Department of Psychiatry, Midland Regional Hospital, Portlaoise

ID Number: AC0030

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, Midland Regional Hospital, Portlaoise, Co Laois

Approved Centre Type: Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Registered Proprietor: HSE

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor Nominee: Ms Dervila Eyres, General Manager, CHO8

Inspection Team:
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Inspection Date: 30 May – 2 June 2017

Previous Inspection Date: 22 – 25 November 2016

Inspection Type: Unannounced Annual Inspection

Date of Publication: 9 November 2017

2017 COMPLIANCE RATINGS

REGULATIONS

- 3 Compliant
- 1 Non-compliant
- 27 Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

- 1 Compliant
- 1 Non-compliant

CODES OF PRACTICE

- 2 Compliant
- 4 Non-compliant
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 approved centre from the register and the prosecution of the registered proprietor.
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

Food safety audits had been undertaken, and documented analysis had been completed to identify opportunities for improving food safety processes. Food temperatures were not always recorded. Food serving areas and the kitchen was clean. At least two person-specific resident identifiers were in use in the approved centre. The approved centre had a written policy in relation to health and safety, and a safety statement. Hazards were minimised, but ligature points had not been minimised. A ligature audit had identified significant ligature risks, and the approved centre was awaiting funding approval to progress ligature minimisation works. A comprehensive written risk management policy in place. The processes of ordering, prescribing, storage and administration of medication was safe. Training records indicated that not all health care professional had up-to-date mandatory training in fire safety, Basic Life Support, management of aggression and violence and the Mental Health Act 2001.

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

The needs of residents identified as having special nutritional requirements were regularly reviewed by a nutritionist. The approved centre did not use an evidence-based nutrition tool to assess residents with special dietary needs. Each resident had a multidisciplinary individual care plan (ICP). Residents’ assessed needs, appropriate goals, and the care and treatment required were identified, as were the resources required to meet the identified goals and needs. The range of available therapeutic services and programmes was appropriate to the assessed needs of residents, as outlined in their individual care plans. Positive comments were made by residents concerning provision of and access to various therapeutic services. Residents could access general health services or be referred to other health services, as required and had a physical examination at least every six months. Clinical files were maintained in good order.

There were a number of deficits in complying with the Rules Governing the Use of Seclusion. Not all staff involved in the use of seclusion had read and understood the policy; there were documentation deficits,
deficiencies in observation; lack of information given to a secluded resident; and residents in seclusion did not have access to adequate toilet/washing facilities. The approved centre did not adhere to the code of practice with regard to physical restraint in a number of areas. The approved centre was compliant with the code of practice with regard to ECT. There had been six child admissions since the 2016 inspection. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. There were 19 non-complings with the code of practice in relation to admission, transfer and discharge.

AREAS REFERRED TO

Respect for residents’ privacy and dignity
Residents were supported to keep and wear their personal clothing, and residents’ clothing was observed to be clean and appropriate to their needs. Residents were supported to manage their own property, and there were secure facilities in the clinical nurse manager’s office for the safe-keeping of resident valuables and personal effects. Residents in the male ward were not facilitated in making private phone calls. There were no toilet facilities in the male seclusion area, and residents in seclusion had to cross the corridor to use the facilities, which did not ensure their privacy or dignity.

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

Responsiveness to residents’ needs
Residents were provided with a range of wholesome and nutritious food choices. Food, including modified consistency diets, was presented in an appealing manner. The approved centre ran a well-developed activation programme. At weekends, recreational pursuits were facilitated by nursing staff, when they were available. Opportunities were available for indoor and outdoor exercise and physical activity. Residents complained that, where they were not engaged in the activation/recovery programme, there was little to occupy them on the ward. There was access to an internal garden. Community meetings with residents were held every six weeks. There was a visiting room available in each ward area and a separate visitors’ room in the main corridor, which was suitable for children. Residents had access to telephone, mail, fax, e-mail, and Internet. Information was given to residents at admission in a welcome pack. Details were provided of the available care and services as well as of housekeeping arrangements, complaints procedures, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents’ rights. A variety of diagnosis- and medication-related information, including risks and potential side-effects, was readily available.

Communal sitting/TV rooms were not appropriately sized and could only seat a limited number of residents at any one time. The approved centre was in a good state of repair, inside and out. There was a programme of general maintenance, and the approved centre was clean, hygienic, and free from offensive odours.
Furnishings throughout the approved centre were sparse. There were a number of high-back armchairs, some of which were torn, and there were no additional furnishings that would offer comfort to residents outside of their beds. The complaints procedure was robust and well advertised.

**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**

The approved centre had significantly augmented its governance processes over the last 12 months. The senior management team, incorporating the Quality and Safety Committee, met weekly to review governance issues affecting the whole service, including the approved centre. There were also regular meetings of a local approved centre Governance Committee, which focused on issues pertinent to the approved centre in the light of recent inspection findings. An active and intensive governance process was in place with a current focus on risk minimisation and on addressing various areas of non-compliance with required regulations and rules. Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, as appropriate. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines, and they were communicated to all relevant staff. 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

1. Renovation of a new child-friendly visiting room was completed during the course of this inspection. This room will facilitate parents interacting with their children away from the ward environment.

2. Pending structural remediation of outstanding ligature risks, a multi-disciplinary team (MDT) anti-ligature committee has been established. Among the control measures introduced was an increase in the level of recorded observation to hourly over the course of 24 hours.

3. All incidents occurring and all episodes of seclusion now undergo formal review at weekly MDT meetings.

4. The Drugs and Therapeutics Committee has undertaken review of various aspects of the medication management process, including review of the Medication Prescription and Administration Records structure.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was located within the Midlands General Hospital. It consisted of separate male and female wards with a maximum capacity of 23 residents in each. Each ward had a six-bed high observation area, which had a nursing staff presence at all times. A total of ten multi-disciplinary teams admitted residents to the unit. These included six community teams (including one from the Kildare/West Wicklow), psychiatry of old age, rehabilitation, intellectual disability, and young adult mental health team. Up to ten beds could be occupied by residents from the Kildare/West Wicklow area, which is outside the Community Health Organisation (CHO) 8 area.

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><strong>Number of registered beds</strong></td>
<td>46</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>40</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>9</td>
</tr>
<tr>
<td><strong>Number of Wards of Court</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>3</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

The approved centre had four conditions in place at the time of inspection.

**Condition 1:** To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 2:** To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy, and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 3:** To ensure adherence to Regulation 23: Ordering Prescribing, Storing and Administration of Medicines, the approved centre shall audit their Medication Prescription and Administration Records (MPARs) on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 4:** To ensure adherence to the Rules Governing the Use of Seclusion, the approved centre shall provide the Mental Health Commission with a report on the rate and duration of episodes of seclusion within the approved centre in a form and frequency prescribed by the Commission.
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 approved centre had significantly augmented its governance processes over the last 12 months. The senior management team, incorporating the Quality and Safety Committee, met weekly to review governance issues affecting the whole service, including the approved centre. There were also regular meetings of a local approved centre Governance Committee, which focused on issues pertinent to the approved centre in the light of recent inspection findings. Minutes of recent Drugs and Therapeutic Committee meetings were also provided. The documented proceedings of these various groups confirmed an active and intensive governance process in place within the approved centre. Discussion with members of senior management confirmed a current focus on risk minimisation and on addressing various areas of non-compliance with required regulations and rules.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 22 – 25 November 2016 identified the following areas that were non-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 7: Clothing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</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 Admission of Children under the Mental Health Act 2001</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>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 21: Privacy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</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>Rules Governing the Use of Seclusion</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children under the Mental Health Act 2001</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 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

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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

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

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

During the course of this inspection, seven residents requested to meet privately with the inspectors and this was facilitated. Another resident submitted a user experience questionnaire. Residents were positive about their relationship with staff. Residents complained that, where they were not engaged in the activation/recovery programme, there was little to occupy them on the ward. Residents were generally satisfied with the quality of food but asked for a greater choice of meals.

A meeting was held with local IAN representative. Comments outlined above about food were reinforced. In addition, it was claimed that some staff were rude to residents and that access to and communication with staff was sometimes difficult. Positive comments were made concerning provision of and access to various therapeutic services.
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:

- Executive Clinical Director
- Director of Nursing
- Principal Social Worker
- Principal Psychologist
- Occupational Therapy Manager
- General Manager
- Risk Manager
- Chief Pharmacist

Meetings with heads of services outlined the current flux in the overall service management. The principal social worker had only been in the role for a short time and was in an acting role at the time of the inspection. The occupational therapy manager, who had been acting for some time, was reverting to her previous role at the end of June and was not aware of any definitive replacement plans. The principal psychologist was in an acting role and had only recently taken over the position.

Discussion with the various heads of discipline confirmed a focus on governance issues within the service. In particular, the service was seeking to obtain funding to definitively address outstanding ligature issues within the approved centre. A memorandum of understanding was under consideration in relation to the utilisation of beds within the approved centre by Kildare/West Wicklow residents. Social work, psychology, occupational therapy, and nursing were all struggling with staffing shortages. The nursing discipline had undertaken a management reorganisation to ensure effective oversight and input within the approved centre. The chief pharmacist outlined the increased input within the approved centre by pharmacists and the associated improvement in service that this oversight had engendered. As with other disciplines, loss of staff and their non-replacement was an ongoing risk.
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
- Business Manager (representing Registered Proprietor nominee)
- Principal Social Worker
- Director of Nursing
- Compliance Officer
- Chief Pharmacist
- OT Manager
- ADON x 2
- CNM 3 x 2
- CNM 2 x 2
- Risk 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. The service representatives provided a number of clarifications. In particular, when queried about the cessation of episodes of seclusion while the patient was asleep in the seclusion room at night without informing the resident, the service indicated that it had received advice that such practice was in order to lessen the timed duration of seclusion.
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.

**COMPLIANT**

Quality Rating  
Excellent

**INSPECTION FINDINGS**

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

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

**Monitoring:** An annual audit had been undertaken to ensure that clinical files contained appropriate resident identifiers. Actions and outcomes had been identified. Documented analysis had been completed to identify opportunities for improving the resident identification process.

**Evidence of Implementation:** At least two person-specific resident identifiers were in use in the approved centre. Name and date of birth were the first two identifiers consulted. The identifiers, which were appropriate to residents’ communication abilities, were used before the administration of medication, the undertaking of medical investigations, and the provision of health care services and therapeutic services and programmes. Where residents were undergoing Electro-Convulsive Therapy, a wristband was used as part of the identification process. Documentation was marked in red to alert staff to the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.
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 January 2014. It included requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities for food and nutrition within the approve centre.
- The process for monitoring food and water intake.

Training and Education: Not all relevant staff had signed the signature sheet 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: At the time of the inspection, a systematic review of menu plans to ensure that residents received wholesome and nutritious food in accordance with their needs was under way. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Residents were provided with a range of wholesome and nutritious food choices, which were properly prepared. 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. Menus were not analysed by a nutritionist/dietician to ensure nutritional adequacy in accordance with residents’ needs.

The needs of residents identified as having special nutritional requirements were regularly reviewed by a nutritionist. The approved centre did not use an evidence-based nutrition tool to assess residents with special dietary needs. The nutritional and dietary requirements of residents were assessed, where necessary, and addressed in the 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 processes, training and education, and evidence of implementation pillars.
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 March 2017. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature sheet 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 not 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 been undertaken, and documented analysis had been completed to identify opportunities for improving food safety processes. Food temperatures were not always recorded. The temperatures of hot lunchtime meals were checked but hot evening meals were not similarly monitored.

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

The approved centre was compliant with this regulation. The quality assessment was 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 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 March 2017. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature sheet, indicating that they had read and understood the policy on clothing. 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 there was an account with a local department store for the purchase of clothing when necessary. A record of residents wearing nightclothes during the day was maintained and updated hourly. Residents in the high observation wards were nursed in nightclothes.

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, which took account of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plan (ICP). The ICP included a checkbox for recording whether residents should be prescribed nightclothes during the day. Two charts from the male ward were inspected. In each case, the instruction for wearing nightclothes during the day was also written in full by the treating team as an intervention. All residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 8: Residents’ Personal Property and Possessions

(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 March 2015. It included requirements of the *Judgement Support Framework*, with the exception of processes for the following:

- Communicating with residents and their representatives regarding residents’ entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.
- Allowing residents to have access to or control over their personal property, unless this posed a danger to themselves or others, as indicated in their individual care plans (ICPs), following a risk assessment.

**Training and Education:** Relevant staff had signed the signature sheet, 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 did not monitor personal property 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 ICPs. Residents’ personal property and possessions were secured when the approved centre assumed responsibility for them. There were secure facilities in the clinical nurse manager’s office for the safe-keeping of resident monies, valuables, and personal effects. A checklist detailing each resident’s property and possession was maintained and kept separately from the ICPs.

Access to and use of resident monies was overseen by two members of staff or by a staff member and the resident or their representative. Small amounts of money kept on the unit were signed for by the nurse and countersigned by the resident or his/her representative.
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, monitoring, and evidence of implementation 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 August 2016. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature sheet, indicating that they had read and understood the policy. Relevant staff interviewed could clearly articulate the processes relating to recreational activities, as set out in the policy.

Monitoring: A record was maintained of the occurrence of planned recreational activities, including a log of resident uptake/attendance. Analysis had not been completed to identify opportunities to improve the processes for recreational activities.

Evidence of Implementation: The approved centre ran a well-developed activation programme that was available to any resident who had been referred to the service and was not accommodated in the high observation ward. Residents in the high observation ward had access to books, magazines, daily newspapers, and television. The activation programme incorporated recreational pursuits.

The comprehensive therapeutic programme was scheduled from Monday to Friday. At weekends, recreational pursuits were facilitated by nursing staff, when they were available. For example, residents in the male ward had regular access to cookery sessions. Information about recreational activities was provided to residents in an accessible format. Activities were developed, maintained, and implemented with resident involvement. This was usually done at community meetings, held every six weeks. There was also a separate, timetabled recreational programme for residents in the approved centre who had been diagnosed with a learning disability.

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 the activation programme were maintained.

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 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 March 2017. It included all of the requirements of the Judgement Support Framework.

Training and Education: All relevant staff had signed the signature sheet, 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: A review of the policy’s implementation had been completed to ensure that residents’ identified religious needs were met.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. There was an on-site oratory. Communion was provided in the approved centre twice weekly for Roman Catholic residents, and the local Church of Ireland minister visited regularly. Residents had access to multi-faith chaplains and, following a risk assessment, could attend religious services outside of the approved centre, if deemed appropriate.

The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature sheet, 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, reviewed, and audited. Analysis had been completed to identify opportunities for improving visiting processes, and this was documented.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre. There was a visiting room available in each ward area and a separate visitors’ room in the main corridor, which was suitable for children and had a good supply of toys. Residents were facilitated in meeting visitors in private, unless there was an identified risk to the residents or others or a health and safety risk. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 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 March 2017. It included requirements of the Judgement Support Framework, with the exception of a process for assessing resident communication needs.

Training and Education: Not all relevant staff had signed the signature sheet, 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 been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to external communications, including telephone, mail, fax, e-mail, and Internet. Residents in the high observation unit could not use mobile phones, but they were facilitated to make calls using a landline. In certain circumstances, they could also use their mobile phones outside the high observation area. Individual assessments were not completed for residents in relation to risks associated with their external communication, as evidenced by the ban on the use of mobile phones in the high observation area.

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 evidence of implementation 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 be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed the signature sheet 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 on each ward. There was no documentary evidence that analysis had been completed to identify opportunities for improving search processes.

Evidence of Implementation: Four clinical files were inspected in relation to searches. The property search forms indicated that a risk assessment was completed in advance of a search and that resident consent to the search was sought and received in all cases. The searches were attended by three clinical staff and 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.

All of the files inspected contained a written record of the 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 monitoring pillar.
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 two written policies in relation to care of the dying: a care of the dying policy dated May 2016 and Management of Suicide, Homicide, or Sudden Death, dated January 2015. The policies included requirements of the Judgement Support Framework, with the exception of a 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: All relevant staff had signed the signature sheet, indicating that they had read and understood the policies. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policies.

Monitoring: End of life care had been systematically reviewed to ensure section 2 of the regulation was complied with. Although there had been one sudden death in the approved centre since the last inspection, systems analysis had not been undertaken.

Evidence of Implementation: No resident had received end of life care in the approved centre since the last inspection. There had been one sudden death, and it was managed in accordance with legal requirements and with the resident’s religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident, next of kin, and friends. Support was given to other residents and to staff following the death. The death was notified to the Mental Health Commission within the required 48-hour time frame.

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 monitoring pillars.
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). Entitled Policy and Guideline for Multi-disciplinary Individual Care Planning, it was last reviewed in October 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed the signature sheet, indicating that they had read and understood the policy. All 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 were audited on a weekly basis to assess compliance with the regulation. Not all audits were dated and not all audits cited recommendations or actions based on areas of non-compliance.

Evidence of Implementation: The ICPs relating to 14 residents were inspected. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from nursing notes. Each resident was assessed at admission and an initial care plan was drawn up to address immediate needs. A comprehensive template was used for recording resident assessments at admission, but this was not completed in two of the ICPs examined. Evidence-based assessments were used where possible.

A key worker was identified in all cases to ensure continuity in the implementation of the ICP. Residents’ assessed needs, appropriate goals, and the care and treatment required were identified, as were the resources required to meet the identified goals and needs. The ICPs included individual risk management plans. They were reviewed by the MDT in consultation with residents on a regular basis and were subsequently updated, as indicated by residents’ changing needs, condition, circumstances, and goals. Where residents consented, family members were involved in the ICP process, and this was recorded.

In two cases, the multi-disciplinary team (MDT) had not drawn up the ICP within seven days. In three ICPs, the involvement of the resident in the care planning process was not recorded, and in five cases, residents had not signed their ICPs. There was no evidence that residents had received a copy of their ICPs. In two of the ICPs inspected, there was no preliminary discharge plan in place.

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, monitoring, and evidence of implementation pillars.
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 August 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had acknowledged 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 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 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 therapeutic services and programmes provided by the approved centre were evidence-based and included decision skills, art therapy, mindfulness, healthy living, and the Wellness Recovery Action Plan.

A list of all therapeutic services and programmes available in the approved centre was provided in the welcome pack booklet. Where a resident required a therapeutic service or programme that was not provided internally, community teams accepted referrals. A recovery programme ran from Monday to Friday and was facilitated in rooms off the main corridor, which were available for services and programmes at weekends. Residents’ participation and engagement in therapeutic services and programmes and outcomes achieved were documented.

The intermittent need to redeploy therapy staff elsewhere due to staff shortages could, on occasion, affect the facilitation of therapeutic programmes.

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, monitoring, and evidence of implementation pillars.
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.

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<th>INSPECTION FINDINGS</th>
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<td>As the approved centre had not admitted any children who were in need of educational services since the last inspection, this regulation was not applicable.</td>
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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 an up-to-date written policy in relation to the transfer of residents. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature sheet, 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, and each transfer record had not been reviewed to ensure that all relevant information was sent to the receiving facility. Analysis had not 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&E was examined, and all communications with the receiving facility were documented. The resident’s consent to the transfer was recorded. The clinical notes indicated that an assessment of the resident was undertaken in advance of the transfer.

Written information regarding the resident was transferred to the receiving facility. The clinical file contained a copy of the referral letter, but copies of the transfer form and record of medications required for the resident during the transfer were not retained in the clinical file. No checklist had been completed to ensure comprehensive resident records were transferred to the receiving facility.

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, monitoring, and evidence of implementation pillars.
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 to residents, which was last reviewed in March 2017. There was also a medical emergencies policy, dated August 2016. Together, the policies included requirements of the Judgement Support Framework, with the exception of the following:

- The management, response, and documentation of a medical emergency, including cardiac arrest.
- 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 acknowledged that they had read and understood the policy. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policy.

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

Evidence of Implementation: Each unit in the approved centre had a resuscitation trolley and an Automated External Defibrillator. These were checked weekly on the female unit but not on the male unit. Records were available of any medical emergency in the approved centre and of the care provided.

Six residents had been in the approved centre for over six months, and all had received a six-monthly general health check. Records of residents’ completed health checks and the associated results were maintained in the clinical files. Residents received appropriate general health care as indicated in their individual care plans. Residents could access general health services or be referred to other health services, as required. Residents also had access to age- and gender-appropriate national screening programmes, but no information was provided in relation to these.

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, monitoring, and evidence of implementation pillars.
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 March 2017. It included requirements of the Judgement Support Framework, with the exception of the methods for providing information to residents on an ongoing basis.

Training and Education: Not all staff had signed the signature sheet, 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 monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. 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/or their representatives at admission in the welcome pack. Details were provided of the available care and services as well as of housekeeping arrangements, complaints procedures, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents’ rights. The welcome pack also included a template that nursing staff used to provide residents with information on their multi-disciplinary team.

Residents had access to evidence-based written information about their diagnosis, unless, in the view of the treating psychiatrist, the provision of such information might be prejudicial to a resident’s physical or mental health. A variety of diagnosis- and medication-related information, including risks and potential side-effects, was readily available. Printed information was contained in a readily accessible folder, and staff also consulted MIND (a mental health support body) and the Royal College of Psychiatrists when necessary.

Medication information provided was appropriate to the residents’ needs, and the content of the medication information sheets included indications for use of all medications administered to the resident, including possible side-effects. Residents had access to interpretation and translation services as required.
Information documents provided by or within the approved centre had not been appropriately reviewed and approved prior to use.

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, monitoring, and evidence of implementation 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 March 2017. It included requirements of the Judgement Support Framework, with the exception of the process applied where resident privacy and dignity were not respected by staff.

Training and Education: Not all staff had signed the signature sheet, 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: No 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 not 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 were appropriately attired and conducted all conversations relating to residents’ clinical and therapeutic needs in private. Hourly checks were completed on the wards due to the acute nature of the approved centre. Staff occasionally had to enter rooms without permission, but this was managed respectfully. Residents were observed to be wearing clothing that respected their privacy and dignity. Residents in high observation wards were nursed in nightclothes that afforded privacy and dignity. Bathrooms, showers, toilets, and single rooms had locks on the inside of the doors, and these had an override facility. Most of the accommodation comprised of single, en suite rooms. There were also six- and four-bed wards, which had suitable and adequate screening in place between the beds to ensure privacy. Windows and observation panels in doors had appropriate screening. It was noted that the windows in the seclusion room, which made the approved centre non-compliant under this regulation in the 2016 inspection, had been fitted with appropriate screening. Noticeboards did not display identifiable resident information.

There were no toilet facilities in the male seclusion area, and residents in seclusion had to cross the corridor to use the facilities, which did not ensure their privacy or dignity. Residents were not facilitated in making and taking private phone calls. The public phone on the male ward was broken. In addition, it was situated in a busy public area and had no privacy hood. Residents in the high observation areas relied on this phone or on the phone in the nurses’ station, which was neither portable nor private.

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

a) Residents in the male ward were not facilitated in making private phone calls.
b) Occupants of the male seclusion area had to cross the corridor to use the bathroom.
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 May 2017. The policy included requirements of the Judgement Support Framework, with the exception of the approved centre’s utility controls and requirements and the process for identifying hazards and ligature points.

Training and Education: Not all relevant staff had signed the signature sheet, 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 a ligature audit, which had identified significant ligature risks. There was no evidence that a hygiene audit had been completed. Senior management had identified areas in need of improvement in the premises. All required improvements require substantial investment.

Evidence of Implementation: Residents had access to personal space, including suitable accommodation and outdoor space, which was accessible from both units. Communal sitting/TV rooms were not, however, appropriately sized and could only seat a limited number of residents at any one time.

Communal areas were adequately lit to facilitate reading and other activities. Rooms were comfortably heated and ventilated, and heating could be safely controlled in residents’ rooms. Appropriate signage was in place to support resident orientation needs.

Hazards were minimised, but ligature points had not been minimised. A ligature audit had identified significant ligature risks, and a proposal of works had been submitted. At the time of the inspection, the approved centre was awaiting funding approval to progress ligature minimisation works.
The approved centre was in a good state of repair, inside and out. There was a programme of general maintenance, which was documented, and a system for reporting maintenance issues was in use. A cleaning schedule was in place, and the approved centre was clean, hygienic, and free from offensive odours. National infection control guidelines were followed.

The approved centre had a sufficient number of showers and toilets, as well as adequate assisted needs facilities. There were designated sluice, cleaning, laundry, and therapy/examination rooms. Bedrooms were appropriately sized to address resident needs.

Furnishings throughout the approved centre were sparse. There were a number of high-back armchairs, some of which were torn, and there were no additional furnishings that would offer comfort to residents outside of their beds.

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

a) It did not have adequate and suitable furnishing having regard to the number and mix of residents, 22(2).

b) Significant ligature risks had not been minimised, meaning that the physical structure and overall environment were not maintained with 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 October 2016. It included requirements of the Judgement Support Framework, with the exception of the processes for managing medication during a resident transfer and reviewing resident medication.

Training and Education: All nursing and medical staff had signed the signature sheet, 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 up-to-date information on all aspects of medication management, including evidence-based web sites such as Medicines Complete and Up to Date. All clinical staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Regular 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 issues using the National Incident Management System. Analysis of the medication management processes was presented to the Drug and Therapeutic Committee on a monthly basis.

Evidence of Implementation: An MPAR was maintained for each resident, and 27 of these were inspected. Two appropriate resident identifiers were used when medication was being administered. Names of medications were written in full. The frequency of administration, the dosage, and the administration route for medications were recorded. In two of the MPARs inspected, the trade name was recorded for one medication instead of the generic name; this was subsequently rectified by the pharmacist.

Where there were alterations in the medication order, the medical practitioner rewrote the prescription. Medication was administered by two registered nurses in accordance with the directions of the prescriber, and good hand-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.

Controlled drugs were checked by two staff members against the delivery form and recorded in a controlled drug book. The controlled drug balance corresponded with the balance recorded in the book. Directions to crush medication were only accepted from residents’ medical practitioner, but no resident was receiving crushed medication at the time of the inspection.
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.

The medication trolley was locked and secured, and scheduled controlled drugs were secured in a separate cabinet. Medication dispensed to residents was stored in a locked storage unit. A system of stock rotation was in place. An inventory of medications was not completed monthly.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
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 March 2017, and a safety statement, dated February 2017. The policy and safety statement included requirements of the Judgement Support Framework, with the exception of 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 both 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 written policy in relation to the use of CCTV, dated March 2017. It included requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities for the use of CCTV in the approved centre.
- Provisions in relation to the maintenance of CCTV cameras.
- The process to end monitoring of a resident using CCTV in certain circumstances.

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

Monitoring: The quality of CCTV images was not checked regularly to ensure that the system was operating appropriately. Analysis was completed to identify opportunities for improving the use of CCTV.

Evidence of Implementation: There was prominent signage indicating where CCTV cameras were located in the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The Mental Health Commission had been informed about the approved centre’s use of CCTV.

Cameras were incapable of recording or storing a resident’s image in any format. CCTV cameras used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for 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 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 August 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 address the following:

- The job description requirements.
- Requirements around staff performance and evaluation.
- The required qualifications of training personnel.
- The evaluation of training programmes.

Training and Education: All relevant staff had signed the signature sheet, 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: There was documented evidence that the approved centre had reviewed the implementation and effectiveness of the staff training plan. Training had been reviewed to ensure maximum effectiveness. The number and skill mix of staff had been assessed 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: The safety statement contained an organisational chart to identify the leadership and management structure and lines of authority and accountability. Planned and actual staff rotas were in place. The number and skill mix of staffing were sufficient to meet residents’ needs. An appropriately qualified member of staff was in charge at all times.
Staff were recruited, selected, and vetted in line with the HSE’s national recruitment policy and 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 with the staffing agency.

The approved centre did not have a staffing plan that addressed the following requirements:

- The skill mix, competencies, number, and qualifications of staff.
- The assessed needs of the resident group profile.
- The process for reassigning staff in response to changing resident needs or staff shortages.

Annual staff training plans had been completed for various staff groups to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training had been completed by staff.

Training records indicated that not all health care professional had up-to-date mandatory training:

- 32/58 nursing staff did not have current fire safety training.
- 34/55 nursing staff did not have up-to-date Basic Life Support (BLS) training.
- 10/44 nursing staff did not have Therapeutic Management of Violence and Aggression (TMAV).
- Not all staff had received training in the Mental Health Act 2001.

At least one staff member was trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training delivered in manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, and risk management. 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 regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in each ward.

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>Male Ward</td>
<td>CNM3</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
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<td>-</td>
</tr>
<tr>
<td>Female Ward</td>
<td>CNM3</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
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<td></td>
<td>RPN</td>
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<td>3</td>
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<td></td>
<td>HCA</td>
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<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 because not all staff had up-to-date mandatory training in fire safety, BLS, TMAV, and the Mental Health Act 2001, 26(4).
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 July 2016. The policy addressed requirements of the Judgement Support Framework, including 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 following:

- The way in which entries in residents’ records were made, corrected, and overwritten.
- 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 the signature sheet, 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. Not 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, and correction points had been developed.

Evidence of Implementation: Residents’ records were secure, up to date, and in good order. Records 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. All resident records were physically stored in filing cabinets in the locked nurses’ office. 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, including record number, name and address, and date of birth. Records were developed and maintained in a logical sequence and were accessible only to authorised clinical staff. Only authorised staff made entries in resident records, which were maintained appropriately. However, there was no record of all signatures used in resident records.

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, training and education, and evidence of implementation 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 a documented register of residents, which was up to date and contained all of the required information listed in Schedule 1 to the regulations.

The approved centre was compliant with this regulation.
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: The approved centre had a written policy on the development and review of operating policies and procedures, which was last reviewed in March 2017. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: There was no documentary evidence that an annual audit was undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the process of developing and reviewing policies.

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders, as appropriate. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines, and they were communicated to all relevant staff. Operating policies and procedures were appropriately approved before being implemented.

All policies and procedures required by the regulations had been reviewed within three years. Operating policies and procedures were presented in a standardised format. Any generic policies in use were appropriate to the approved centre and the resident group profile.

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 monitoring pillar.
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, which was last reviewed in March 2017. It included all of the requirements of the Judgement Support Framework.

Training and Education: All relevant staff had signed the signature sheet, 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: There was documentary evidence that 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 private facilities and adequate resources. 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 rated excellent because the approved centre met all criteria of the Judgement Support Framework.
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 2017. It addressed all of the requirements of the Judgement Support Framework.

Training and Education: All relevant staff had received formal training on complaints management processes, and all staff had signed the signature sheet, 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 been completed and documented. Complaints data was analysed, and required actions were identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the resident information booklet. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. Details of the HSE’s Your Service Your Say complaints procedure were displayed throughout the approved centre.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

All complaints were logged, and residents’ verbal queries or concerns were addressed by nursing staff as appropriate. When minor complaints could not be addressed locally, they were dealt with by the nominated person and recorded in the complaints log. All non-minor complaints were addressed by the
complaints officer and fully recorded in the complaints log. The process for managing complaints was thorough and collaborative, as appropriate. Details of complaints, subsequent investigations, and outcomes were fully documented and kept distinct from the resident’s individual care plan.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 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 written policy in relation to risk management procedures, which was last reviewed in March 2017. It addressed requirements of the *Judgement Support Framework*, including processes for the following:

- Identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- 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.
- Responding to emergencies.
- Protecting children and vulnerable adults in the care of the approved centre.

The policy did not specify the responsibilities of multi-disciplinary team in relation to risk or the person responsible for completing six-monthly incident summary reports.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management, and managerial staff were trained in organisational risk management. All staff had been trained in incident reporting and documentation. Not all staff had signed the policy indicating that they had read and understood it. Staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training in risk management processes was documented.
Monitoring: The risk register had not been audited at least quarterly to determine compliance with the approved centre’s risk management policies. All incidents in the approved centre were documented and risk-rated and forwarded to management for review. There was no documented evidence that 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. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Health and safety risks were identified, assessed, treated, reported, and monitored. Structural risks, including ligature points, had not been removed or mitigated, despite audits that had identified potential ligature risks. To address this risk on a temporary basis the approved centre had implemented an increased frequency of overall observational review.

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 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, and clinical incidents were regularly reviewed by the MDT. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission by the risk manager or Mental Health Act administrator. The approved centre had an emergency plan within its safety statement that included evacuation 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, training and education, monitoring, and evidence of implementation pillars.
### 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 auspices of 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 in the entrance area.

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

(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 three written policies in relation to the use of Electro-Convulsive Therapy (ECT). These addressed the care and treatment of patients receiving ECT (April 2016), the care and treatment of voluntary patients receiving ECT (May 2016), and the preparation and checking of the ECT equipment and suite (January 2014). Together, the policies covered all 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: The two nurses involved in delivering ECT were trained in line with best international practice and had up-to-date Basic Life Support training, completed in February 2017.

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

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed in the treatment room. A named consultant and named consultant anaesthetist had responsibility for ECT, and a designated ECT nurse and a registered psychiatric nurse were in the ECT suite at all times when ECT was being delivered. The designated ECT nurse was responsible for checking emergency equipment and drugs on a weekly basis.

The clinical file of one patient who was receiving ECT was examined. It indicated that appropriate information about ECT was given to the patient by the consultant psychiatrist, including details of likely adverse effects of ECT treatment. The information provided was in clear and simple language that the patient could understand. The patient was informed of his/her rights to an advocate and had the opportunity to raise questions at any time.

COMPLIANT
The patient was incapable of giving informed consent for ECT, following an assessment of capacity by the consultant psychiatrist. A Form 16, Treatment without Consent Electroconvulsive Therapy Involuntary Patient (Adult), was completed. One copy of the form was placed in the clinical file and another was sent to the Mental Health Commission within five days.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies before prescribing ECT, the communication with the patient and/or next of kin, a mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded.

The consultant psychiatrist, in consultation with the patient, reviewed the progress of the treatment and the need for continuation of ECT. The ECT record was retained in the clinical file, as were all post-ECT assessments.

The approved centre was compliant with this rule.
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 May 2017. It addressed all of the elements of this rule, including the following:

- Those authorised to initiate seclusion.
- The provision of information to the patient.
- Ways of reducing seclusion rates.
- Staff training requirements in relation to the use of seclusion.

Training and Education: Not all staff involved in the use of seclusion had signed the signature sheet, indicating that they had read and understood the policy. Records were maintained of staff attendance at training and were available to the inspection team.

Monitoring: An annual report on the use of seclusion had been completed and was available for inspection.

Evidence of Implementation: The clinical files of three residents who had been placed in seclusion were inspected. In each case, seclusion was initiated by a registered medical practitioner (RMP) and/or registered nurse. The consultant psychiatrist was notified of the use of seclusion as soon as was practicable, and this was recorded in the clinical files. Where seclusion was initiated by an RMP, a comprehensive assessment, including a risk assessment, was completed in advance. The episodes of seclusion were recorded in the clinical files and seclusion register, which was signed by the responsible consultant psychiatrist within 24 hours.

In each episode, seclusion was used only in exceptional circumstances, in the best interests of the resident, and after all other interventions to manage patients’ unsafe behaviour had first been considered. Cultural awareness and gender sensitivity were demonstrated in each episode of seclusion. In all cases, the implementation and use of CCTV to monitor patients was appropriate. Patients were informed of the reasons for, duration of, and circumstances leading to the discontinuation of seclusion, and next of kin were informed.
In each episode of seclusion, direct observation of the patients by a registered nurse for the first hour was not possible because of a blind spot in the seclusion area. A record of the patients in seclusion was made by the nurse every 15 minutes, but the resident’s level of distress and behaviour were not recorded. Residents in seclusion did not have adequate toilet/washing facilities. They had to cross a corridor used by members of the public and other residents to access same. Screening was in place, but this was not adequate to ensure residents’ privacy.

Following a risk assessment, a nursing review of the patients took place every two hours. A medical review was undertaken every four hours. All uses of seclusion were clearly recorded in the clinical files but not fully documented in the seclusion register.

In two of the episodes of seclusion examined, there was no record that patients were informed of the ending of seclusion and the reasons for ending seclusion were not recorded in the clinical files. In one episode, the duration of the seclusion was not recorded. One of the files examined indicated that the episode of seclusion was not reviewed by the multi-disciplinary team (MDT).

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

   a) Not all staff involved in the use of seclusion had read and understood the policy, 10.2(b).
   b) In one episode, the duration of the episode of seclusion was not recorded, 3.4(c).
   c) Direct observation of the resident for the first hour of seclusion was not possible because of a blind spot in the seclusion area, 5.1(a).
   d) The 15-minute nursing record did not document the level of distress and behaviour of the resident in seclusion, 5.2.
   e) In two episodes, the residents were not informed of the ending of seclusion, 7.3.
   f) In two episodes, the reasons for ending seclusion were not recorded in the clinical files, 7.4.
   g) Residents in seclusion did not have access to adequate toilet/washing facilities, 8.1.
   h) In two episodes, the use of seclusion was not clearly recorded in the register, 9.2.
   i) In one case, the episode was not reviewed by the MDT, 10.3.
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 the approved centre did not use mechanical means of bodily restraint, 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 files of two residents who had been in the approved centre for more than three months and in continued receipt of medication were examined. In each case, a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed, and copies of the form were retained in the relevant clinical files. In one case, there was no documented evidence that the patient’s ability to understand the nature, purpose, and likely effects of the medication had been assessed.

In both cases, the Form 17 detailed the following:

- The name(s) of the medication prescribed.
- 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.
In one case, the Form 17 did not record the potential risks associated with the medication(s) being administered.

The approved centre was not compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment for the following reasons:

a) There was no evidence that one patient’s ability to understand the nature, purpose, and likely effects of the medication(s) had been assessed and documented, 56(a).

b) The potential risks associated with the medication(s) being administered were not recorded for one patient, 56(b).
12.0 Inspection Findings – Codes of Practice

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

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

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

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

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, dated May 2017. It addressed the provision of information to residents and the training requirements in relation to the use of physical restraint, including details of those who could initiate restraint, those who should receive training, areas to be addressed in training, and alternatives to the use of physical restraint. The policy did not refer to the mandatory nature of training.

Training and Education: Not all staff involved in physical restraint had signed the signature sheet, 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 had been produced.

Evidence of Implementation: Four clinical files were inspected in relation to the use of physical restraint. In three of the four cases, the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others, after other interventions had first been considered, and following a risk assessment. None of this was documented for the fourth episode of physical restraint.

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. Gender sensitivity was demonstrated during each episode.

In one episode, it was not documented that the consultant psychiatrist was notified as soon as practicable. In one episode, a registered medical practitioner did not conduct a medical examination of the resident within three hours of the start of physical restraint; in another episode, the time of the medical examination was not recorded.

There was no documentary evidence that the four residents were informed of the reasons, likely duration, and circumstances leading to the discontinuation of physical restraint. In each case, next of kin were informed of the use of physical restraint, but it was not recorded whether the residents had consented to this.

In three episodes, the use of physical restraint was not reviewed by the multi-disciplinary team (MDT) or documented in the clinical files within two working days. In one clinical file inspected, no rationale for the use of physical restraint was recorded.

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

a) Not all staff involved in physical restraint had acknowledged that they had read and understood the policy, 9.2(b).
b) The policy and procedures for training staff in the use of physical restraint did not reference the mandatory nature of training, 10.1(e).

c) In one episode, it was not evident that physical restraint had been used in exceptional circumstances and in the resident’s best interests, 1.1.

d) In one episode, it was not documented whether staff had first considered other interventions to manage the resident’s unsafe behaviour before initiating physical restraint, 1.2.

e) In one files, it was not documented that the clinical psychiatrist was notified of the use of physical restraint as soon as was practicable, 5.3.

f) In one episode, a medical examination of the resident was not completed within three hours of the start of physical restraint and the time of the medical examination was not recorded in another episode, 5.4.

g) There was no evidence that residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, 5.8.

h) It was not documented whether residents had consented to their next of kin being informed of the use of physical restraint, 5.9(a).

i) In three episodes, the use of physical restraint was not reviewed by the MDT or documented in the clinical file within two working days, 9.3.

j) In one episode, no rationale for the use of physical restraint was clearly recorded in the clinical file, 8.1.
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 September 2016. 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 of the child admission. The policy also referenced procedures in relation to family liaison, parental consent, and confidentiality.

Training and Education: Staff had received Children First training. The training was documented.

Evidence of Implementation: There had been six child admissions since the 2016 inspection, and the admission charts for each were reviewed. Provisions were in place to ensure the safety of the child, to respond to each child’s special needs as a young person in an adult setting, and to ensure the right of the child to have his/her views heard.

Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided by the approved centre.

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 child residents, and gender sensitivity was displayed in all cases. Children admitted to the approved centre had their rights explained, and information about the ward and facilities were provided in an accessible form. Advice from the Child and Adolescent Mental Health Service was available when necessary. Consent for treatment was obtained from one or both parents.

The approved centre was not compliant with this code of practice because it did not provide age-appropriate facilities and a programme of activities appropriate to the age and ability of the child residents, 2.5(b).
### Notification of Deaths and Incident Reporting

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a risk management policy in place in relation to the notification of deaths and incident reporting to the Mental Health Commission (MHC), dated March 2017. The policy met all the criteria of this code of practice. It specified the risk manager, and it outlined the roles and responsibilities of staff in relation to the following:

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

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

**Evidence of Implementation:** The approved centre was compliant with Regulation 32: Risk Management Procedures. It 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.

One resident in the approved centre had died since the last inspection, and the death had been notified to the MHC within the required 48-hour time frame.

The approved centre was compliant with this code of practice.
INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to working with people with an intellectual disability. The policy reflected person-centred treatment planning, presumption of capacity, 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 referenced the training of staff in working with people with an intellectual disability, but it did not address induction training for new staff or specify the frequency of training.

Training and Education: Staff had not 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: During the inspection, there were three residents in the approved centre who had been diagnosed with an intellectual disability. Two clinical files were inspected. These indicated that the residents 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 residents had comprehensive assessments. These 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 residents’ preferred way of giving and receiving information was established, and information provided was appropriate and accessible. Opportunities were made available for the residents’ engagement in meaningful activities, based on individual preference.

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

a) Staff had not received training in support of the principles and guidance of this code of practice, including person-centred approaches and relevant human rights principles, 6.1.

b) The procedures for training staff in working with people with intellectual disability did not reference induction training for new staff or the frequency of 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 policy in relation to the use of Electro-Convulsive Therapy (ECT). It addressed all criteria of this code of practice, including provisions in relation to the following:

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

Training and Education: The two staff members involved in delivering ECT were trained in line with best international practice and had appropriate Basic Life Support training, which was completed in February 2017.

Evidence of Implementation: The approved centre had a dedicated suite for the delivery of ECT, including a private waiting room and adequately equipped treatment and recovery rooms. There had been two high-risk residents in the approved centre, who were treated in theatre in the general hospital. The recovery room was spacious enough to accommodate the number of residents receiving ECT. Material and equipment for ECT were in line with best international practice, and there was documentary evidence that ECT machines were regularly maintained.

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed in the treatment room. A named consultant and named consultant anaesthetist had responsibility for ECT, and a designated ECT nurse and a registered psychiatric nurse were in the ECT suite at all times. The designated ECT nurse was responsible for checking emergency equipment and drugs on a weekly basis.

The clinical file of one discharged resident who had recently completed a voluntary programme of ECT was examined. It indicated that appropriate information about ECT was given to the resident by the consultant psychiatrist, including details of likely adverse effects of the treatment. The information provided was in clear and simple language that the resident could understand. The resident was informed of his/her rights to an advocate and had the opportunity to raise questions at any time.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies before prescribing ECT, the communication with the resident and/or next of kin, a mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded.

The consultant psychiatrist, together with the resident, reviewed the progress of the treatment and the need for continuation of ECT. The ECT record was retained in the clinical file, as were all post-ECT assessments. A comprehensive capacity to consent assessment was undertaken and documented in the
Clinical file. Consent was obtained in writing for each ECT treatment by the consultant psychiatrist or a registered medical practitioner under supervision of the consultant psychiatrist.

The approved centre was compliant with this code of practice.
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: Entitled *Pre-admission and the Admission Process to the Dept. of Psychiatry*, the admission policy was dated August 2016. It included all criteria of this code of practice, including processes relating 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 confidentiality, privacy, and consent.

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

Discharge: The approved centre had a number of policies in relation to discharge: *Discharge from the Approved Centre, Discharge from Dept. of Psychiatry/Involuntary Resident, Resident Discharge against Medical Advice, and Admission and Discharge of a Person with Intellectual Disability*. The policies referenced prescriptions and supply of medication on discharge and included protocols for discharging homeless people, older persons, and people with an intellectual disability. They also addressed the management of discharge against medical advice. Although aftercare was mentioned, the policies did not comprehensively address the following:

- Relapse prevention.
- Crisis management.
- The roles and responsibilities of staff in relation to providing follow-up care.
- Details of when and how much follow-up contact residents should have.
- The process for following up and managing missed appointments.

Training and Education: There was no documentary evidence that all staff 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: Four clinical files were inspected in relation to admission. These indicated that the approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was taken by the registered medical practitioner (RMP). Residents were admitted to the unit most appropriate to their needs.
A comprehensive assessment did not take place in three of the admissions inspected: No psychiatric assessment was completed or documented in the clinical files. Admission assessments did not include a history of the presenting problem, previous psychiatric history, family history, medical history, current and historical medication, social history, mental state examination, and full physical examination. Nursing assessments were completed in the four cases and documented in the clinical files. Family members/carers were involved in the admission process.

The approved centre’s admission process was compliant under Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents, and Regulation 27: Maintenance of Records.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical files of two residents were inspected in relation to transfer. The decision to transfer was made by the RMP.

In one case, the decision to transfer was not agreed with the receiving facility, an assessment was not completed prior to transfer, there was no MDT input into the transfer, and there was no copy of the referral letter in the clinical file.

In both cases, efforts were made to respect the residents’ wishes and obtain consent and a family member/carer/advocate was involved in the transfer process. One of the transfers was on an involuntary basis, and the appropriate statutory forms were completed in line with the Mental Health Act 2001.

**Discharge:** The files of two recently discharged residents were inspected. In each case, the residents were discharged without notice and there was no estimated date of discharge in the residents’ individual care plans (ICPs). No MDT discharge meeting took place, and there was no evidence of appropriate MDT input into discharge planning. Both residents underwent a full medical review prior to their discharge, and this was documented.

There was no evidence that the discharge was coordinated by the key worker or that a preliminary discharge summary was sent to the relevant primary care/community mental health team within three days. In one case, there was no evidence that a comprehensive discharge summary followed within 14 days. There was no evidence of family/carer/advocate involvement in the discharge process.

The admission, transfer, and discharge processes were compliant under Regulation 32: Risk Management Procedures.

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

a) The discharge policy did not include comprehensive follow-up procedures, 4.14.

b) There was no documentary evidence that staff had read and understood the admission, transfer, or discharge policies, 9.1.

c) There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission or discharge policies, 4.19.

d) There was no comprehensive resident assessment at admission in three clinical files inspected, 15.1.

e) In three clinical files examined, admission assessments did not include a history of the presenting problem previous psychiatric history, family history, medical history, current and historical medication, social history, mental state examination, and full physical examination, 15.3.

f) Psychiatric assessments were not documented in three clinical files inspected in relation to the admission process, 15.5.
g) In one of the transfers inspected, the decision to transfer was not agreed with the receiving facility, 26.2.

h) In one transfer, an assessment was not completed prior to the transfer, 27.1.

i) There was no MDT involvement in one of the transfers reviewed, 29.1.

j) There was no copy of the referral letter in one of the clinical files, 31.2.

k) There was no discharge plan in place as part of the ICP in the two files inspected, 34.1.

l) No estimated date of discharge was recorded for either discharge, 42.1(e).

m) No MDT discharge meeting took place, 34.4.

n) There was no evidence of MDT input into discharge planning, 36.1.

o) There was no evidence that the key worker coordinated the discharges, 37.1.

p) There was no evidence that a preliminary discharge summary was sent to primary care/community mental health teams within three days, 38.3 and 38.4.

q) In one of the discharges, there was no evidence that a comprehensive discharge summary was issued within 14 days, 38.3(b) and 38.4.

r) There was no evidence of family/carers/advocate involvement in the discharge process, 39.1.

s) The two files inspected in relation to discharge indicated that both residents were discharged without notice, 40.1.
### Appendix 1: Corrective and Preventative Action Plan Template - 2017 Inspection Report

#### Regulation 21: Privacy

*Report reference: Page 39*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</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>New plan; plan carried over from 2016; or monitored as per Condition</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>
</tbody>
</table>
| 1. Residents in the male ward were not facilitated in making private phone calls. | New | Plan required | Corrective Action(s):  
Phone in male ward is now working  
Phone Hood will be delivered 3/10/2017 to facilitate the taking and making of calls with more privacy  
Post-Holder(s) responsible: CNM ‘s in the Approved centre | Observational | Achieved | 31/10/2017 |
| | | | Preventative Action(s):  
Notice displayed advising of self reporting of any | Notice in place | Notice in place | Completed |

---

1. Area of non-compliance reoccurring from 2016  
2. Area of non-compliance new in 2017
2. Occupants of the male seclusion area had to cross the corridor to use the bathroom.  
   Reoccurring  
   To be monitored as per Condition 3; no CAPA plan required at this time.

---

**Area(s) of non-compliance**  

<table>
<thead>
<tr>
<th>Taken from the inspection report</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| Interruptions in phone service.  
Post-Holder(s) responsible: CNM’s in the Approved centre |
| 2.Occupants of the male seclusion area had to cross the corridor to use the bathroom.  
Reoccurring  
To be monitored as per Condition 3; no CAPA plan required at this time. |
| 3. It did not have adequate and suitable furnishing having regard to the number and mix of residents.  
New  
Plan required |
| Corrective Action(s): Occupational Therapist, CNM3 & ADON have undertaken a business case with user involvement.  
Post-Holder(s) responsible: Registered Proprietor |
| Preventative Action(s):  
On going monitoring through monthly service user meetings |
| Any furnishing needing upholstering etc will be removed from the service. |

---

3. To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy, and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.
coupled with audit of state of furniture
Post-Holder(s) responsible: CNMs in the approved centre

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Significant ligature risks had not been minimised, meaning that the physical structure and overall environment were not maintained with due regard to the safety and well-being of residents.</td>
<td>Reoccurring</td>
<td>To be monitored as per Condition²; no CAPA plan required at this time.</td>
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</tbody>
</table>

Regulation 26: Staffing


<table>
<thead>
<tr>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Not all staff had up-to-date mandatory training</td>
<td>Reoccurring</td>
<td>Please provide a plan to include training in Mental Health Act 2001.</td>
<td>Corrective Action(s): Bi annual meeting with Trainers being organised to</td>
<td>A new Data base for training has been introduced.</td>
<td>31/12/2017</td>
</tr>
<tr>
<td>in fire safety, BLS, TMAV, and the Mental Health Act 2001.</td>
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<tr>
<td>agree training scheduling and course content. Post-Holder(s) responsible: Individual Line Managers / HOD's to co ordinate their staff</td>
<td></td>
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</tr>
<tr>
<td>Preventative Action(s): An annual staff training programme with periodic evaluations Post-Holder(s) responsible: Individual Line managers / HOD's to engage with Training scheduling.</td>
<td></td>
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<tr>
<td>A new Data base for training has been introduced.</td>
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<tr>
<td>staff attend mandatory training.</td>
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</table>

<table>
<thead>
<tr>
<th>Individual Line Managers / HOD's to co ordinate their staff</th>
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</thead>
<tbody>
<tr>
<td>Individual Line managers / HOD's to engage with Training scheduling.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>An annual staff training programme with periodic evaluations Post-Holder(s) responsible: Individual Line managers / HOD's to engage with Training scheduling.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A new Data base for training has been introduced.</th>
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<tbody>
<tr>
<td>ongoing</td>
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</tbody>
</table>

| 31/12/2017 |
### Section 69: The Use of Seclusion

Report reference: Page 63-64

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</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 or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>6. Not all staff involved in the use of seclusion had read and understood the policy.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>In order to capture out-of hours staff, the Seclusion Policy will be discussed and signed by the individual staff members at each Sunday Ward Meeting until all staff have read and signed that they understood the policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nursing/Medical staff to be informed of on-going obligation to sign and understand Seclusion Policy.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nursing/Medical staff to be trained on use of seclusion pack/policy.</td>
<td></td>
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<td></td>
<td>Post-Holder(s) responsible: ECD/DON</td>
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<td></td>
<td></td>
<td></td>
<td>Signature Register of staff attendance at Seclusion Compliance Training to be maintained.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Evidence of staff signatures to be available on Seclusion Policy Signature Page.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Training records for staff attendance to be maintained</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Time/resources needed to train all stakeholders involved in Seclusion Practice.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>4-6 weeks to allow all staff time to be trained on use of Seclusion Pack and Policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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</tr>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>Preventative Action(s): Seclusion Policy discussed at each Sunday meeting and importance of compliance reinforced.</td>
<td></td>
<td></td>
<td>Record of discussion kept within Ward Meeting Folder.</td>
<td>Achievable, no barriers to implementation.</td>
<td>Currently implemented.</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: CNM 3/ADON/Consultants</td>
<td></td>
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<tr>
<td>7. In one episode, the duration of the episode of seclusion was not recorded.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Seclusion duration currently recorded in Seclusion Register/ Seclusion Pack (Front Page) Observations Section of Seclusion Pack. Duration of Seclusion Episodes also captured during on-going audits and Quarterly Seclusion Reports for Mental Health Division.</td>
<td>Implementation to be monitored during monthly seclusion audits.</td>
<td>Achievable, no barriers to implementation.</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: ECD/DON</td>
<td></td>
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<tr>
<td>Preventative Action(s): Staff training to be provided on Seclusion Compliance issues.</td>
<td></td>
<td></td>
<td>Signature Register of staff attendance at Seclusion Compliance Training to be kept.</td>
<td>Achievable, no barriers.</td>
<td>4-6 weeks - mid November to allow all staff time to be trained on use of</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
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<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
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<td></td>
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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>
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<td></td>
<td>Seclusion Pack and Policy.</td>
</tr>
<tr>
<td>8. Direct observation of the resident for the first hour of seclusion was not possible because of a blind spot in the seclusion area.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Need for a second camera in each of the seclusion rooms and a request has been made for funding approval for same.</td>
<td>Evidence of implementation available once cameras have been fitted.</td>
<td>31/12/2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: Registered Proprietor</td>
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<td></td>
<td>Preventative Action(s): Need for safety mirror to be placed on Ceiling of each Seclusion Room to prevent blind spot.</td>
<td>Once fitted in Seclusion Room, mirrors will provide greater vision of all ‘blind spots’ within seclusion rooms.</td>
<td>31/12/2017</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Post-Holder(s) responsible: Registered Proprietor</td>
<td>Need viable option to implement plan, i.e. Establish name of company who can provide this service / liaise with services who have similar issues.</td>
<td></td>
</tr>
<tr>
<td>9. The 15-minute nursing record did not document the level of distress and</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Space for ‘Level of Distress’ implemented into ‘Seclusion Pack’ Observations Page</td>
<td>Visual evidence of level of distress recorded in observations section of seclusion pack</td>
<td>Completed on 22/07/2017</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>None</td>
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<tr>
<td>Area(s) of non-compliance</td>
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<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
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<tr>
<td><strong>behaviour of the resident in seclusion.</strong></td>
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<td>Audit tool</td>
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<td>Post-Holder(s) responsible:ECD/Don</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Preventative Action(s): Training to be provided to staff on areas of non-compliance.</td>
<td>Signature Register of staff attendance at Seclusion Compliance Training to be kept.</td>
<td>None</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Post-Holder(s) responsible: ECD/DON</td>
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<td></td>
<td>Practice will be monitored during monthly seclusion audits.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td><strong>New</strong></td>
<td><strong>Plan required</strong></td>
<td>Corrective Action(s): Seclusion ended while patients were asleep as per directive from Mental Health Division members. Monitor Seclusion episodes to ensure episodes are no longer ended while residents are asleep. Question to be built into seclusion audit tool to highlight incidents of seclusion being ended while patient is asleep.</td>
<td>Staff will be educated on change in practice, Signature Register of staff attendance at seclusion compliance training to be kept.</td>
<td>Practice no longer in place, all staff aware of same.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Post-Holder(s) responsible:ECD/DON</td>
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<td></td>
<td>Practice no longer in place, all staff aware of same.</td>
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<td></td>
<td>Episodes are audited on an ongoing basis.</td>
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<td></td>
<td>Completed on 21/09/2017.</td>
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<tr>
<td>Area(s) of non-compliance</td>
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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>
<tr>
<td>Preventative Action(s): Practice no longer in place following feedback from Mental Health Commission from previous inspection</td>
<td>Post-Holder(s) responsible: ECD/DON</td>
<td>Staff will be educated on the change in practice, signature register of staff attendance at seclusion compliance training to be kept.</td>
<td>None</td>
<td></td>
<td>In place.</td>
</tr>
<tr>
<td>11. In two episodes, the reasons for ending seclusion were not recorded in the clinical files.</td>
<td>New</td>
<td>Corrective Action(s): Ending of Seclusion to be documented in Nursing/Medical Note. Reasons for ending Seclusion to be documented in ‘Risk Assessment’</td>
<td>Staff will be educated on need to document ending of seclusion within nursing/medical notes. Signature Register of staff attendance at Seclusion Compliance Training to be kept.</td>
<td>None</td>
<td>31/11/2017 to allow all staff time to be trained on use of Seclusion Pack and Policy.</td>
</tr>
<tr>
<td></td>
<td>Plan required</td>
<td>Preventative Action(s): Training on documentation and compliance to be provided to staff. Post-Holder(s) responsible: Seclusion lead</td>
<td>Signature Register of staff attendance at Seclusion Compliance Training to be kept. Is incorporated in the seclusion audit.</td>
<td>None</td>
<td>30/11/2017 to allow all staff time to be trained on use of Seclusion Pack and Policy.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
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<td>Achievable / Realistic</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 details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>12. Residents in seclusion did not have access to adequate toilet/washing facilities.</td>
<td>Reoccurring</td>
<td>To be monitored as per Condition; no CAPA plan required at this time.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>13. In two episodes, the use of seclusion was not clearly recorded in the register.</td>
<td>New</td>
<td>Corrective Action(s): Staff to be educated on the importance of completing ‘Clinical Practice Forms’ and compliance issues. Episodes to be monitored in an ongoing basis, Seclusion Audits to highlight deviations from best practice. Post-Holder(s) responsible: ECD/DON / MHA Administrator</td>
<td>Register of staff attendance at seclusion compliance training to be kept.</td>
<td>None</td>
<td>30/11/2017 to allow time for training to be provided to all stakeholders. Currently in place.</td>
</tr>
<tr>
<td>14. In one case, the episode was not</td>
<td>New</td>
<td>Corrective Action(s): Need for MDT Review to be incorporated in ‘Seclusion Pack’ Checklist.</td>
<td>Checklist will be updated to reflect need to place reminder</td>
<td>None</td>
<td>Completed on 21/09/2017.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
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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>
<tr>
<td>reviewed by the MDT.</td>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: CNMs/ADON/Consultants</td>
<td>of ‘MDT Review’ in ward diary after each seclusion episode. Each NIMS form now discussed at MDT to review incident.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Preventative Action(s): Staff to be informed and trained on use of Seclusion Pack and Compliance. Post-Holder(s) responsible: CNMs/ADON/Consultants</td>
<td>Register of staff attendance at seclusion compliance training to be kept</td>
<td>None</td>
</tr>
</tbody>
</table>

Area(s) of non-compliance | Plan required | Specific | Measureable | Achievable / Realistic | Time-bound |
### Part 4: Consent to Treatment

*Report reference: Page 67-68*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
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<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>15. There was no evidence that one patient’s ability to understand the nature, purpose, and likely effects of the medication(s) had been assessed and documented.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): A template has been devised that will capture this information. To be completed by the Registered Consultant Psychiatrist. Post-Holder(s) responsible: ECD/DON</td>
<td>Training will be provided and records maintained.</td>
<td>In place and training in progress</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preventative Action(s): An audit of the template will be undertaken quarterly Post-Holder(s) responsible: ECD / MHA Administrator</td>
<td>Audit results will be available.</td>
<td>Audit plan to be developed</td>
</tr>
<tr>
<td>16. The potential risks associated with the medication(s) being administered</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): The template as described above will address this issue</td>
<td>Training will be provided and records maintained</td>
<td>In place and training in progress</td>
</tr>
</tbody>
</table>
were not recorded for one patient.

<table>
<thead>
<tr>
<th>Preventative Action(s):</th>
<th>Audit results will be available</th>
<th>Audit plan to be developed</th>
<th>31/12/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>An audit of the template will be undertaken quarterly</td>
<td>Post-Holder(s) responsible: ECD / MHA Administrator</td>
<td>Post-Holder(s) responsible: ECD / MHA Administrator</td>
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### Code of Practice: The Use of Physical Restraint

**Report reference: Page 70-71**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
<th>Specific</th>
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<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>17. Not all staff involved in physical restraint had acknowledged that they had read and understood the policy.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): In order to capture out-of-hours staff, the physical restraint policy will be discussed and signed by the individual staff members at each Sunday Ward Meeting until all staff have read and signed that they understood the policy.</td>
<td>Signature Register of staff attendance at physical restraint Compliance Training to be kept.</td>
<td>Evidence of staff signatures to be available on physical restraint policy signature page.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<tr>
<td>Taken from the inspection report</td>
<td>Reoccuring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>Post-Holder(s) responsible: ADON / CNM3/Consultants</td>
<td>Preventative Action(s): Physical Restraint Policy discussed at each Sunday meeting and importance of compliance reinforced.</td>
<td>Record of discussion kept within Ward Meeting folder.</td>
<td>Achievable, no barriers to implementation.</td>
<td>30/10/2017</td>
<td></td>
</tr>
<tr>
<td>18. The policy and procedures for training staff in the use of physical restraint did not reference the mandatory nature of training.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): In order to capture out-of hours staff, the physical restraint policy will be discussed and signed by the individual staff members at each Sunday Ward Meeting until all staff have read and signed that they understood the policy.</td>
<td>Signature register of staff attendance at physical restraint compliance training to be kept.</td>
<td>Time/resources needed to train all stakeholders involved in physical restraint practice</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>
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<td></td>
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<td></td>
<td>Nursing/Medical staff to be informed of on-going obligation to sign and understand physical restraint policy. Nursing/Medical staff to be training on use of physical restraint policy Post-Holder(s) responsible: ADON/CNM 3/Consultants</td>
<td>Evidence of staff signatures to be available on physical restraint policy signature page. Signature register of staff attendance at physical restraint compliance training to be kept</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Preventative Action(s): Physical restraint policy discussed at each Sunday meeting and importance of compliance reinforced. Post-holder(s) responsible ADON/CNM3</td>
<td>Record of discussion kept within Ward meeting folder</td>
<td>Achievable, no barriers to implementation.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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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>
<tr>
<td>19. In one episode, it was not evident that physical restraint had been used in exceptional circumstances and in the resident’s best interests.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Introduction of a Physical Restraint checklist used in other CHO8 areas which will include that physical restraint had been used in exceptional circumstances and in the resident’s best interests. It will take into consideration the information on the checklist in the Best Practice Guidance for Mental Health.</td>
<td>Currently this checklist is being developed and will be incorporated into the policy.</td>
<td>Time allowed to train all staff in the amended policy</td>
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<td>Post-Holder(s) responsible: ADON/CNM 3</td>
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<td></td>
<td></td>
<td>Preventative Action(s): A quarterly audit of the checklist.</td>
<td>Audits of checklist and policy by the Approved Centre Governance Group</td>
<td>No barriers</td>
<td>30/11/2017</td>
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<td>Post-Holder(s) responsible: ADON/CNM3</td>
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<tr>
<td>20. In one episode, it was not documented whether staff had first</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Introduction of a Physical Restraint checklist used in</td>
<td>Staff will be educated on the purpose and use of the change in practice at</td>
<td>No barriers</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
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<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>considered other interventions to manage the resident’s unsafe behaviour before initiating physical restraint.</td>
<td></td>
<td></td>
<td>other CHO8 areas to include whether staff had first considered other interventions to manage the resident’s unsafe behaviour before initiating physical restraint. It will take into consideration the information on the checklist in the Best Practice Guidance for Mental Health. Post-Holder(s) responsible: ADON / CNM3</td>
<td>physical restraint compliance training.</td>
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</tr>
<tr>
<td>Preventative Action(s): Quarterly Audit of completed checklists Post-Holder(s) responsible: ADON / CNM3</td>
<td></td>
<td></td>
<td>The monitoring of staff training and education attendance will be measured through audit</td>
<td>No barriers</td>
<td>30/11/2017</td>
</tr>
<tr>
<td>21.In one files, it was not documented that the clinical psychiatrist was notified of the use of</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Introduction of A Physical Restraint checklist used in other CHO8 areas to include that the clinical psychiatrist</td>
<td>Staff will be educated on the purpose and use of the change in practice at physical restraint compliance training</td>
<td>Checklist completed</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Achievable / Realistic</td>
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<td>physical restraint as soon as was practicable.</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>
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<td>was notified of the use of physical restraint as soon as possible. It will take into consideration the information on the checklist in the Best Practice Guidance for Mental Health.</td>
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<td>Post-Holder(s) responsible: ADON / CNM3</td>
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<td>Preventative Action(s): Quarterly Audit of completed checklists</td>
<td></td>
<td>No barriers</td>
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<td></td>
<td>Post-Holder(s) responsible: ADON / CNM3</td>
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<tr>
<td>22.In one episode, a medical examination of the resident was not completed within three hours of the start of physical restraint and the time of the medical examination was not</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Introduction of A Physical Restraint checklist used in other CHO8 areas to include if a medical examination of the resident was completed within 3 hrs of the start of physical restraint. Dates and times must be clearly</td>
<td>All medical and nursing staff will be educated on the purpose and use of the change in practice at physical restraint compliance training</td>
<td>No barriers</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Specific</td>
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<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>
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<tr>
<td>recorded in another episode.</td>
<td></td>
<td>documented. It will take into consideration the information on the checklist in the Best Practice Guidance for Mental Health.</td>
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<td>Post-Holder(s) responsible: ADON / CNM3</td>
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<td>Preventative Action(s): Quarterly Audit of completed checklists</td>
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<td>Post-Holder(s) responsible: ADON / CNM3</td>
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<tr>
<td>No barriers</td>
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<td>31/12/2017</td>
</tr>
<tr>
<td>23. There was no evidence that residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Introduction of A Physical Restraint checklist used in other CHO8 areas to include that the residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.</td>
<td>Checklist will be audited on a quarterly basis to ensure compliance.</td>
<td>No Bariers</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
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<td>Taken from the inspection report</td>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</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>All medical and nursing staff will be educated on the purpose and use of the change in practice at physical restraint compliance training</td>
<td>Signed attendance sheet for all training relevant to this code of practice</td>
<td>Time allowed to train all staff in the amended policy</td>
<td>31/12/2017</td>
<td></td>
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</tr>
<tr>
<td>Post-Holder(s) responsible: Consultants/ ADON / CNM3</td>
<td>Preventative Action(s): Quarterly Audit of completed checklists</td>
<td>The monitoring of staff training and education attendance will be measured through audit</td>
<td>No barriers</td>
<td>31/12/2017</td>
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<tr>
<td>Post-Holder(s) responsible: ADON / CNM3</td>
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<tr>
<td>24. It was not documented whether residents had consented to their next of kin being informed of the use of physical restraint.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Introduction of A Physical Restraint checklist used in other CHO8 areas which includes a section related to whether the resident had consented to their next of kin being informed of the use of physical restraint.</td>
<td>The service will introduce a monthly physical restraint audit similar to monthly seclusion audit and will take into consideration the information on the checklist in the Best Practice Guidance for</td>
<td>No barriers</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
<td>Specific</td>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
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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>
<td>Provide the timeframe of the completion of the action(s)</td>
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<td></td>
<td>Post-Holder(s) responsible: ADON / CNM3</td>
<td>Mental Health. This will monitor practice.</td>
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<tr>
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<td></td>
<td>Preventative Action(s): Quarterly Audit of completed checklists</td>
<td>Analysis of audit on a quarterly basis</td>
<td>No barriers</td>
<td>Development of audit tool to be completed by 15/11/2017. Quarterly audits to be planned from completion of the audit tool.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff will be educated on change in practice.</td>
<td>Records of attendance at physical restraint compliance training.</td>
<td>Time allowed to train all staff in the amended policy</td>
<td>Training to be completed 30/11/2017</td>
</tr>
<tr>
<td>25.In three episodes, the use of physical restraint was not reviewed by the MDT or documented in the clinical file within two working days.</td>
<td>New Plan required</td>
<td>Corrective Action(s): Introduction of A Physical Restraint checklist used in other CHO8 areas which includes a section related to the need for MDT review.</td>
<td>The service will introduce a monthly physical restraint audit similar to monthly seclusion audit and will take into consideration the</td>
<td>No barriers</td>
<td>31/12/17.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
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<td>Achievable / Realistic</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
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<td></td>
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<td></td>
<td>Checklist will include requirement to reflect need to place reminder of ‘MDT Review’ in Ward diary after each Physical Restraint episode. Each Incident form for the physical restraint episode will be discussed at MDT to review incident. Post-Holder(s) responsible: ADON/ CNM3 DOP.</td>
<td>information on the checklist in the Best Practice Guidance for Mental Health. This will monitor practice.</td>
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<td></td>
<td></td>
<td>Preventative Action(s): Staff to be informed and trained on use of Physical Restraint. Post-Holder(s) responsible: ADON / CNM3</td>
<td>Register of staff attendance at Physical Restraint compliance training to be kept</td>
<td>None</td>
<td>30/11/2017 to allow all staff time to be trained on use of Physical Restraint and relevant Policy.</td>
</tr>
<tr>
<td>26.In one episode, no rationale for the use of physical restraint was clearly recorded in the clinical file.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Need for MDT review to be incorporated in physical restraint checklist. Post-Holder(s) responsible: ADON/CNM3 DOP</td>
<td>Checklist will be developed to reflect need to place reminder of MDT review in ward diary after each physical restraint episode. Each NIMS form</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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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>
<tr>
<td>Preventative Action(s): Staff to be informed and trained on use of physical restraint Post-Holder(s) responsible: ADON / CNM3</td>
<td></td>
<td></td>
<td>now discussed at MDT to review incident</td>
<td></td>
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<td></td>
<td>Register of staff attendance at physical restraint compliance training.</td>
<td>No barriers</td>
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</table>
## Code of Practice: Admission of Children

**Report reference:** Page 72

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</th>
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<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016</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>
</tbody>
</table>
| 27. It did not provide age-appropriate facilities and a programme of activities appropriate to the age and ability of the child residents. | Reoccurring | CAPA plans carried over from 2016. Please:  
- Revise the plans as necessary  
- Provide revised timeframes in the time-bound column | Corrective action(s):  
A programme of age appropriate educational activities in so far as practicable, have been devised with the assistance of the specialised adolescent unit. Supporting documentation is attached.  
We will continue to strive to source age appropriate facilities for admission, as soon as possible after decision to admit. | List of age appropriate educational activities available in the approved centre.  
Log of all attempts to source age appropriate admission facilities for Children is available in the Approved Centre. | National shortage of age appropriate beds. | List of age appropriate educational activities is completed.  
The log is completed for every child admission to the adult approved centre. |

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### Code of Practice: Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities
<table>
<thead>
<tr>
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<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>28. Staff had not received training in support of the principles and guidance of this code of practice, including person-centred approaches and relevant human rights principles.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Regional Mental Health Act Trainer to deliver appropriate training interventions to staff in addition to staff self-directed training modules on HSE Land</td>
<td>Attendance records for the training will be available. Staff who partake of the HSELand training will provide certification of completion of the course online to their line manager. A record of this training will be included in the training data sheet.</td>
<td>Currently arranging training dates and facilitating staff access to HSELand</td>
</tr>
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<td>Post-Holder(s) responsible: MHA Trainer with Line Managers / HOD’s</td>
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<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Monitoring of staff attendance at training</td>
<td>Attendance records will be available</td>
<td>Currently arranging training dates and facilitating staff access to HSELand</td>
<td>Feb 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: MHA Trainer with Line Managers / HOD’s</td>
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<td></td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s):</td>
<td>Preventative Action(s):</td>
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<tr>
<td>29. The procedures for training staff in working with people with intellectual disability did not reference induction training for new staff or the frequency of training.</td>
<td></td>
<td></td>
<td>The policy is being reviewed. When the policy document has been reviewed and signed off by management it will be disseminated to the staff through staff meetings and training. Member’s of staff trained in Intellectual Disability have been identified and are currently preparing induction training in ID for new staff. Post-Holder(s) responsible: ACG / MHA Trainer with Line Managers / HOD’s</td>
<td>Monitoring of attendance at Induction training for new staff. Training records will be included in the training data sheet. Post-Holder(s) responsible: ACG / MHA Trainer with Line Managers / HOD’s</td>
<td></td>
</tr>
</tbody>
</table>

|   |   |                                                                              | All staff will be requested to read and sign that they have understood the policy. Training plan and induction pack will be available | Attendance records for training |   |
|   |   |                                                                              | No barriers                                                                 | Currently arranging training dates and facilitating staff access to HSELand         |   |

|   |   |                                                                              | The identified staff are preparing an Induction programme for new staff.         |   | 31/01/2018 |

|   |   |                                                                              |   |   | 28/2/2018 |

|   |   |                                                                              |   |   |   |
### Code of Practice: Admission, Transfer and Discharge

**Report reference: Page 77-79**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Plan required</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 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 details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>30. The discharge policy did not include comprehensive follow-up procedures.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Review discharge Policies to include (1-5)</td>
<td>All staff will be requested to read and sign that they have understood the policy.</td>
<td>No barriers</td>
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<td></td>
<td></td>
<td></td>
<td>1. Relapse prevention.</td>
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<td>2. Crisis Management.</td>
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<td>3. The roles and responsibilities of staff in relation to providing follow-up care.</td>
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<td>4. Details of when and how much follow-up contact residents should have.</td>
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<td>5. The process for following up and managing missed appointments.</td>
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<td>In line with the Judgement Support Framework.</td>
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<td>Area(s) of non-compliance</td>
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<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>
</tbody>
</table>
| 31. There was no documentary evidence that staff had read and understood the admission, transfer, or discharge policies. | New | Plan required | Corrective Action(s):  
Training to be provided for staff in Admission, Transfer and Discharge Policy.  
Training at Friday teaching sessions on the policy for NCHD’s / Consultants. | .  
All staff will be requested to read and sign that they have understood the policy. | None | New policy complete. Training will be completed by 30/11/2017. |
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Measureable</th>
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<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Staff to be informed of the changes in the policy at staff meetings and training sessions.</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>
<td>New policy complete. Training will be completed by 30/11/2017</td>
</tr>
<tr>
<td>32. There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission or discharge policies.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): Audit Tool is being designed for implementation of Admission and Discharge Policies by members of the Approved Centre Governance Group/Audit Team. Audit team to be assigned from this group. Post-Holder(s) responsible: Heads of Depts. Preventative Action(s): Monitoring of audit results on a quarterly basis and development of an action plan for any recommendations from the audit results.</td>
<td>Analysis of audit on a quarterly basis.</td>
<td>No barriers</td>
<td>31/12/2017.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Plan required</td>
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<td>Measureable</td>
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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>
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<tr>
<td>33. There was no comprehensive resident assessment at admission in three clinical files inspected.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Review current admission proforma to ensure that a comprehensive resident assessment at admission is included. Audit Tool is being designed for implementation of Admission and Discharge Policies</td>
<td>Analysis of audit on a quarterly basis.</td>
<td>No barriers</td>
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<td>Preventative Action(s): Documentation Training for NCHD’s in relation to the requirement for full completion of the proforma in all cases including readmissions.</td>
<td>Attendance records at training sessions</td>
<td>No barriers</td>
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<td>Post-Holder(s) responsible: Heads of Depts</td>
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<td>Post-Holder(s) responsible: ECD/ Heads of Dept</td>
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<td>Post-Holder(s) responsible: ECD</td>
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<tr>
<td>Area(s) of non-compliance</td>
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<td>Specific</td>
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<td>Taken from the inspection report Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</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>
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</tr>
<tr>
<td>34. In three clinical files examined, admission assessments did not include a history of the presenting problem previous psychiatric history, family history, medical history, current and historical medication, social history, mental state examination, and full physical examination.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Review current admission proforma against headings listed to ensure admission assessments include a history of the presenting problem previous psychiatric history, family history, medical history, current and historical medication, social history, mental state examination, and full physical examination included.</td>
<td>Audit Tool is being designed for implementation of Admission and Discharge Policies Analysis of audit on a quarterly basis.</td>
<td>30/11/ 2017</td>
</tr>
<tr>
<td>35. Psychiatric assessments were not documented in three clinical files inspected in relation to the admission process.</td>
<td>New</td>
<td>Plan required</td>
<td>Audit Tool is being designed for implementation of Admission and Discharge Policies Analysis of audit on a quarterly basis.</td>
<td>Audit Tool is being designed for implementation of Admission and Discharge Policies Analysis of audit on a quarterly basis.</td>
<td>30/11/ 2017</td>
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<tr>
<td>Post-Holder(s) responsible: ECD</td>
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<td></td>
<td>No barriers</td>
<td>30/11/ 2017</td>
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<tr>
<td>Post-Holder(s) responsible: ECD</td>
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<td></td>
<td>No barriers</td>
<td>30/11/ 2017</td>
</tr>
<tr>
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<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td>Preventative Action(s): Audit Tool is being designed for implementation of Admission and Discharge Policies by members of the Approved Centre Governance Group/Audit Team. Audit team to be assigned from this group. Post-Holder(s) responsible: ECD / ACG</td>
<td>Analysis of audit on a quarterly basis.</td>
<td>No barriers</td>
</tr>
<tr>
<td>36. In one of the transfers inspected, the decision to transfer was not agreed with the receiving facility.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Checklist for transfer will be developed to include the documented reason for transfer and if the transfer is declined by the receiving hospital, the reason for not agreeing to the transfer will be recorded on the checklist</td>
<td>Checklist will be audited monthly and analysis of audit will be discussed at the weekly ACG meeting.</td>
<td>No barriers</td>
</tr>
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<td>Area(s) of non-compliance</td>
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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>
<tr>
<td>Preventative Action(s): Audit of checklist. Education at weekly NCHD teaching</td>
<td>Checklist will be audited monthly and analysis of audit will be discussed at the weekly ACG meeting. Attendance sheets Minutes from weekly meetings</td>
<td>No barriers</td>
<td>In place</td>
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<tr>
<td>Post-Holder(s) responsible: ECD</td>
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<td>Preventative Action(s): Audit of checklist. Education at weekly NCHD teaching</td>
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<td>No barriers</td>
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<tr>
<td>Preventative Action(s): Audit of checklist.</td>
<td>Checklist will be audited monthly and analysis of audit will be discussed at the weekly ACG meeting. Attendance sheets Minutes from weekly meetings</td>
<td>No barriers</td>
<td>31/11/2017</td>
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<tr>
<td>37. In one Transfer, an assessment was not completed prior to the Transfer.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Checklist for transfer will be developed to include the assessment prior to transfer. Education at weekly NCHD teaching</td>
<td>Checklist will be audited monthly and analysis of audit will be discussed at the weekly ACG meeting. Attendance sheets Minutes from weekly meetings</td>
<td>No barriers</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: ACG/ ECD.</td>
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<tr>
<td>Preventative Action(s): Audit of checklist.</td>
<td>Checklist will be audited monthly and analysis of audit will be discussed at the weekly ACG meeting. Attendance sheets Minutes from weekly meetings</td>
<td>No barriers</td>
<td>31/10/2017</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
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</tbody>
</table>
38. There was no MDT involvement in one of the transfers reviewed.

<table>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
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<td></td>
<td>ACG/ ECD.</td>
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<tr>
<td>38. There was no MDT involvement in one of the transfers reviewed.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Discharge Planning is part of all MDT reviews. For those patients discharged before the weekly MDT is held, the ICP will be updated and the patient discharge plan and follow up &amp; continuing care will be discussed at the Community MDT team meeting, and all relevant appointments arranged. The ICP audit should include that there is MDT involvement in all transfers/discharges. Post-Holder(s) responsible: ECD</td>
<td>Checklist &amp; ICP audit results</td>
<td>No barriers</td>
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<td></td>
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<td></td>
<td>Preventative Action(s): Education at weekly NCHD teaching</td>
<td>Attendance sheets</td>
<td>No barriers</td>
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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>
<tr>
<td>39. There was no copy of the referral letter in one of the clinical files.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): Checklist for transfer as noted above to include referral letter being filed</td>
<td>Checklist will be audited monthly and analysis of audit will be discussed at the weekly ACG meeting</td>
<td>On going</td>
</tr>
<tr>
<td>40. There was no discharge plan in place as part of the ICP in the two files inspected.</td>
<td>Reoccurring</td>
<td>Please provide an updated plan</td>
<td>Corrective Action(s): Discharge planning integral at all MDT meetings and part of the regular ICP audits</td>
<td>ICP audit results</td>
<td>In place</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>Heads of Dept</td>
<td>Preventative Action(s):</td>
<td>Training records for all grades of staff</td>
<td>In place</td>
<td>Complete</td>
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<tr>
<td>Regular ICP training sessions for all Clinical staff</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
<td>ACG/ ECD</td>
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<tr>
<td>41. No estimated date of discharge was recorded for either discharge</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>ICP audit results</td>
<td>In place</td>
<td>Complete</td>
</tr>
<tr>
<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td>Plan required</td>
<td>Discharge planning integral at all MDT meetings and part of the regular ICP audits</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
<td>Heads of Dept</td>
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<tr>
<td>Preventative Action(s):</td>
<td>Regular ICP training sessions for all Clinical staff</td>
<td>Training records for all grades of staff</td>
<td>In place</td>
<td>Complete</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
<td>ACG/ECD</td>
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<tr>
<td>42. No MDT discharge meeting took place.</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>ICP audit results</td>
<td>In place</td>
<td>Complete</td>
</tr>
<tr>
<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td>Plan required</td>
<td>For those patients discharged before the weekly MDT is held, the ICP will be updated and the</td>
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<td>Post-Holder(s) responsible:</td>
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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>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>43. There was no evidence of MDT input into discharge planning.</td>
<td>New plan; plan carried over from 2016; or monitored as per Condition</td>
<td>patient discharge plan and follow up &amp; continuing care will be discussed at the Community MDT team meeting, and all relevant appointments arranged.</td>
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<td>Post-Holder(s) responsible: Heads of Dept</td>
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<td>Preventative Action(s): Education at weekly NCHD teaching and at Nursing and community staff meetings. A memo to circulate to Community teams.</td>
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<td>Post-Holder(s) responsible: ECD</td>
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<td>Preventative Action(s): Training records for all grades of staff</td>
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<td>In place</td>
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<td>Complete</td>
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<tr>
<td>44. There was no evidence that the key worker coordinated the discharges.</td>
<td>New</td>
<td>Corrective Action(s): Checklist to be completed by Key Worker designated on the day. It should be noted that the keyworker could change during the course of the admission and on different shifts.</td>
<td>Checklist will be audited monthly and analysis of audit will be discussed at the weekly ACG meeting.</td>
<td>No barriers</td>
<td>31/10/ 2017.</td>
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<td></td>
<td>Plan required</td>
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<tr>
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<td>Plan required</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<td>New plan; plan carried over from 2016; or monitored as per Condition</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>Post-Holder(s) responsible: CNM’s</td>
<td>Preventative Action(s): Keyworker involvement in coordinating discharge to be audited as part of the ICP audit.</td>
<td>ICP audit results will be analysed</td>
<td>No barriers</td>
<td>31/10/2017</td>
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<tr>
<td>45. There was no evidence that a preliminary discharge summary was sent to primary care/community mental health teams within three days. 46. In one of the discharges, there was no evidence that a comprehensive discharge summary was issued within 14 days.</td>
<td>New</td>
<td>Corrective Action(s): A process will be put in place that ensures preliminary discharge summaries are completed. There is a daily check on discharge summaries. This will now include notification to the teams by designated clerical staff of any outstanding discharges. A copy of the preliminary discharge summary is filed in the Clinical file. A comprehensive typed discharge summary will be</td>
<td>Audit of the preliminary discharge summary and audit of the 14 day typed version of discharge summary</td>
<td>No barriers</td>
<td>31/10/2017</td>
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<tr>
<td>Area(s) of non-compliance</td>
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<td>completed within fourteen days.</td>
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<td>Post-Holder(s) responsible: Admin staff/ADON/Consultant</td>
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<td>Preventative Action(s): A weekly report of outstanding discharge summaries will be completed and forwarded to the Clinical Tutor &amp; ECD for discussion at weekly NCHD teaching.</td>
<td>The weekly reports can be audited</td>
<td>No barriers</td>
<td>31/10/2017</td>
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<td>Post-Holder(s) responsible: Admin staff/ADON/Consultants/ECD</td>
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<td>47. There was no evidence of family/carer/advocate involvement in the discharge process.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): In as far as is possible and with residents consent, carer / family / advocate involvement will be actively involved in the discharge process. This is captured in the Discharge plan documentation. This documentation will be modified to include an explanation if the</td>
<td>Monthly analysis of the ICP audit</td>
<td>In place</td>
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<td>carer/family member or advocate are not involved in the discharge process. This needs to be included in the ICP audit</td>
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<td>Post-Holder(s) responsible: ADON/Consultants</td>
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<td>Preventative Action(s): All efforts are made to involve family members/carer or advocate assuming the resident has provided consent. Post-Holder(s) responsible: ADON/Consultant</td>
<td>Monthly analysis of the ICP audit</td>
<td>In place</td>
<td>31/10/2017</td>
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<td>48. The two files inspected in relation to discharge indicated that both residents were discharged without notice.</td>
<td>New</td>
<td>Plan required</td>
<td>Corrective Action(s): In as far as is practicable, residents will be given notice of discharge. Some admissions by their nature can be brief and where clinically indicated, discharge may occur sooner and this will be documented in the clinical file. Post-Holder(s) responsible:</td>
<td>Monthly analysis of the ICP audit</td>
<td>In place</td>
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<td>Preventative Action(s): This code of practice will be discussed at the weekly NCHD teaching and staff information meetings. Post-Holder(s) responsible: Clinical Tutor &amp; ADON / CNM3</td>
<td>Training records and minutes of meetings</td>
<td>On going</td>
<td>30/11/2017</td>
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