPAR. The Medical Council Registration Number (MRCN) of the medical practitioners prescribing medication to residents was not recorded in six MPARs.
Residents' medication was reviewed at least six-monthly, with the MPAR requiring renewal after 24 weeks. Where there was an alteration in the medication order, the medical practitioner rewrote the prescription. Medication was appropriately administered by a registered nurse or registered medical practitioner. The expiration date of medication was checked by the pharmacy technician. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. 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.

Controlled drugs were not being prescribed for any residents at the time of the inspection. Directions to crush medication were only accepted from residents' medical practitioner, and specific advice from the pharmacy was recorded in MPARs regarding procedures to be followed when crushing medication.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Where medication required refrigeration, a daily temperature log was maintained. The medication fridge was also alarmed. Medication was stored in a locked trolley or in locked cabinets in a secure room, and there was a separate secure cabinet for storing scheduled controlled drugs.

Medication storage areas were free from damp and mould and were clean and well maintained. No food or drinks were stored in areas used for storing medication. A system of stock rotation was in place, and an inventory of medications was completed monthly by the pharmacy technician.

The approved centre was non-compliant with section 1 of this regulation for the following reasons:

a) **The MCRN of the prescriber was not recorded in six MPARs, as required by law.**
b) **The allergy section was not completed in one MPAR.**
c) **The generic name of medication was not recorded in three MPARs.**

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating	Requires Improvement
Risk Rating	CRITICAL

(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 FOCUS

The full regulation was inspected, including adherence to the *Judgement Support Framework* to ascertain whether appropriate actions have been taken to address the risks identified.

INSPECTION FINDINGS

Processes: The approved centre did not have a written staffing policy.

Training and Education: There was no policy for relevant staff to read and understand. Relevant staff interviewed were able to articulate the processes relating to staffing in the approved centre.

Monitoring: There was documented evidence that the implementation and effectiveness of the staff training plan had been reviewed annually. The numbers and skill mix of staff had been reviewed by the clinical nurse manager (CNM) 2 against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place to identify the leadership and management structure and lines of authority and accountability. A planned and actual staff rota was in place. All staff had been Garda vetted. All nursing staff were registered psychiatric nurses and, therefore, appropriately qualified for their roles. The approved centre did not use agency staff.

The numbers and skill mix of staffing were not sufficient to meet residents' needs. At the time of the inspection, there was no consultant psychiatrist and no multi-disciplinary team (MDT) for the approved centre. Specifically, there was no occupational therapist, no social worker, and no psychologist in the approved centre. In addition, there were only two nursing staff on duty on some weekends, with no manager. The needs of residents indicated that a CNM 2 was required at weekends, but coverage was provided by a CNM 3, who was not on-site, meaning that an appropriately qualified staff member was not on duty and in charge at all times. Residents had no access to speech and language therapy, except on a "favour" basis and no access to physiotherapy or to occupational therapy for seating assessments.

The approved centre did not provide a written staffing plan to the inspection team. Annual staff training plans had been completed, and staff training was documented. Not all health care professional had up-

to-date mandatory training in fire safety, Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act (MHA) 2001. No staff member had been trained in Children First.

Staff were trained in manual handling, infection control and prevention, and incident reporting. Staff had not received training in dementia care, care for residents with an intellectual disability, end of life care, resident rights, risk management, recovery-centred approaches to mental health care and treatment, and the protection of children and vulnerable adults.

The MHA 2001, the associated regulation, and Mental Health Commission rules and codes were not available on the ward.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Rehab and Recovery Mental Health Unit	CNM 2	1 (not at weekends)	0
	RPN	2	2
	Intern	1	0
	MTA	1	
	Occupational Therapist	0	
	Social Worker	0	
	Psychologist	0	

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Multi-Task Assistant (MTA)

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

a) **There was no written policy in relation to the recruitment, selection, and vetting of staff, 26(1).**
b) **The numbers and skill mix of staff were not appropriate to the assessed needs of residents or the size and layout of the approved centre, 26(2):**
    - **There was no consultant psychiatrist.**
    - **There was no occupational therapy, social work, or psychology input into the approved centre.**
    - **Residents did not have formal access to speech and language therapy.**
    - **There was no physiotherapist.**
c) **An appropriately qualified staff member was not on duty and in charge at all times in the approved centre and there was insufficient nursing cover at weekends, 26(3).**
d) **Not all staff had up-to-date mandatory training in BLS, fire safety, the management of aggression and violence, and the MHA 2001, 26(4) and (5).**
e) **Copies of the MHA 2001 and associated regulations and rules were not available on the ward, 26(6).**

Section 69: The Use of Mechanical Restraint

NOT APPLICABLE

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

INSPECTION FINDINGS

As mechanical means of bodily restraint had not been used in the approved centre since the last inspection, this rule was not applicable.

APPENDIX 1 – Corrective and Preventative Action Plan

Regulation 9: Recreational Activities

Report reference: Page 11-12

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring[1] or New[2] area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
1. Residents were not provided with access to appropriate recreational activities.	Reoccurring	• Corrective Action(s): SLMHS will ensure the implementation of a programme of structured walking and exercise groups. • Art therapy and music therapy wil be introduced. • Funding will also be approved for the purchase of recreational equiptment. • Bedrooms will be decorated to ensure they are conducive to rest and relaxation. • Outings will be prioritised for the weekends with planning in advance to ensure all reasonable measures are in place to ensure that these occur. • Occupational Therapy will provide Inservcie Training to staff in regards to Recreational Activities as identified within the residents ICP's. Post-Holder(s) responsible: ADON, CNM2, Business Manager.	Residents satisfaction with recreational activities will be a standing agenda for the ward meetings, this will be recorded by staff with 3 monthly analysis from CQPS.	There are no barriers to the implementation of actions 1-4. Staffing levels at the weekend may affect availability of outings but all reasonable measures will be in place to ensure that these outings occur.	30/9/17. 30/9/2017. Immediate. 30/9/2017. Immediate.
		Preventative Action(s): Ongoing programme of recreational activities with 3 monthly analysis of ward meetings and complaints book to determine satisfaction with same by CQPS.	Residents satisfaction with recreational activities will be a standing agenda for the ward meetings, this will be	No barriers.	Immediate.

[1] Area of non-compliance reoccurring from 2016
[2] Area of non-compliance in 2017

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
		Ideas regarding introduction of different recreational activities will be an agenda item for team meetings. Post-Holder(s) responsible: ADON, CNM2,CQPS.	recorded by staff with 3 monthly analysis from CQPS		

Regulation 15: Individual Care Plan

Report reference: Page 13-14

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
2. The ICPs were nursing care plans and did not receive MDT or medical input.	Reoccurring	Corrective Action(s): 1. All members of the Multidsicplinary team to participate in the development of the ICP. 2. A Clinical Consultant Lead will be insitu from Monday 11th September to lead on this coorective action. 3. Agreement from Managers of Multidisciplinary team to provide resources with immediate effect to Service Users. 4. Adherence required to SLMHS Maintenance of Records Policy HM43/CM8. 5. Adherence to SLMHS MDT Recovery Integrated Care Planning Policy HM61/CM40. Post-Holder(s) responsible: All members of the MDT through the Executive Clincial Director as Lead.	Audit of policy implementation monthly for first 6 months and 3 monthly thereafter by CQPS.	No Barriers perceived. Agreement from all members of the MDT to be involved with this process.	1. Immediate. 2. Immediate. 3. Immediate. 4. Immediate. 5. Immediate.
		Preventative Action(s): 1. All MDT team members to participate in the development of the ICP where appropriate.	Audit of the policy implementation monthly for 6 months and 3 monthly thereafter.	Achieveable as resources have been agreed for Additional MDT services through	Immediate.

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
		2. MDT members to sign and date ICP as appropriate. 3. Adherence to SLMHS MDT Recovery Integrated Care Planning Policy HM61/CM40. Post-Holder(s) responsible: All members of the MDT through Consultant Executive Clinical Director.	Audit findings to be presented as Quality Item on Agenda of Monthly Quality and Risk Group and Area Management Team.	Managers from differenty disciplines within the MDT.	
3. The resources required to address identified care and treatment for residents were not specified in the ICPs inspected.	Reoccurring	Corrective Action(s): ICP template was reviewed August '17 and amended to identify resources. Will be signed off at PPG Sept 2017 Post-Holder(s) responsible: PPG,CQPS	ICP will be reviewed annualy to ensure compliance with regulation 15, Judgement support framework.	Achievable and Realistic.	30/9/17.
		Preventative Action(s): ICP will reviewed annualy to ensure compliance with JSF Post-Holder(s) responsible: CQPS, PPG.	ICP will be reviewed annualy to ensure compliance with regulation 15, Judgement Support Framework.	Achievable and Realistic	Annual Review
4. There was no evidence that residents, their representatives, family, or next of kin were involved in the	Reoccurring	Corrective Action(s): All staff will be reminded of requirements for care planning as per Regulation 15 ICP training for all staff All residents will be invited to attend all care plan reviews, and to bring a family	Monthly ICP audit for 6 monthly and 3 monthly thereafter.	All actions are achievable and realistic	Immediate. October 2017.

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
care planning process.		member/NOK if they wish to do so. If a resident declines to attend a care plan review this will be clearly documented on the care plan. Post-Holder(s) responsible: Medical staff, CNM2,ADON,PPG,ECD			Immediate.
		Preventative Action(s): 3 monthly ICP audit to ensure compliance with Regulation 15 Post-Holder(s) responsible: ECD,ADON,CNM2, all team members,CQPS	Monthly ICP audit for 6 monthly and 3 monthly thereafter.	Achievable and realistic.	Immediate.

Regulation 16: Therapeutic Services and Programmes

Report reference: Page 15-16

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
5. Residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their ICPs. 6. Programmes and services provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.	Reoccurring	Corrective Action(s): 1. 3 Hours of Occupational Therapy will be purchased from a preferred provider within the HSE Agency Framework., effective from the 1st September. 2. A commitment has been provided through the Psychology service to review and monitor each ICP as part of the wider MDT. An Assistant Psychologist will be assigned to support the resident's ICP weekly. 3. Speech and Leanguage Therapy Services (SLT)– The SLT services have agreed to make direct contact with the residents in the Approved Centre regarding their assessed needs. 4. The Social Work Service has have agreed to put in place dedicated hours towards the ICP regarding input of goals and specific identified needs/actions as agreed with the client and/or their family. These cannot be completed until the work begins. 5. A Memorandum from Business Manager was issued advising that funding is in place to access Private Clinicans in the fields of Physiotherapy, Speech and Language Therapy, Occupational in liaison with HSE Management in Primary Care or Mental Health Services as required by Service Users. Post-Holder(s) responsible: Occupational Therapy Manager. Business Manager. Speech and Language Therapy Manager. Chief Psychologist.	A key Performance Indicator will be put into place monitoring the input from each of these professions listed under points 1,2,3 and 4.	No barriers perceived as agreement gained from all Multidisicplianry Team Managers on actions.	Immediate for all actions.
		Preventative Action(s):	These Audit findings will be reported at	No barriers perceived.	The Schedule of audits will be

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
		The MDT will implement a monthly audit on the implementation of this CAPA. Post-Holder(s) responsible: All members of the Multidisicplinary Team.	the Quality Meeting on a Monthly basis.		present at the Quality Meeting in October 2017.

Regulation 22: Premises

Report reference: Page 17-18

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
7. The premises were in a poor state of repair.	Reoccurring	Corrective Action(s): 1. The HSE Estate Manager and the SLMHS Maintenance Manager have completed the initial works assessment. 2. The HSE Estates Manager and SLMHS Maintennace Manager will develop a St. John's Project Team to action the recommendations as identified in the MHC Draft Report. 3. The initial focus will be on the residents living area including bedrooms bathrooms sitting rooms. 4. A refurbishment plan will be part of this work plan. Post-Holder(s) responsible: Maintenance Manager, Estates Manager.	A monthly audit will be completed for first 6 months and bi monthly thereafter to ensure work is being completed.	No barriers perceived, acknowledgement of work to be done by all in Management Team.	Immediate
		Preventative Action(s): A Monthly audit of works will be completed against work planned each month. Post-Holder(s) responsible: Maintennace Manager, Estates Manager.	A monthly audit will be completed for first 6 months and bi monthly thereafter to ensure work is being completed.		Immediate
8. Bathrooms were damp and poorly	Reoccurring	Corrective Action(s):	A monthly audit will be completed for first 6 months and bi monthly thereafter to	No barriers perceived, acknowledgement of work to	Immediate

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
ventilated and there was poor drainage in showers.		1. The HSE Estate Manager and the SLMHS Maintenance Manager have completed the initial works assessment. 2. The HSE Estates Manager and SLMHS Maintennace Manager will develop a St. John's Project Team to action the recommendations as identified in the MHC Draft Report. 3. The initial focus will be on the residents living area including bedrooms bathrooms sitting rooms. 4. A refurbishment plan will be part of this work plan. Post-Holder(s) responsible: Maintenance Manager	ensure work is being completed.	be done by all in Management Team.	
		Preventative Action(s): A schedule of audits will be implemented. Post-Holder(s) responsible: Maintenance Manager, Estates Manager.	A monthly audit will be completed for first 6 months and bi monthly thereafter to ensure work is being completed.	No barriers perceived, acknowledgement of work to be done by all in Management Team.	Immediate.
5. There was no ongoing programme of maintenance.	Reoccurring	Corrective Action(s): The Estates Manager and the SLMHS Maintennace Manager who have completed the initial minor works assessment will develop a St. John's Project team to action the recommendations as identified. Post-Holder(s) responsible: Maintenance Manager, Estates Manager.	A monthly audit will be completed for first 6 months and bi monthly thereafter to ensure work is being completed as scheduled.	No barriers perceived, acknowledgement of work to be done by all in Management Team.	Immediate

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
		Preventative Action(s): Monthly audits will be implemented to ensure compliance to work planned. Post-Holder(s) responsible: Maintenance Manager, Estates Manager.	A monthly audit will be completed for first 6 months and bi monthly thereafter to ensure work is being completed.		Immediate.
6. There was no laundry room or training kitchen for the rehabilitation needs of residents.	New	Corrective Action(s): Suitable rooms will be identified within the unit to facilitate a laundry room and a kitchen. This refurbishment will be included as part of the maintenance schedule. Post-Holder(s) responsible: Maintenance Manager, Estates Manager.	A monthly audit will be completed for first 6 months and bi monthly thereafter to ensure work is being completed.		Immediate.
		Preventative Action(s): A Monthly schedule will be put in place to ensure works are beingh completed on. Post-Holder(s) responsible: Maintennace Manager, Estates Manager.	A monthly audit will be completed for first 6 months and bi monthly thereafter to ensure work is being completed.		Immediate.

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

Report reference: Page 19-20

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
7. The MCRN of the prescriber was not recorded in six MPARs, as required by law.	Reoccurring	Corrective Action(s): New format of MPAR to be introduced to Approved centre following discussion at August Quality and Risk. This will ensure MCRN is written by each prescribing doctor. Post-Holder(s) responsible: ECD,DON,ADON,CQPS	3 monthly audit of MPARs	Achievable and realistic	30/9/17
		Preventative Action(s): 3 monthly audit of MPARs to ensure compliance with regulation 23 as per JSF Post-Holder(s) responsible: CQPS,ECD,Pharmacist	3 monthly audit of MPARs	Achievable and realistic	Immediate
8. The allergy section was not completed in one MPAR.	New	Corrective Action(s): New format MPAR tio be introduced to the Approved Centre requiring allergy section to be completed. The Executive Clincial Director will issue a Memo with the requirement to ensure the Allergy section of the MPAR is completed. Post-Holder(s) responsible: Executive Clincial Director.	3 monthly audit	Acheiveable and realistic	Immediate
		Preventative Action(s): 3 monthly audit of MPARs to ensure compliance with regulation 23 as per JSF. Post-Holder(s) responsible: ECD and Pharmacist			Immediate.

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
9. The generic name of medication was not recorded in three MPARs.	Reoccurring	Corrective Action(s): The Executive Clincial Director will issue a Memo with the requirement to ensure the Generic name of Medications is recorded. Post-Holder(s) responsible: Executive Clincial Director.	Monthly audit for first 6 months and 3 monthly thereafter.	Achievable and Realistic.	Immediate.
		Preventative Action(s): 3 Monthly audit to ensure compliance Post-Holder(s) responsible: Executive Clinical Director.	3 Monthly Audit for first 6 months and 6 monthly thereafter.	Achievable and Realistic.	Memo issued – prior to 18th September 1st Audit completed before 16th October 2017.

Regulation 26: Staffing

Report reference: Page 21-22

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
10. There was no written policy in relation to the recruitment, selection, and vetting of staff.	New	Corrective Action(s): Policy in draft format August 2017, for sign off at PPG Sept 2017 Post-Holder(s) responsible: PPG	Annual review of policy to ensure they are reviewed within timeframes and comply with Regulation 26 as per JSF	Achievable and realistic	30/9/2017
		Preventative Action(s): Annual review of policy to ensure they are reviewed within timeframes and comply with Regulation 26 as per JSF Post-Holder(s) responsible: CQPS, PPG	Annual review of policy to ensure they are reviewed within timeframes and comply with Regulation 26 as per JSF	Achievable and realistic	Yearly review

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
11. The numbers and skill mix of staff were not appropriate to the assessed needs of residents or the size and layout of the approved centre, 26(2): – There was no consultant psychiatrist. – There was no occupational therapy, social work, or psychology input into the approved centre. – Residents did not have formal access to speech and language therapy. – There was no physiotherapist.	Reoccurring	Update on business case: • A locum Consultant Psychiatrist will be employed from Monday 11th September. This initial cover will be from 11th September -1st October offered by Dr. Michael Creene. From 2nd October 2017 Dr. Gillihand will be the Consultant Lead reporting to the ECD for the following 16 weeks. This service is being lead by Dr. Owen Mulligan. • A key worker nominee will be assigned for each resident's ICP. • Each ICP will be governed and supported through an MDT process overseen and monitored by the Clinical Lead in accordance with residents individual wishes and preferences. • Social Worker – this service has committed specific hours into the coordination of the ICP each week. • Occupational Therapy – 3 hours service will be purchased from a preferred provider within the HSE Agency Framework. • Speech and Language Therapy Services – The SLT Services from St. John's Community Hospital will make contact with the residents on the approved centre regarding their assessed needs. • Details of staff requested within the Business Case include a Consultant Psychiatrist, Psychologist, Senior Speech and Language Therapist, Physiotherapist, Social Worker, and Occupational Therapist • The Business Case is being developed in line with a Vision for Change (2006) with the following Service User potential needs being considered; 1. Long stay inpatients 2. Discharged long-stay service users 3. New long-stay service users 4. New service users with servere and complex Mental health problems. • The plan is to ensure the safe professional care of the current residents whilst impprvements are made to meet the requirements of a Rehavbilitation and Recovery Unit • In addition to the immediate actions committed to within this CAPA Response , no admissions and or transfers will take place within the current St John's unit until the service is fully resourced for a larger group.			
12. An appropriately qualified staff member was not on duty and in charge at all times in the approved centre and	New	Corrective Action(s): All nursing rosters will identify a suitably qualified senior staff nurse in charge at all times. Post-Holder(s) responsible: ADON,DON,CNM2	ADON will review rosters weekly to ensure suitably qualified staff are identified to be in charge of each shift	Achievable and Realistic	Immediate

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
Taken from the inspection report	*Reoccurring or New area of non-compliance*	*Provide corrective and preventative action(s) to address the area of non-compliance*	*Provide the method of monitoring the implementation of the action(s)*	*Provide details of any barriers to the implementation of the action(s)*	*Provide the timeframe of the completion of the action(s)*
there was insufficient nursing cover at weekends.		Preventative Action(s): All nursing rosters will identify a suitably qualified senior staff nurse in charge at all times. Post-Holder(s) responsible: ADON,DON,CNM2	ADON will review rosters weekly to ensure suitably qualified staff are identified to be in charge of each shift	Achievable and Realistic	Immediate
13. Copies of the MHA 2001 and associated regulations and rules were not available on the ward.	New	Corrective Action(s): Copies of MHA 2001 and regulations and rules will be available in approved centre at all times Post-Holder(s) responsible: CQPS,CNM2	CNM2 will ensure copies of these documents are available and will contact CQPS if they are not.	Achievable and Realistic	Immediate
		Preventative Action(s): Copies of MHA 2001 and regulations and rules will be available in approved centre at all times Post-Holder(s) responsible: CQPS,CNM2	CNM2 will ensure copies of these documents are available and will contact CQPS if they are not.	Achievable and Realistic	Immediate
14. Not all staff had up-to-date mandatory training in BLS, fire safety, the management of aggression and violence, and the MHA 2001.	Reoccurring	BLS		80% trained	
		FIRE		20% trained (an immediate formal request has been lodged to the HSE Fire Training Dept. to provide all frontline staff with current training in this area)	
		PMVA		10% trained	
		MHA		0% trained	