Department of Psychiatry, Roscommon University Hospital

ID Number: AC0011

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry, Roscommon University Hospital
Athlone Road
Roscommon

Approved Centre Type: Acute Adult Mental Health Care
Psychiatry of Later Life

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee: Mr Steve Jackson, General Manager, CHO 2 - Mental Health Services

Inspection Date: 5 – 8 September 2017

Previous Inspection Date: 15 - 18 November 2016

Inspection Type: Unannounced Annual Inspection

The Inspector of Mental Health Services: Dr Susan Finnerty MCRN009711

Date of Publication: 15 March 2018

2017 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspector of Mental Health Services

Dr Susan Finnerty

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

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

Safety in the approved centre

The approved centre had a written policy in relation to health and safety of staff and an associated safety statement. Clinical risk was not managed in accordance with the risk management policy and risks that were managed in the approved centre were not included in the risk register. The risk management policy did not address the identification and assessment of capacity risks relating to the number of residents in the approved centre or include the precautions in place to control the risks identified.

There was no evidence that food safety audits were completed periodically. Facilities for the refrigeration of food were inadequate and milk was being stored at recorded temperatures of over 10°C. Although a damaged refrigerator seal had been identified in June 2017, it had not been replaced by the time of inspection (September 2017). Good hand-hygiene and cross-infection control techniques were not observed during the dispensing of medications and all hand sanitiser dispensers in the approved centre were empty. Medication was ordered, prescribed, stored and administered in a safe manner. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, the 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

All residents had individual care plans (ICPs), which included reviews and individual risk management plans. However, they were not always developed by the multi-disciplinary team (MDT). They were developed with the participation of the resident and their representative, family, and next of kin.

The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of residents in the care of the rehabilitation team. The relevant MDT had no input from social work or psychology, and two clinical files inspected indicated that psychology needs had not been addressed. There were adequate and appropriate facilities for the provision of therapeutic services and programmes. General health needs were not assessed or addressed in all residents’ ICPs, and appropriate interventions and referrals were not made. Three clinical files inspected indicated that the residents did not have a physical
examination at least every six months. Residents could access general health services or be referred to other health services, as required. Not all resident records were maintained in good order.

The approved centre was compliant with Part 4 of the Mental Health Act: Consent to Treatment. It was not compliant with the Rules Governing the Use of Seclusion or with the Code of Practice on the Use of Physical Restraint in Approved Centres.

With regard to the care of people with intellectual disability, the approved centre did not have a policy for training staff in working with people with intellectual disability; the use of restrictive practices was not reviewed periodically and the relevant resident’s ICP did not address environmental considerations or list available resources and supports. The approved centre was non-compliant with 11 elements of the Code of Practice on Admission, Transfer and Discharge to and from Approved Centre.

**AREAS REFERRED TO**


**Respect for residents’ privacy and dignity**

Residents were supported to keep and wear their personal clothing, which was observed to be clean and appropriate to their needs. Personal possessions could be brought into the approved centre and residents were supported to manage their own property, with secure facilities for the safe-keeping of their property and valuables. Searches were carried out where indicated. There was no evidence that a minimum of two appropriately qualified staff were in attendance at all times during searches or that all searches were undertaken with due regard to the residents’ gender.

The residents’ rights to privacy was not respected at all times. One single room and one en suite toilet could not be locked from the inside, the window on a door to one of the single rooms was inadequately screened and passers-by could see inside, the practice of administering medication in the dining area did not show due regard to resident privacy and dignity, and a noticeboard displaying residents’ full names could be observed by other residents and families.

**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**

Meal choices were limited and often nutritionally inadequate, with a range of high-salt, high-fat options. The menu did not give sufficient information for residents to make choices. There was a range of recreational activities on weekdays only; there was no schedule of activities at the weekends. Recreational activities were not appropriately resourced. Residents did not have access to a garden, the occupational therapy room was closed in the evening, residents had no access to books, and there was a limited supply of recreational materials in the night sitting room. A walking group only took place once a week.
Residents were facilitated in the practice of their religion insofar as was practicable. There was an oratory just outside the main door of the approved centre, which residents had access to. Multi-faith chaplains were available. There were no separate visitors’ rooms or visiting areas where residents could meet visitors in private. Residents had access to communications, including telephone, mail, fax, and e-mail. Required information was given to residents and/or their representatives at admission in an information booklet. Residents received written and verbal information about their diagnosis and the likely adverse effects of treatments. There was a robust complaints procedure in place.

The accommodation provided by the approved centre did not ensure comfort and privacy or meet all residents’ needs: toilet areas and the assisted shower room needed a deep clean and windows were dirty, there were broken handles on lockers and wardrobes, and the shower in the assisted bathroom used by female residents was not adequate for the needs of residents.

The only outdoor space was a small cage-like area, which was a smoking area. This was accessed for ten minutes every hour with a nurse present. There was no access to outside space for those who did not smoke unless they went into the smoking area, and there was no area in which to walk around. This was restrictive, unhealthy, and a breach of human rights. This situation had been highlighted in previous inspection reports, but there was no evidence that it had been addressed.

**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 Department of Psychiatry at Roscommon University Hospital was part of Community Healthcare Organisation 2 and admitted residents from Galway/Roscommon areas 5 and 6. The approved centre had new governance structures since the last inspection and there was evidence that the new structures were operational. Each clinical discipline had its own governance structure with clear line management. All disciplines held monthly meetings and relevant issues were brought to four subgroups and/or the overarching Clinical Governance Group. The subgroups included Health and Safety, Drugs and Therapeutics, Audit and Quality Improvement, and Policies and Procedures. Issues not resolved at these meetings were addressed at the area management team meeting.

It was apparent that the number of core staff was not adequate and the approved centre relied heavily on agency staff. One consultant psychiatrist did not have enough staff to ensure that there was a multi-disciplinary team approach to care and treatment of the residents in his care.

There was evidence that the approved centre had not adopted appropriate risk management strategies. The risk register only recorded items that were escalated. Risks that were managed in the approved centre were not included on the risk register. There was evidence that some risks were not analysed and control measures were not documented. Senior management interviewed had not attended risk management training.
A new audit subgroup had been set up and had completed some audits. Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. All of the 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. A health and fitness survey was presented in draft form. All service users will be given an opportunity to fill it out and the results will direct health and fitness practice and activities.

2. A project was in development with Roscommon Sports Partnership to run more physical activities.

3. A peer educator from the Roscommon, East Galway Advancing Recovery College (REGARI) was attending once a fortnight to deliver modules from the college to the residents. Current modules include “let’s talk mental health”, “let’s talk anxiety, hope and empowerment”, and “let’s talk depression”. New modules will be delivered by social workers, occupational therapists, psychologists, and service users.

4. Clinical nurse managers grade 2 were attending first-line management training.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was registered for 22 residents and was located on the premises of the county hospital on the Dublin Road in Roscommon town. It was on the ground floor, situated directly behind the hospital’s main reception. The approved centre was divided into two main areas, both adjoining a main conservatory area located at the entrance door, which was locked. The main dining room and kitchen servery, activity therapy rooms, a day room, and a number of offices were in one area. This area was closed off in the evening time. The other area comprised all the sleeping accommodation, bathroom and toilet facilities, the high-dependency unit, a night sitting room, a night kitchen facility, and nursing offices. There was no access to a garden area, although funding was approved to commence the building of a sensory garden.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>22</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>18</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>1</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>3</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection:

**Condition:** 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.

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. However, current national infection control guidelines were not being followed, as indicated by the following:

- All hand sanitiser dispensers in the approved centre were empty.
- Good hand-hygiene and cross-infection control techniques were not observed during the dispensing of medications.
4.4 Governance

The Department of Psychiatry at Roscommon University Hospital was part of Community Healthcare Organisation 2 and admitted residents from Galway/Roscommon areas 5 and 6. The approved centre had new governance structures since the last inspection. All disciplines held monthly meetings and relevant issues were brought to four subgroups and/or the overarching Clinical Governance Group. The subgroups included Health and Safety, Drugs and Therapeutics, Audit and Quality Improvement, and Policies and Procedures. Ultimately, issues not resolved at these meetings were addressed at the area management team meeting. The inspection team was given copies of minutes from these meetings and there was evidence that the new structures were operational.

It was apparent that the number of core staff was not adequate and the approved centre relied heavily on agency staff. There had been problems sourcing staff through the agency framework and nurse managers spent a lot of time making phone calls and sending e-mails to ensure that gaps in the roster were filled. One consultant psychiatrist did not have enough staff to ensure that there was a multi-disciplinary team approach to care and treatment of the residents in his care. A recent initiative was the development of a training needs analysis and some training courses were planned to ensure staff were adequately trained.

There was evidence that the approved centre had not adopted appropriate risk management strategies. The risk register only included items that were escalated. Risks that were managed in the approved centre were not included on the risk register. There was evidence that some risks were not analysed and control measures were not documented. Senior management interviewed had not attended risk management training. A further training date was confirmed.

A new audit subgroup had been set up and had completed some audits. Staff interviewed were committed to addressing identified areas of non-compliance and implementing quality improvement.
### 5.0 Compliance

#### 5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 15 – 18 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 6: Food Safety</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>Non-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 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>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 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 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 5: Food and Nutrition</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 6: Food Safety</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>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>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>✓</td>
<td>✓</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 area was rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 10: Religion</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.

Four residents met privately with the inspectors. They outlined a variety of issues of personal or general concern, including having no outdoor space or garden. One bathroom was closed to residents because it was unsafe and there was an issue with the flow of water from one shower. Residents generally described positive engagement with staff. They perceived staff to be helpful and supportive. Residents were positive about activities during the day but said it could be boring at weekends with little to do. Five service users completed the questionnaire and some did not feel their privacy and dignity were respected.

The IAN representative was not available to meet the inspection team.
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
- Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker

The following did not meet the inspection team:

- Principal Psychologist

Some heads of discipline outlined issues relating to both recruitment and retention of staff. Each clinical discipline had its own governance structure with clear line management. Occupational therapy and social work managers described the supervision process in place. There was no appraisal process for any staff group. All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments. Business plans had been put forward to enhance the therapeutic and recreational programmes and they were due to become operational.

All of the heads of discipline reported that they held department meetings monthly and there were clear processes for escalating issues of concern. Two heads of discipline did not have training in health and safety training and none of the heads of discipline had up-to-date clinical risk management training. All had attended training in the National Incident Management System.
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:

- General Manager
- Clinical Director
- Clinical Psychiatrist
- Consultant Psychiatrist x 2
- Consultant Psychiatrist of Later Life
- Occupational Therapist
- Non-Consultant Hospital Doctor x 2
- Area Director of Nursing
- Assistant Director of Nursing
- Acting Clinical Nurse Manager 2
- Clinical Nurse Manager 3
- Business Manager
- Section Officer, Roscommon Mental Health Service

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. Clarification was sought from both the inspection team and representatives from the approved centre. These have been included in the relevant sections of the report.
## 9.0 Inspection Findings – Regulations

<table>
<thead>
<tr>
<th>EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)</th>
</tr>
</thead>
</table>

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.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in October 2016. It addressed all of the requirements of the *Judgement Support Framework*.

Training and Education: Not all relevant staff had signed the signature sheet to indicate 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 and Medication Prescription and Administration Records contained appropriate resident identifiers. 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, including name, date of birth, and patient record number. The identifiers were appropriate to residents’ communication abilities. Two identifiers were used before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and 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 pillar.
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 in draft form. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: A systematic review of menu plans had been undertaken by the catering department in the main hospital to ensure that residents received wholesome and nutritious food in accordance with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: The dietitian in the approved centre had no input into the existing menu or the development of a new menu, which was under way at the time of inspection. Food was prepared in the main hospital and the new menu was being developed by the dietitian there in consultation with the catering department. Nevertheless, the allocation of a dietitian to the approved centre was a positive development, and implementation of the menu development plans had the potential to contribute to the health and well-being of the resident group.

A sample of the two-week menu cycle was inspected. Meal choices were limited and often nutritionally inadequate, with a range of high-salt, high-fat options. Residents were given options in advance that included a fish dish or soup, but the menu did not give sufficient information for residents to make choices.

Food was presented in an appealing manner. At the time of inspection, no resident required a modified consistency diet. Residents had regular access to hot and cold drinks and to a source of safe, fresh drinking water. Hot meals were served daily.

At the time of inspection, the approved centre was in the process of introducing the St. Andrew’s Nutritional Screening Instrument (SANSI), an evidence-based nutrition assessment tool. The dietitian was working with staff on the ward in relation to the implementation of SANSI.

Weight charts were implemented, but there was no evidence that concerns were acted upon appropriately, with referrals to the dietitian. There was no evidence that residents, their representatives, family, and next of kin were educated about residents’ diets.

The approved centre was non-compliant with this regulation because menus did not provide wholesome and nutritious meals or adequate choice, 5(2).
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 November 2016. It included requirements of the Judgement Support Framework, with the following exceptions:

- The processes relating to food preparation, handling, storage, distribution, and disposal controls.
- The process for managing catering and food safety equipment.

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

Monitoring: There was no evidence that food safety audits were completed periodically. Food temperatures were recorded and in line with food safety recommendations, and a temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities for improving food safety processes, leading to an upgrade of the kitchenette.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. There was suitable catering equipment. Facilities for the refrigeration, storage, preparation, cooking, and serving of food were inadequate because the seal was worn in the fridge in the serving area. This had resulted in milk being stored at recorded temperatures of over 10°C. Although the damaged seal had been identified in June 2017, it had not been replaced by the time of inspection.

Hygiene was maintained to support food safety. Catering areas and associated equipment were appropriately cleaned. A cleaning schedule was maintained and documented daily. Residents had access to a supply of suitable crockery and cutlery.

The approved centre was non-compliant with this regulation because a damaged fridge seal meant that proper facilities were not available for the refrigeration of food, 6.1(b).
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 two written policies in relation to clothing, a provision of clothes policy and a night clothing policy, both of which were last reviewed in June 2017. Together, the policies addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: An emergency supply of clothing was maintained and monitored. During the inspection, two residents were observed wearing nightclothes. This was documented in the relevant clinical files.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing. All residents had a supply of their own clothes, which were sent home for washing or, if necessary, could be laundered in the approved centre. Residents’ clothing was observed to be clean and appropriate to their needs.

A supply of emergency clothing was available that 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 plans.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ personal property and possessions, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of the process for allowing residents access to and control over their personal property and possessions, unless this posed a danger to the resident or others, as indicated by a risk assessment and the resident individual care plan (ICP).

Training and Education: All relevant staff had signed the signature log to indicate 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: Personal property logs were maintained and monitored. Analysis had been completed to identify opportunities for improving the processes around residents’ personal property and possessions, but this was not documented.

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 safeguarded when the approved centre assumed responsibility for them. While the approved centre recommended that valuables and large sums of money were sent home, it provided secure facilities for the safe-keeping of residents’ property and valuables.

A signed property checklist was developed in triplicate, with one copy given to the resident, the second copy placed in the clinical file, and the third copy remaining in the triplicate book. The property checklist was kept separately to the ICP.

Access to and use of resident money was overseen by staff. The money log indicated that the process was overseen by either one staff member and the resident or by two staff. Records of staff handling residents’ money were maintained and countersigned by the resident or their 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 did not have a written policy in relation to the provision of recreational activities.

Training and Education: There was no policy for relevant staff to read and understand.

Monitoring: A record was maintained by occupational therapy staff of the occurrence of planned recreational activities, including a log of resident uptake/attendance. Analysis had been completed to identify opportunities for improving the processes relating to recreational activities and a new timetable was introduced.

Evidence of Implementation: The approved centre provided a range of recreational activities, including bowling, exercise, art therapy, a walking group, DVDs, TV, and newspapers, on weekdays only. Residents in the high observation area did not have access to any appropriate recreational activities.

There was no schedule of activities at the weekends. Recreational activities were not developed, maintained, and implemented with resident involvement. The community meetings book indicated that residents had made suggestions regarding activities, but none of these had been implemented.

Recreational activities were not appropriately resourced. Residents did not have access to a garden, the occupational therapy room was closed in the evening, residents had no access to books, and there was a limited supply of recreational materials in the night sitting room. Opportunities were not available for regular outdoor exercise and physical activity. A walking group took place that was poorly attended.

Information about recreational activities was provided to residents in the form of a timetable, which included information on the types and frequency of appropriate recreational activities. Where appropriate, individual risk assessments were completed for residents at admission in relation to the selection of activities, and resident decisions on whether or not to participate in activities were respected and documented.

Suitable communal areas were available for recreational activities, including a day room with a table tennis table and a TV. Records of resident attendance at events were maintained in clinical files.

The approved centre was non-compliant with this regulation because residents did not have access to appropriate recreational activities.
**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 November 2016. It included all of the requirements of the *Judgement Support Framework*.

**Training and Education:** Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

**Monitoring:** The policy’s implementation had been reviewed, and residents’ assessed religious needs were documented in their clinical files.

**Evidence of Implementation:** Residents were facilitated in the practice of their religion insofar as was practicable. There was an oratory just outside the main door of the approved centre, which residents had access to. Multi-faith chaplains were available, and residents were supported to attend local religious services, following a risk assessment.

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. Where relevant, religious requirements relating to the provision of services, care, and treatment in the approved centre were documented.

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*. 

| COMPLIANT | Quality Rating | Excellent |
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 October 2016. It addressed requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

Training and Education: All relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes relating to visits, as set out in the policy.

Monitoring: Restrictions on residents’ rights to receive visitors were monitored and reviewed at the weekly multi-disciplinary team meetings. Documented analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed on the door of the approved centre alongside national visiting guidelines. At the time of the inspection, no visiting restrictions were in place for any resident.

There were no separate visitors’ rooms or visiting areas available where residents could meet visitors in private. As there were no designated visitors’ areas, there was no way to ensure the safety of visitors and residents and visitors were sitting in various communal rooms and in shared bedrooms. Appropriate arrangements and suitable facilities for visiting children were not available in the approved centre.

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

   a) As there were no designated visitors’ areas, the safety of visitors and residents could not be assured during visits, 11(2).

   b) Residents could not receive visitors in private, 11(3).

   c) Appropriate arrangements and facilities were not available for visiting children, 11(4).
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 all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature log to indicate 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: There was no evidence that residents’ communication needs and restrictions on communication were monitored on an ongoing basis. Analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to communications that included telephone, mail, fax, and e-mail. Residents could access the Internet on their phones. They could also have supervised access to the Internet in the approved centre when information regarding care and treatment was required.

At the time of the inspection, there were no restrictions on resident communications.

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

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 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The policy did not specify the processes for communicating the approved centre’s search policies and procedures to residents and staff.

Training and Education: Not all relevant staff had signed the signature log to indicate 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: A search log was maintained in the nurses’ office. Each search record was reviewed to ensure the requirements of the regulation were complied with. Documented analysis had been completed to identify opportunities for improving search processes.

Evidence of Implementation: When staff identified a risk, they conducted a search of a resident, their property, or the environment, and this was documented in the nursing notes. However, there was no process for putting control measures in place or completing monitoring and review.
Resident consent was sought prior to all personal searches and documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. General written consent was not sought for routine environmental searches. There was no documentation in relation to environmental searches. The inspection team was informed that the approved centre did not conduct environmental searches.

The resident search policy was communicated to all residents in the information booklet, and residents were informed by those implementing a search of what was happening and why. Policy requirements were implemented when illicit substances were found during a search.

The files relating to two personal searches were inspected. There was no documentation available to indicate that a minimum of two clinical staff were in attendance at all times when the searches were being conducted. Similarly, there was no documentary evidence that searches were implemented with due regard to the residents’ dignity, privacy, and gender or that at least one of the staff members conducting the search was the same gender as the resident being searched. Each search of a resident and every property search was documented in the nursing notes, but there was no information in relation to the staff undertaking and attending the searches.

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

a) There was no evidence that a minimum of two appropriately qualified staff were in attendance at all times during searches, 13(6).

b) There was no evidence that all searches were undertaken with due regard to the residents’ gender, 13(7).

Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to care of the dying, which was last reviewed in November 2016. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- Requirements relating to advance directives in relation to end of life care and Do Not Attempt Resuscitation orders.
- The supports available to other residents and staff following a resident’s death.
- The process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred to another facility.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policy.

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

The approved centre was compliant with this regulation.
Regulation 15: Individual Care Plan

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in November 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed could articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: The resident ICPs had not been audited on a quarterly basis to assess compliance with the regulation. Analysis had not been undertaken to identify opportunities for improving the individual care planning process.

Evidence of Implementation: The ICPs of 18 residents were inspected. Each was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. The ICPs included reviews and individual risk management plans.

Residents were assessed at admission, and an initial care plan was put in place by the admitting clinician. The ICPs were subsequently drawn up following a comprehensive assessment, but they were not always developed by the MDT. Evidence-based assessments were used where possible. The ICPs were discussed, agreed where practicable, and developed with the participation of the resident and their representative, family, and next of kin. In all cases, a key worker was identified to ensure continuity in the implementation of the ICP.

The ICPs were not always reviewed by an MDT at least every six months because there was no rehabilitation and recovery MDT. The ICPs were updated, as indicated by the residents’ changing needs, condition, circumstances, and goals. Residents had access to their ICPs and were informed of changes. There was documented evidence that the residents were offered copies of their ICPs. Where a resident declined or refused a copy of their ICP, this was documented. No child resident had been admitted to the approved centre since the last inspection, meaning that educational requirements did not apply.

In one of the ICPs inspected, the resident’s assessed needs were not specified. In one ICP, appropriate goals for the resident were not identified. The interventions required to address the resident’s goals were not specified in one ICP, and the resources required to provide the care and treatment identified were not appropriately documented in four ICPs. One ICP inspected did not include a preliminary discharge plan.
The approved centre was non-compliant with this regulation for the following reasons:

a) ICPs were not always reviewed and updated by the MDT.
b) In one ICP inspected, appropriate goals for the resident were not identified.
c) The interventions required to address the resident’s goals were not specified in one ICP.
d) The resources required to provide the care and treatment identified were not appropriately documented in four ICPs.
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 last reviewed in November 2016. The policy addressed the roles and responsibilities in relation to the provision of therapeutic services and programmes and the actual provision of therapeutic services and programmes within the approved centre, but it did not include any of the other following requirements of the Judgement Support Framework:

- The planning of therapeutic services and programmes.
- The process for assessing residents as to the appropriateness of services and programmes and the resource requirements of therapeutic services and programmes.
- The recording requirements for therapeutic services and programmes.
- The process for reviewing and evaluating therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.
- The process for the provision of therapeutic services and programmes by external providers in external locations.

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

Monitoring: The range of therapeutic services and programmes provided was monitored and analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of residents, as documented in their individual care plans (ICPs). At the time of inspection, the assessed needs of all residents in the care of the rehabilitation team were not being met. The relevant multi-disciplinary team had no input from social work or psychology, and two clinical files inspected indicated that psychology needs had not been addressed.

The therapeutic services and programmes provided by the approved centre were evidence-based and included arts and crafts, yoga, music, and cooking. Residents attended programmes at the Roscommon East Galway Advancing Recovery in Ireland (REGARI) Recovery College in Roscommon. The occupational therapist and student clinical psychologist had introduced a new group therapy session in the approved centre, incorporating occupational therapy and psychology. The programme was directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of all therapeutic services and programmes provided in the approved centre was displayed in day areas. There were adequate and appropriate facilities for the provision of therapeutic services and...
programmes, namely the occupational therapy room, the Qualia relaxation room, and the night sitting room. A record of resident participation and engagement in and outcomes achieved in therapeutic services and programmes was maintained in residents’ ICPs or clinical files.

Where residents required a service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate alternative location. For example, a resident was facilitated to attend training in the REGARI college, accompanied by staff.

The approved centre was non-compliant with this regulation because not all residents had access to therapeutic services and programmes that met their assessed needs, as documented in their ICPs, 16(1).
Regulation 17: Children’s Education

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

INSPECTION FINDINGS

As there had been no admission of a child with educational needs since the last inspection, this regulation was not applicable.
Regulation 18: Transfer of Residents

| COMPLIANT |

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the transfer of residents, dated October 2016. It included requirements of the *Judgement Support Framework*, with the exception of processes for the following:

- Managing resident medications during transfer from the approved centre.
- Ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- Managing resident property during a transfer.

**Training and Education:** Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy. As no resident had been transferred from the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this regulation.
Regulation 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 and the response to medical emergencies, which was last reviewed in November 2016. It included requirements of the Judgement Support Framework, with the exception of the following:

- The management of the resuscitation trolley and Automated External Defibrillator (AED).
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The incorporation of general health needs into the resident individual care plan.
- The documentation requirements in relation to general health assessments.

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

Monitoring: At the time of the inspection, no resident was availing of national screening programmes. A systematic review was not undertaken to ensure that six-monthly general health assessments of all residents occurred; only involuntary residents were tracked in relation to six-monthly physicals. Analysis had not been completed to identify opportunities to improve general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and an AED, which were stored in the clinical room and checked weekly. Records were maintained of medical emergencies and of the care implemented, but there had been no recent emergency.

All 18 clinical files were inspected. General health needs were not assessed or addressed in all residents’ individual care plans, and appropriate interventions and referrals were not made. Three clinical files inspected indicated that the residents did not have a physical examination at least every six months.

Residents could access general health services or be referred to other health services, as required. Records were maintained of health checks and associated results. Where relevant, residents had access to appropriate national screening programmes through their GPs. No information on these programmes was available in the approved centre.

The approved centre was non-compliant with this regulation because not all residents’ general health needs were assessed at least every six months, as indicated by their individual care plans, 19(1)(b).
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 written policy in relation to the provision of information to residents, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of the interpreter and translation services available within the approved centre.

Training and Education: Not all staff had signed the signature log to indicate 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 audited on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Analysis had 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 an information booklet. 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, residents’ rights, and the multi-disciplinary team.

Residents received written and verbal information about their diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition. Information was provided on the likely adverse effects of treatments, including indications for use of all medications administered to residents and risks and potential side-effects. Medication information sheets and verbal information were provided in a format that was appropriate to residents’ needs and were evidence-based. Information documents provided by or within the approved centre were 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 and training and education pillars.
INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to resident privacy.

Training and Education There was no policy for staff to read or articulate.

Monitoring: There had been no annual review to ensure that 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 were observed to engage respectfully with residents. Staff were appropriately attired and sought permission before entering residents’ rooms. Staff were discreet in their interactions with residents or when discussing residents’ clinical and therapeutic needs. Residents were observed to be wearing clothing that respected their privacy and dignity.

Bathrooms and showers had locks on the inside of the doors, and these had an override facility. However, one single room and one en suite toilet could not be locked from the inside, which was not conducive to resident privacy.

Where rooms were shared, there was appropriate bed screening in place to ensure resident privacy. Not all observation panels on doors were appropriately screened. The window on a door to one of the single rooms was fitted with opaque film, but it included a transparent strip that meant passers-by could see into the room. This was not conducive to the privacy of the resident.

The practice of administering medication in the dining area did not show due regard to resident privacy and dignity. The noticeboard in the nurses’ station displayed the full names of residents and could be seen through the observation panel in the adjacent female dorm.

Residents were facilitated in making and taking private phone calls.

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

a) One single room and one en suite toilet could not be locked from the inside, which was not conducive to resident privacy.

b) The window on a door to one of the single rooms was inadequately screened and passers-by could see inside.

c) The practice of administering medication in the dining area did not show due regard to resident privacy and dignity.

d) The practice of displaying the full names of residents on a noticeboard that could be observed by other residents and families did not ensure privacy.
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 did not have a written policy in relation to its premises.

Training and Education: There was no policy for staff to read or articulate.

Monitoring: The approved centre had not completed a hygiene audit. A ligature audit had been completed. Documented analysis had been undertaken to identify opportunities for improving the premises.

Evidence of Implementation: Residents in the approved centre had access to an appropriately sized communal room, including a conservatory, night sitting room/television room, dining room, and table tennis/television room. Communal areas were adequately lit to facilitate reading and other activities, and rooms were comfortably heated and ventilated.

The accommodation provided by the approved centre did not assure comfort and privacy or meet all residents’ needs. Appropriate signage was not in place to support resident orientation needs. In particular, toilets were not clearly marked; one room marked as a toilet was a laundry room. The only outdoor space was a small cage-like area which was a smoking area. This was accessed for 10 minutes every hour with a nurse present. There was no access to outside space for those who did not smoke and no area to walk around.

Hazards, including large open spaces, steps and stairs, slippery floor, hard and sharp edges, and hard or rough surfaces, had been minimised. Ligature points had not been minimised, and the inspection team identified numerous ligature points throughout the approved centre. There were ligature points in one bathroom and so it was closed to residents.
The approved centre was not in a good state of repair. One female assisted shower was not working properly, curtain hooks were missing in a number of areas, and other maintenance issues were awaiting remediation.

The approved centre had a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. An appropriate maintenance reporting process was used to report faults; however, issues were outstanding
A cleaning schedule was in place, but the approved centre was not clean, hygienic, and free from offensive odours throughout. The toilets adjacent to the occupational therapy offices and the assisted shower room were both in need of a deep clean, the window in one male toilet was stained, and all windows needed cleaning.

Heating in the approved centre was centrally controlled, and heating could not be controlled in individual bedrooms. Radiators were observed to be warm. Current national infection control guidelines were not being followed because all hand sanitiser dispensers in the approved centre were empty.

Bathroom facilities in the approved centre were not adequate. There was no dedicated female shower. Female residents could use the shower in the assisted bathroom, but it was not working properly and water pressure was low. One bathroom had a broken toilet seat.

There were wheelchair-accessible toilet facilities. There were designated sluice, cleaning, laundry, and therapy/examination rooms. Assisted devices and equipment were available, where required. Where substantial changes were required to the premises, the approved centre appropriately assessed works for possible impact on the residents and staff prior to implementation.

Not all resident bedrooms were appropriately sized to address resident needs. Not all furnishings supported resident independence and comfort. During the inspection, broken handles were noted on lockers and wardrobes, which made them difficult to open.

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

a) Toilet areas and the assisted shower room needed a deep clean and windows were dirty, 22(1)(a).
b) Broken handles on lockers and wardrobes meant that furnishings were not adequate, 22(2).
c) The shower in the assisted bathroom used by female residents was not adequate for the needs of residents, 22(3).
d) Residents did not have access to outdoor space, 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 processes for the following:

- Management of medication on transfer.
- Medication reconciliation.
- Review of resident medication.

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

Monitoring: An audit of Medication Prescription and Administration Records (MPARs) had been undertaken in July 2017 to determine compliance with the policies and procedures and the applicable legislation and guidelines, but there was no evidence that quarterly audits were conducted. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management.

Evidence of Implementation: An MPAR was maintained for each resident, and ten of these were inspected. Two appropriate resident identifiers were used in each MPAR, and the allergy section was completed in all cases. The generic names of medications were recorded, and names of medications were written in full. All medications administered to residents were recorded. The frequency of administration, the dosage, and the administration route for medications were documented, and medications refused by or withheld from the resident were noted.

Medication was reviewed at least six-monthly, and all medicines were administered by a registered nurse or registered medical practitioner. Where there was an alteration in the medication order, the medical practitioner rewrote the prescription. All medicines, including scheduled controlled drugs, were administered by a registered nurse or registered medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber, and the expiry dates of medications were checked prior to their administration.

Good hand-hygiene and cross-infection control techniques were not observed during the dispensing of medications. Nursing staff were not seen to wash their hands before administering medication or to use hand sanitising gel. Medication was administered to residents sitting at communal tables in the dining...
room during mealtimes, which was an institutionalised practice that was not conducive to resident privacy and dignity.

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. At the time of inspection, no resident was self-administering medication or had been prescribed crushed medication.

Medication arriving from the pharmacist was verified against the order to ensure that it was correct and accompanied by appropriate directions for use. Medication was stored in the appropriate environment. Where medication required refrigeration, a daily log of medication fridge temperatures was maintained. Medication storage areas were clean and tidy, and food and drink was not stored in areas used for the storage of medication.

Medication was stored securely in a locked cupboard; however, the cupboard was positioned at a height that necessitated nurses to use a step ladder to access it. The medication trolley was locked at all times and secured in a locked room. Scheduled controlled drugs were secured separately. At the time of the inspection, a system of stock rotation had been newly introduced by the pharmacist following an audit to avoid the accumulation of old stock. An inventory of medications was completed monthly, and medications that were no longer required or were out of date were disposed of appropriately.

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 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 the health and safety of staff, which was last reviewed in March 2017, and an associated safety statement, dated 2017. Together, these documents addressed requirements of the Judgement Support Framework, with the exception of the following:

- The fire management plan.
- Infection control measures relating to the following:
  - Raising awareness of residents and their visitors to infection control measures.
  - Covering of cuts and abrasions.
  - Management and reporting of an infection outbreak.
  - The control of particular infection types, including MRSA, Norovirus, and C. difficile.
- Falls prevention initiatives.
- Vehicle controls.

Training and Education: Not all staff had signed the signature log to indicate 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

As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and veting 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 the recruitment, selection, and veting of staff, which was last reviewed in November 2016. It addressed requirements of the Judgement Support Framework, including the following:

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

The policy did not address the following:

- The staff performance and evaluation requirements.
- The process for transferring responsibility between staff members.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan had been reviewed annually, and a central register for recording all staff training had been developed. The numbers and skill mix of staff were assessed against the levels recorded in the approved centre’s registration and were reviewed in relation to the number of residents in the approved centre and whether additional staff were required to observe residents. Analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents, leading to changes to the process for procuring agency staff.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. A planned and actual staff rota was in place. Staff were recruited, selected, and vetted in accordance with the approved centre’s policy and procedure for recruitment, selection, and appointment. All staff were appropriately vetted, and staff were
suitably qualified for their roles. An appropriately qualified staff member was on duty and in charge at all times. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency. There was a heavy reliance on agency staff, and the procurement process was cumbersome and time consuming for nurse managers, in that staff were not readily available.

There was no evidence that the approved centre had a staffing plan that addressed the following:

- 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 all staff 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, but not all health care professionals had up-to-date, mandatory training in fire safety, Basic Life Support (BLS), the Therapeutic Management of Aggression and Violence (TMAV), and the Mental Health Act (MHA) 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, resident rights, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults. At the time of inspection, staff were due to have training in 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 MHA 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in the nursing offices.

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>Department of Psychiatry</td>
<td>CNM2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CNM3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>2</td>
<td></td>
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<tr>
<td></td>
<td>Occupational Therapist</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy Assistant</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

6 teams admit to unit: 4 General Adult, 1 Psychiatry of Later Life and 1 rehab and recovery.

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

The approved centre was non-compliant with this regulation because not all staff had up-to-date mandatory training in BLS, fire safety, TMAV, and the MHA 2001, 26(4) and 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in April 2017. It addressed all of the requirements of the Judgement Support Framework, including policies and procedures relating to the following:

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

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate 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 not been completed to identify opportunities for improving the processes relating to the maintenance of records.

Evidence of Implementation: A record had been initiated for every resident in the approved centre. Records were secure and up to date, and they were constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and national guidelines and legislative requirements. Residents’ records were stored together in a lockable cabinet in the nurses’ station.

The 18 clinical files inspected indicated that records were reflective of residents’ current status and the care and treatment being provided. Two appropriate resident identifiers were recorded on all documentation. Residents’ records were accessible to authorised staff only. Records were maintained appropriately, with factual, consistent, and accurate entries. They were secured from loss or destruction, tampering, and unauthorised access or use. Documentation relating to health and safety, food safety, and fire inspections was maintained in the approved centre.
Not all of the clinical files inspected were maintained in good order. Seven files contained loose pages, and the files of the three residents who had been in the approved centre for more than six months were heavy and bulky. In three files inspected, the time at which entries were made was not recorded using the 24-hour clock.

The approved centre was non-compliant with this regulation because not all resident records were maintained in good order, 27(1).
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. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record residents’ diagnosis on discharge.

The approved centre was non-compliant with this regulation because the register of residents did not record residents’ diagnosis on discharge, 28(2).
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 in relation to the development and review of operating policies and procedures, which was last reviewed in June 2017. It addressed all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff received training on approved operational policies and procedures at induction and as required. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: The approved centre used Q Pulse, a software program that tracked policy review times. The Q Pulse system alerted the administration one month before each policy was due for renewal. Analysis had been completed to identify opportunities for improving the processes for 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. Policies and procedures, which incorporated relevant legislation, evidence-based best practice, and clinical guidelines, were communicated to all relevant staff. They were appropriately approved by the clinical governance group before being implemented.

All of the policies and procedures required by the regulations had been reviewed within three years. No generic policies were in use in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 30: Mental Health Tribunals

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 log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the process for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: To support the tribunals process, the approved centre provided a private room for tribunals. However, the room was also used for the storage of old clinical files and other items. Staff assisted and supported residents to attend and participate in Mental Health Tribunals, where necessary.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
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 October 2015. It also used the HSE’s Your Service, Your Say procedure. The policies included requirements of the Judgement Support Framework, with the exception of the confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.

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

Monitoring: Audits of the complaints log and related records were not completed. Complaints data had not been analysed, and required actions had not been 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 complaints policy. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives, via the information booklet and posters.

Details of complaints logged in the approved centre indicated that 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.
There was a method for addressing minor complaints in the approved centre, and minor complaints were recorded in the complaints log. Where minor complaints could not be addressed locally, they were dealt with by the nominated person. All complaints that were not minor were addressed by the complaints officer and recorded in the complaints log. Details of complaints, subsequent investigations, and outcomes were fully documented and kept distinct from residents’ individual care plans.

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 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, which was last reviewed in October 2016. It addressed requirements of the Judgement Support Framework, including processes for the following:

- The identification, assessment, treatment, reporting, and monitoring of risks:
  - Organisational risks.
  - Structural risks such as ligature points.
  - Health and safety risks to residents, staff, and visitors.
  - Risks to the resident group during the provision of general care and services.
  - Risks to individual residents during the delivery of individualised care.
- Rating identified risks.
- Controlling risks associated with 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 following:

- The responsibilities of the registered proprietor in relation to risk.
- The process for the identification, assessment, treatment, reporting, and monitoring of capacity risks relating to the number of residents in the approved centre.
**Training and Education:** Relevant staff had completed training in health and safety. Managerial staff were not trained in risk management. All staff had been trained in incident reporting and documentation. Relevant staff had not received training in the identification, assessment, and management of risk. Clinical staff were not trained in individual risk management processes. Not all staff had signed the signature log to indicate that they had read and understood the policy. Not all staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

**Monitoring:** The risk register had not been audited at least quarterly to determine compliance with the approved centre’s risk management policy. All incidents in the approved centre were documented and risk-rated. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

**Evidence of Implementation:** The person with responsibility for risk was identified and known by all staff. Health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register, as appropriate.

Responsibilities were not allocated at management level and throughout the approved centre to ensure the effective implementation of risk management. Risk management procedures did not actively reduce identified risks to the lowest level of risk. Risks that were being managed locally had not been included in the risk register.

Clinical risks were not always identified or assessed. Sanitising fluid had been removed from the dispensers in the approved centre following an incident involving a resident. The risk was not associated with the current resident profile but the dispensers had not been refilled.

Structural risks, including ligature points, had not been mitigated. A report relating to an incident that occurred in the smoking area contained no documentary evidence that the risk had been identified or assessed. Residents were not risk assessed to go to the smoking area. Mitigation of the risk involved supervising residents at all times when they were using the smoking area. One bathroom was closed as ligature points were identified. Risks that were managed locally were not included in the risk register.

Corporate risks, mainly pertaining to the shortage of staff, were identified, assessed, treated, reported, monitored, and documented in the risk register.

The approved centre completed resident risk assessments at admission to identify individual risk factors. The quality of risk assessments was poor and some had not been completed correctly. Assessments were completed before and during the use of seclusion and physical restraint and prior to resident discharge.

There was no evidence that multi-disciplinary teams (MDTs) had input into the development, implementation, and review of risk management processes. Residents were involved in a risk assessment on admission, but it was not clear whether they were included in individual risk management processes. 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 reviewed by the MDTs at their regular meetings. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. The approved centre had an emergency plan that included evacuation procedures.
The approved centre was non-compliant with this regulation for the following reasons:

a) The risk management policy was not being implemented throughout the approved centre because clinical risk was not managed in accordance with the policy, 32(1).

b) Risks that were managed in the approved centre were not included in the risk register, 32(1).

c) The risk management policy did not address the identification and assessment of capacity risks relating to the number of residents in the approved centre, 32(2)(a).

d) The policy did not address the precautions in place to control risks identified, 32(2)(b).
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 hall. Details of the condition to the certificate of registration were displayed.

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

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

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
   (a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
   (b) where the patient is unable to give such consent –
      (i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
      (ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this rule was not applicable.
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, which was last reviewed in October 2016. It detailed who was authorised to undertake seclusion, the procedure for providing information to residents in seclusion, and a strategy for reducing seclusion rates. The policy contained procedures for training staff in relation to seclusion and outlined the areas to be addressed in training, including alternatives to the use of seclusion, the mandatory nature of training, and the frequency of required training. It did not identify appropriately trained staff to deliver training in the use of seclusion.

Training and Education: Not all staff involved in seclusion had signed the signature log to indicate that they had read and understood the policy. A record of attendance at training in the use of seclusion was maintained and made available to the inspector.

Monitoring: The approved centre produced an annual written report on the use of seclusion, which was available to the inspector.

Evidence of Implementation: Residents in seclusion had access to adequate bathroom facilities. The seclusion room was furnished, maintained, and cleaned to protect residents’ dignity and privacy, as far as was practicable. The furniture and fittings were designed with patient safety in mind.

The records relating to two episodes of seclusion were reviewed. In both cases, seclusion was initiated by a registered medical practitioner and/or registered nurse and the clinical psychologist was notified of the use of seclusion as soon as was practicable. Each episode was based on a risk assessment and followed efforts to use other less restrictive means to manage residents’ unsafe behaviour.

Seclusion was only used in rare and exceptional circumstances, when residents posed an immediate or serious threat to themselves or others. Cultural awareness and gender sensitivity were demonstrated in each episode. Both residents were informed of the reasons, duration, and circumstances leading to discontinuation of seclusion, unless that information was detrimental to their well-being.

The residents were under direct observation by a registered nurse for the first hour and were continuously observed thereafter, which included a nursing record every 15 minutes, a nursing review every 2 hours
following a risk assessment, and a medical review every 4 hours. Both residents were informed of the ending of seclusion, and the reasons for ending seclusion were recorded in the respective clinical files. The uses of seclusion were clearly recorded in the clinical files and the seclusion register.

In one episode, there was no evidence that next of kin were informed of the use of seclusion and the reason for this was not documented in the clinical file. The episodes of seclusion were not reviewed by the multi-disciplinary team (MDT) or documented within the clinical files within two working days.

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

   a) The procedures for training staff in relation to seclusion did not identify appropriately trained staff to deliver training, 11.1(d).
   b) Not all staff involved in the use of seclusion had signed the signature log to indicate that they had read and understood the policy, 10.2(b).
   c) In one episode of seclusion, there was no evidence that next of kin were informed of the use of seclusion and no justification for this was documented, 3.7(a).
   d) The episodes of seclusion were not reviewed by the MDT or documented in the clinical files within two working days, 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.

58. – 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.

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

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

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

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

INSPECTION FINDINGS

There was one involuntary patient in the approved centre for more than three months and in continuous receipt of medication. The consultant psychiatrist had undertaken a capacity assessment, and the patient had consented to treatment. Inspection of the relevant clinical file indicated that the record of consent detailed the following:

- The names of the medications prescribed.
- Confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s).
- Discussions with the patient in terms of the nature and purpose and effects of the medication(s), including risks and benefits and any view expressed by the patient.
- Supports provided to the patient in relation to the discussion and their decision-making.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
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.
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. The policy, which had been reviewed annually, included details of the following:

- The provision of information to residents regarding the use of physical restraint.
- The individuals authorised to initiate and implement physical restraint.
- The training requirements relating to physical restraint.

Training and Education: No record was made available to the inspector to indicate that all staff involved in the use of physical restraint had read and understood the policy. A staff training policy was in place, which specified who should receive training, areas to be addressed during training, frequency of training, the identification of appropriately qualified individuals to deliver training, and the mandatory nature of training. This policy did not address training in alternatives physical restraint. A record of attendance at training was maintained, and physical restraint was never used to ameliorate staff shortages.

Monitoring: An annual report had been completed in relation to physical restraint.

Evidence of Implementation: The clinical files relating to four episodes of physical restraint involving two residents were reviewed. These indicated that physical restraint was initiated in rare and exceptional circumstances, where a resident posed an immediate and serious threat of harm to self or others. Physical restraint was initiated after staff had first considered other interventions and following a risk assessment, and a designated staff member was lead. The episodes of physical restraint were not prolonged beyond the period necessary. Cultural awareness and gender sensitivity were demonstrated in each case.

The consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. The consultant psychiatrist signed and dated the clinical practice forms within 24 hours, and the use of restraint was recorded in the clinical files. Copies of the clinical practice forms were retained in the clinical files.

In two episodes, the registered medical practitioner did not complete a physical examination of the residents within three hours of the start of the episodes of physical restraint. In one episode, next of kin were not informed of the use of physical restraint and a justification for this was not documented in the clinical file.

In two episodes, members of the multi-disciplinary team (MDT) did not review the use of physical restraint within two working days. In one case inspected, the resident did not have the opportunity to discuss the episode with members of the MDT as soon as was practicable.

The approved centre was non-compliant with this code of practice for the following reasons:

a) No record was available to indicate that all staff involved in the use of physical restraint had read and understood the policy, 9.2(b) and (c).
b) The policy in relation to training staff did not address alternatives to physical restraint, 10.1(b).

c) In two episodes, the registered medical practitioner did not conduct a physical examination of the residents within three hours of the start of physical restraint, 5.4.

d) In one episode, next of kin were not informed of the use of physical restraint and no justification for this was documented in the clinical file, 5.9.

e) In two episodes, members of the MDT did not review and document the use of physical restraint within two working days, 9.3.

f) In one case, the resident did not have an opportunity to discuss the episode with members of the MDT as soon as was practicable, 7.2.
Admission of Children

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

INSPECTION FINDINGS

As no child had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
Notification of Deaths and Incident Reporting

NON-COMPLIANT

Risk Rating    LOW

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 that addressed the notification of deaths and incident reporting to the Mental Health Commission (MHC), which was last reviewed in October 2016. The policy identified the risk manager and detailed the roles and responsibilities of staff in relation to the following:

- The reporting of deaths and incidents.
- The completion of death notification forms.
- The submission of forms to the MHC.
- The completion of 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 non-compliant with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

The approved centre used the National Incident Management System for reporting incidents, and the standard incident report form was available to inspectors. A six-monthly summary of all incidents was sent to the MHC.

No deaths had occurred in the approved centre since the last inspection.

The approved centre was non-compliant with this code of practice because it did not comply with Regulation 32: Risk Management Procedures, 3.1.
INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to working with people with an intellectual disability, which was last reviewed in October 2015. It reflected person-centred treatment planning, presumption of capacity, and least restrictive interventions. It addressed 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.

It did not include a policy for training staff in working with people with intellectual disability that addressed the following:

- Induction training for new staff.
- Staff who should receive training.
- Areas to be addressed in training.
- Frequency of training.
- Identification of appropriately qualified people to deliver training.
- Evaluation of training programmes.

Training and Education: Not all staff had received training in support of the principles and guidance in this code of practice. Five staff members had received relevant training, which included person-centred approaches, relevant human rights principles, and 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 had not been reviewed periodically.

Evidence of Implementation: The clinical file of one resident with a diagnosis of intellectual disability was examined. It contained an individual care plan, which addressed the levels of support and treatment required and the resident’s assessed needs. It did not reference environmental considerations or list available resources and supports.

The resident received a comprehensive assessment, and a key worker was appointed. The resident’s preferred way of giving and receiving information was established. Information provided by the approved centre was appropriate and accessible, and the resident’s understanding of the information was documented. Opportunities were made available for resident engagement in meaningful activities.

The approved centre was non-compliant with this code of practice for the following reasons:
a) There was no policy for training staff in working with people with intellectual disability that addressed the following, 6.2:
   - Induction training for new staff.
   - Who should receive training.
   - Areas to be addressed in training.
   - Frequency of training.
   - Identification of appropriately qualified people to deliver training.
   - Evaluation of training programmes.

b) Not all staff had received training in support of the principals and guidance in this code of practice, 6.

c) The use of restrictive practices was not reviewed periodically, 5.3(b).

d) The resident’s individual care plan did not address environmental considerations or list available resources and supports, 8.3.
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**

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was dated October 2016, addressed all relevant criteria of this code of practice, including a protocol for planned admission, with reference to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. It contained a procedure for involuntary admission and a protocol for timely communication with primary care teams. There was a policy on confidentiality, privacy, and consent.

Transfer: The transfer policy, which was dated October 2016, addressed all relevant criteria of this code of practice, including the way in which a transfer was arranged, the provisions for emergency transfer, the roles and responsibilities of staff in relation to the transfer of residents, the transfer of a resident abroad, and the safety of the resident and staff during a transfer.

Discharge: The discharge policy, which was dated April 2014, addressed the discharge of involuntary patients, homeless people, and older people. It referenced prescriptions and supply of medication on discharge and included provisions for discharge against medical advice. It included a follow-up policy that addressed relapse prevention strategies, crisis management plans, the roles and responsibilities of staff in providing follow-up care, and when and how much follow-up contact residents should receive.

The policy did not include a means of following up and managing missed appointments or a protocol for discharging people with an intellectual disability.

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:

The approved centre was non-compliant with Regulation 32: Risk Management Procedures, which is associated with this code of practice.

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 because of a mental illness or disorder, and the decision to admit was made by a registered medical practitioner (RMP). Family members or carers were involved in the admission process in each case.
The residents received a comprehensive admission assessment, which was recorded in the clinical files. All assessments and examinations were documented. Residents were admitted to a unit appropriate to their needs.

The approved centre’s admission process was compliant with the following regulations associated with the code of practice: Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, and Regulation 20: Provision of Information to Residents. It did not comply under Regulation 15: Individual Care Plan and Regulation 27: Maintenance of Records.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents. As no resident had been transferred from the approved centre since the last inspection, the evidence of implementation pillar for this code of practice was not inspected against.

**Discharge:** Three clinical files were inspected in relation to discharge. The decision to discharge was taken by the RMP, and a discharge plan was in place as part of the residents’ individual care plans. The discharge documentation detailed the estimated date of discharge, communication with the primary care or community mental health team, risk, and a follow-up plan. In one of the files inspected, the discharge plan did not reference early warning signs of relapse.

In each case, the residents received a comprehensive pre-discharge assessment. A discharge meeting involving the resident, key worker, relevant members of the MDT, and a family member/carer/advocate took place. Preliminary discharge summaries were issued to the primary care or community mental health care team within 3 days and a more complete discharge summary was issued within 14 days. Timely follow-up appointments were made in all cases.

In one case, two days’ notice of the discharge was not given. In two of the files examined, the discharge summary did not include a mental state examination One discharge summary did not reference outstanding health or social issues or the names and contact details of key people for follow-up.

The approved centre was non-compliant with this code of practice for the following reasons:

  b) The discharge policy did not include a method for following up and managing missed appointments, 4.14.
  c) The discharge policy did not include a protocol for discharging people with an intellectual disability, 4.16.
  d) The discharge policy had not been reviewed within the required three-year time frame, 4.19.
  e) There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge, 9.1.
  f) The implementation of and adherence to the admission and discharge policies had not been audited, 4.19.
  g) The admission process was non-compliant because the approved centre did not comply with Regulation 15: Individual Care Plan, 17.1, and Regulation 27: Maintenance of Records, 22.6.
  h) There was no reference to early warning signs of relapse in one discharge plan inspected, 34.2.
  i) Two discharge summaries did not include a mental state examination, 38.4.
  j) One discharge summary did not reference outstanding health or social issues or the names and contact details of key people for follow-up, 38.4.
  k) In one file inspected, two days’ notice was not given of the discharge, 40.1.
### Regulation 5: Food and Nutrition

*Report reference: Page 21-22*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taken from the inspection report</strong></td>
<td><strong>Reoccurring or New area of non-compliance</strong></td>
<td><strong>Provide corrective and preventative action(s) to address the area of non-compliance</strong></td>
<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>
</tr>
<tr>
<td>1. Menus did not provide wholesome and nutritious meals or adequate choice.</td>
<td>New</td>
<td>Corrective Action(s): We have 0.2 WTE dietetic input in the approved unit. A number of surveys have taken place regarding nutritional content and patient satisfaction. Recommendations have been made to improve nutritional content and patient choice. A Nutrition subcommittee has been set up in the unit to advance these recommendations. Post-Holder(s) responsible: ADON, CNM3, Dietican, Clinical Director</td>
<td>Feedback to local business/governance meeting from the subgroup Evaluation by Dietican Audit of regulation 5 with JSF audit tool developed locally</td>
<td>We are co-located with the General hospital and catering is provided by the general hospital Liaison has taken place requesting alteration to the meals provided and Menus are currently in transition and our dietican will review and feedback if further adjustments are required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Nutritional Committee set up Audit as per JSF Post-Holder(s) responsible: As per corrective action</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Appendix 1: Corrective and Preventative Action Plan Template - 2017 Inspection Report**
## Area(s) of non-compliance

<table>
<thead>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
</tbody>
</table>

2. **A damaged fridge seal meant that proper facilities were not available for the refrigeration of food.**

   - **New**
   - **Corrective Action(s):**
     - New fridge installed
     - Post-Holder(s) responsible: CNM3
   - Measureable: New Fridge purchased and installed
   - Achievable / Realistic: None
   - Time-bound: Actioned and completed

   - **Preventative Action(s):**
     - Monitor as per JSF
     - Ongoing staff training
     - Post-Holder(s) responsible: CNM3
### Regulation 9: Recreational Activities

*Report reference: Page 27*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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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>3. Residents did not have access to appropriate recreational activities.</td>
<td>Corrective Action(s): The improvement and expansion of the recreational activities available for inpatients is and has been prioritised by the Health and fitness group set up in the past year. Monitoring, Patient surveys have taken place (see supplementary evidence forwarded in comments and review) A walking group takes place daily longstanding. Aerobics 4 days per week was introduced in past 4 months. A new inhouse OT Timetable introduced in September 2017. And new initiatives planned for 2018. The health and fitness committee are very motivated, proactive and patient centred</td>
<td>Patient surveys Audit as per JSF</td>
<td>Improvements will be ongoing and proactively pursued. At present the unit has 0.5 OT the provision of a fulltime OT would significantly progress this area</td>
<td>6 months</td>
</tr>
</tbody>
</table>

Post-Holder(s) responsible: Health and Fitness Committee (OT, CNM3, Dietician, Adon, Clinical Director)

Preventative Action(s): Ongoing monitoring, Patient Feedback and Audit Post-Holder(s) responsible: As corrective action
### Regulation 11: Visits

**Report reference: Page 29**

<table>
<thead>
<tr>
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<th>Achievable / Realistic</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
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</table>

**4.** As there were no designated visitors’ areas, the safety of visitors and residents could not be assured during visits.

**New**

**Corrective Action(s):**
Staff are present in the unit 24 hours per day. Staff identify the level of supervision each patient requires on the ward. Parents of children are advised to give advance warning of visiting and great effort is made by staff to plan a family friendly visit and private facilities are arranged in one of our multipurpose rooms. Access to the unit is often arranged at backdoor close to the 2 areas used for private visits to ensure minimal exposure to main unit. Private visit supervised and unsupervised are arranged in this manner when deemed necessary. Ongoing training will take place to ensure staff remain vigilant during visiting times.

Post-Holder(s) responsible:
CNM3 ADON Clinical Director

**Preventative Action(s):**
Ongoing training in JSF and maintenance of visit log Staff to ensure that they are aware of the visitors policy and that they have signed that they have read same.

Post-Holder(s) responsible:
As per corrective action

**Achievable would be enhanced by availability of a designated visitors area which is not a viable option with current approved unit structure but may be an option in the medium to long term**

**6 months**
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tr>
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<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>5. Residents could not receive visitors in private.</td>
<td>Corrective Action(s): As per corrective action above in point 5 Post-Holder(s) responsible: CNM3,ADON,Clinical director</td>
<td>A visit Log will be maintained and audited as per JSF</td>
<td></td>
<td>Currently available on a requested planned basis. Will be a longterm project to expand this availability by potential of restructuring current facilities &gt;24 months</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Audit and feedback of same re JSF requireme Ensure that patients and their families are aware that if they require a private visiting area prior notice is given. Post-Holder(s) responsible CNM3,Adon Clinical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Appropriate arrangements and facilities were not available for visiting children.</td>
<td>Corrective Action(s): As in point 5 above Post-Holder(s) responsible: CNM3,ADON,Clinical Director</td>
<td>Maintain a visit log Audit as per JSF and action plan from same</td>
<td></td>
<td>6 months</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Audit as per JSF Ensure that patients and their families are aware that if they require a private visiting area for children prior notice should given and same will be facilitated. Post-Holder(s) responsible: As in Corrective action</td>
<td></td>
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</tr>
</tbody>
</table>
### Regulation 13: Searches

**Report reference: Page 31-32**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>7.</strong> There was no evidence that a minimum of two appropriately qualified staff were in attendance at all times during searches.</td>
<td>New</td>
<td>Corrective Action(s): Ensure Evidence of same is available by ensuring Search log is maintained Post-Holder(s) responsible: CNM3</td>
<td>Audit annually</td>
<td>achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Audit as per JSF Post-Holder(s) responsible: CNM3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8.</strong> There was no evidence that all searches were undertaken with due regard to the residents’ gender.</td>
<td>New</td>
<td>Corrective Action(s): Ensure evidence of this active practice is available by maintaining a log of same Post-Holder(s) responsible CNM3:</td>
<td>Audit annually</td>
<td>achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Audit of this regulation as per JSF plus ongoing training in JSF Post-Holder(s) responsible: CNM3</td>
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<td></td>
</tr>
</tbody>
</table>
### Regulation 15: Individual Care Plan

**Report reference: Page 34-35**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<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>
</tr>
<tr>
<td>9. ICPs were not always reviewed and updated by the MDT.</td>
<td>Corrective Action(s): Regular Auditing of ICP’S with feedback to MDT’s Further training in Regulation 15 requirements Post-Holder(s) responsible: A Fitzpatrick MHA Facilitator, ADON CNM3, Clinical director</td>
<td>Regular audit and feedback of recommendations to relevant parties</td>
<td>achievable</td>
<td>3 months</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): The current template of care plan has been reviewed and a revision is in progress to ease compliance and audit Regular audit and Training Post-Holder(s) responsible: A Fitzpatrick CNM3 ADON Clinical director</td>
<td>Delivery of new revised care plan</td>
<td>achievable</td>
<td>6 months</td>
</tr>
<tr>
<td>10. In one ICP inspected, appropriate goals for the resident were not identified.</td>
<td>Corrective Action(s): Ensure all 22 ICP’s have appropriate goals through regular audit relevant feedback and ongoing training Post-Holder(s) responsible: A Fitzpatrick, G Grehan, C director</td>
<td>Audit as per JSF And action result of same Maintenance of training log</td>
<td>Audit as per JSF And action result of same</td>
<td>3 months</td>
</tr>
<tr>
<td>11. The interventions required to address the resident’s goals were not specified in one ICP.</td>
<td>Corrective Action(s): Ensure all 22 ICP’s have interventions required listed clearly. Review of the format of current care plan is in progress and revised care plan is being developed Post-Holder(s) responsible: A Fitzpatrick, CNM3, Clinical Director</td>
<td>Audit as per JSF</td>
<td>Achievable</td>
<td>6 months</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<tr>
<td>12. The resources required to provide the care and treatment identified were not appropriately documented in four ICPs.</td>
<td>New</td>
<td>Corrective Action(s): Restucturing of care plan and regular Audit with feedback, ongoing training for staff in MDT care planning</td>
<td></td>
<td>6 months</td>
</tr>
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<td></td>
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<td>Post-Holder(s) responsible: As 11/12 above</td>
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<td>Preventative Action(s): Post-Holder(s) responsible: As above</td>
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<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: A Fitzpatrick CNM3, Clinical Director</td>
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</tr>
</tbody>
</table>
### Regulation 16: Therapeutic Services and Programmes

**Report reference: Page 36-37**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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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>13. Not all residents had access to therapeutic services and programmes that met their assessed needs, as documented in their ICPs.</td>
<td></td>
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</tr>
</tbody>
</table>

**Reoccurring**

Corrective Action(s):

Business cases have been made to fill psychology, social work and OT posts for the relevant teams. These deficits have been flagged with all relevant line managers and recruitment requested and action plan requested to address these deficits

Post-Holder(s) responsible:

Area Management team Galway Roscommon

Preventative Action(s):

Audit as per JSF

Post-Holder(s) responsible:

A Fitzpatrick CNM3

Ongoing quarterly

Ongoing deficits being highlighted proactively to relevant line managers

Barriers Financial restraints

Limited access to cross cover from relevant disciplines due to limited resources

Dependant on sanctioning of posts
### Regulation 19: General Health

*Report reference: Page 40*

<table>
<thead>
<tr>
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</table>

#### 14. Not all residents’ general health needs were assessed at least every six months, as indicated by their ICPs.

**New**

**Corrective Action(s):**
- A call/recall system is in place to ensure 6 monthly examination takes place
- A new NCHD post was sought and has been attained (Jan 2018) which will assist this process. It was noted that the six month reviews were 2 weeks overdue. The extra post will assist addressing this area

**Post-Holders responsible:**
- CNM2, Medical staff

**Preventative Action(s):**
- Audit with relevant feedback as per JSF

**Post-Holders responsible:**
- CNM3, ADON C director

**Audit annually**

Achievable

3 months
### Regulation 21: Privacy

#### Report reference: Page 42

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td><strong>15.</strong> One single room and one en suite toilet could not be locked from the inside, which was not conducive to resident privacy.</td>
<td><strong>Reoccurring</strong> (toilet locks) <strong>To be monitored as per Condition</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>16.</strong> The window on a door to one of the single rooms was inadequately screened and passers-by could see inside.</td>
<td></td>
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</tr>
<tr>
<td><strong>17.</strong> The practice of administering medication in the dining area did not show due regard to resident privacy and dignity.</td>
<td><strong>Corrective Action(s):</strong> Medications are to be administered from the clinical room Post-Holder(s) responsible: CNM3</td>
<td><strong>Change in ward practice</strong> Audit annually</td>
<td>Achievable</td>
<td>1 month</td>
</tr>
</tbody>
</table>

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1 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.
<table>
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<td></td>
</tr>
<tr>
<td>18. The practice of displaying the full names of residents on a noticeboard that could be observed by other residents and families did not ensure privacy.</td>
<td>New</td>
<td>Corrective Action(s): The noticeboard will be repositioned within the nurses station Post-Holder(s) responsible: CNM3 Preventative Action(s): As above Post-Holder(s) responsible:</td>
<td>Documentation and visibility of this change</td>
<td>Achievable</td>
<td>1 month</td>
</tr>
</tbody>
</table>
### Regulation 22: Premises

**Report reference: Page 43-44**

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<thead>
<tr>
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<td><strong>Reoccurring or New area of non-compliance</strong></td>
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<tr>
<td>19. Toilet areas and the assisted shower room needed a deep clean and windows were dirty.</td>
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<tr>
<td>20. Broken handles on lockers and wardrobes meant that furnishings were not adequate.</td>
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</tr>
<tr>
<td>21. The shower in the assisted bathroom used by female residents was not adequate for the needs of residents.</td>
<td><strong>Recurring To be monitored as per Condition¹</strong></td>
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<tr>
<td>22. Residents did not have access to outdoor space.</td>
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</tbody>
</table>
### Regulation 26: Staffing

**Report reference: Page 49-50**

<table>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Achievable</td>
</tr>
<tr>
<td>23. Not all staff had up-to-date mandatory training in BLS, fire safety, TMAV, and the MHA 2001.</td>
<td>Corrective action(s): Training Template in place for all Staff. Training to be provided and priority given to areas of greatest identified need via analysis of template Post-holder(s): CNMIII</td>
<td>Monitor Training Template to achieve 100% compliance for all mandatory training for all Staff</td>
<td>Achievable</td>
<td>12 months</td>
</tr>
<tr>
<td></td>
<td>Preventative action(s): Clinical Governance Group DOP Roscommon will track same Post-holder(s): CNMIII</td>
<td></td>
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<td></td>
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</tbody>
</table>
## Regulation 27: Maintenance of Records

*Report reference: Page 51-52*

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<tr>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>24.</strong> Not all resident records were maintained in good order.</td>
<td>New</td>
<td>Corrective Action(s): Additional administrative support has been proactively requested for the acute unit which has suffered a reduced admin input. Current staff active to maintain records in good order. Post-Holder(s) responsible: CNMIII and Clinical Director</td>
<td>Audit of records per JSF</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Audit annually</td>
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<td></td>
<td></td>
<td>Post-Holder(s) responsible: CNMIII Audit committee</td>
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</tbody>
</table>
## Regulation 28: Register of Residents

Report reference: Page 53

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>25. The register of residents did not record residents’ diagnosis on discharge.</td>
<td>Corrective Action(s): Additional senior Admin support has been provided to the approved unit to support and facilitate compliance. CNMIII will work with new Admin support input to ensure this regulation has no non compliance attached to it going forward. Post-Holder(s) responsible: Admin Staff, CNMIII, Clinical Director</td>
<td>Audit and monthly feedback to clinicians to ensure no deficits</td>
<td>Achievable with additional admin support in the approved centre</td>
<td>Admin support will be increased in the approved unit from the 1st February 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Additional ADMIN support to improve compliance</td>
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<tr>
<td></td>
<td>Post-Holder(s) responsible: ADON CNMIII Clinical Director</td>
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</table>
### Regulation 32: Risk Management Procedures (and Code of Practice: Notification of Deaths and Incident Reporting)

**Report reference: Page 58-60**

<table>
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<tr>
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</table>
| **26.** The risk management policy was not being implemented throughout the approved centre because clinical risk was not managed in accordance with the policy. | **Corrective Action(s):**
Training on risk and incident management is ongoing and is being organised by the Quality and Patient safety risk manager for the approved centre staff. 
Post-Holder(s) responsible: Quality and patienty safety risk manager/Senior management approved unit | **Provide the method of monitoring the implementation of the action(s)** | Achievable              | Audit to be completed within 1 month, Training rolled out within 3-4 months, 12 months to ensure all relevant staff receive training and audit cycle gets completed |
|                                                                                         |                                                                          | **Provide details of any barriers to the implementation of the action(s)** |                        |                                                                            |
|                                                                                         |                                                                          | **Provide the timeframe of the completion of the action(s)**               |                        |                                                                            |
| **Preventative Action(s):**
Ongoing cycle of audit and training Audits to be completed 6 monthly
Post-Holder(s) responsible: | | | | |
| **27.** Risks that were managed in the approved centre were not included in the risk register. | **Corrective Action(s):**
Risk register to be updated to include all risks managed locally
Post-Holder(s) responsible: ADON,CNMIII | | Achievable | 3 months |
<p>|                                                                                         |                                                                          | <strong>Audit Quarterly</strong>                                                       |                        |                                                                            |
|                                                                                         |                                                                          | <strong>Provide the timeframe of the completion of the action(s)</strong>               |                        |                                                                            |</p>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>28. The risk management policy did not address the identification and assessment of capacity risks relating to the number of residents in the approved centre.</td>
<td>New</td>
<td>Corrective Action(s): The risk management policy has been sent for review to the Galway/Roscommon policy and procedure group to address this deficit</td>
<td>Quaterly audit of same</td>
<td>achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: A Fitzpatrick: chair of above group</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>Preventative Action(s): Quaterly audit</td>
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<td>Post-Holder(s) responsible:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. The policy did not address the precautions in place to control risks identified.</td>
<td>New</td>
<td>Corrective Action(s): As 29 above</td>
<td>Quarterly audit</td>
<td>achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: A Fitzpatrick</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Quaterly audit</td>
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### Section 69: The Use of Seclusion


<table>
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<tr>
<th>Area(s) of non-compliance</th>
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</table>
| **30.** The procedures for training staff in relation to seclusion did not identify appropriately trained staff to deliver training. | Corrective Action(s):  
The procedures will be amended to reflect same  
This has been referred to the regional policy and procedure group for appropriate amending  
Post-Holder(s) responsible: ADON, Policy and Procedure commitee | Audit as per Code of Practice | Achievable | 4 months |
|                                                                                         | Preventative Action(s):  
Audit against JSF 6 monthly audits  
Post-Holder(s) responsible: As in corrective action |                                            |                         |              |
| **31.** Not all staff involved in the use of seclusion had signed the signature log to indicate that they had read and understood the policy. | Corrective Action(s):  
Email prompts to relevant staff re importance of providing signed evidence that they have read and understood the policy  
Regular highlighting this ongoing need to all relevant line managers at governance meetings  
Post-Holder(s) responsible: CNMIII | Audit of compliance with same 6 monthly audit | | 6 months |
|                                                                                         | Preventative Action(s):  
Regular prompting of relevant staff re compliance  
Post-Holder(s) responsible: CNMIII |                                            |                         |              |
<table>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</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>
</tbody>
</table>

32. In one episode of seclusion, there was no evidence that next of kin were informed of the use of seclusion and no justification for this was documented.

**Corrective Action(s):**
- Ongoing training and feedback from audit to relevant staff regarding documentation required
- Provision of seclusion checklist as aide memoire to assist compliance
- Post-Holder(s) responsible:

**Preventative Action(s):**
- Ongoing training and audit Post seclusion check list
- Audit 6 monthly
- Post-Holder(s) responsible: As per corrective action

| New | Quarterly seclusion audit | Barriers are the significant amount of documentation replication can lead to genuine omissions | 6 months |

33. The episodes of seclusion were not reviewed by the MDT or documented in the clinical files within two working days.

**Corrective Action(s):**
- Further training and prompting of relevant staff
- Post-Holder(s) responsible: Admin support, CNMIII, ADON, C Director

**Preventative Action(s):**
- Audit as per Code of Practice
- Ensure post seclusion check list is complete and audit 6 monthly
- MDT usually meet weekly so full MDT review within 2 days can be a challenge at times

| New | Audit as per Code of Practice
| Ensure post seclusion check list is complete and audit 6 monthly | MDT usually meet weekly so full MDT review within 2 days can be a challenge at times | 6 months |
### Code of Practice: Use of Physical Restraint

**Report reference: Page 71-72**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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<tbody>
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<td><strong>Taken from the inspection report</strong></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><strong>34.</strong> No record was available to indicate that all staff involved in the use of physical restraint had read and understood the policy.</td>
<td>Corrective action(s): All Staff will have signed that they have read and understood the policy. This is an ongoing need as new staff join service. Preventive action(s): Audit to ensure compliance with corrective actions</td>
<td>Signature sheet Audit</td>
<td>Achievable</td>
<td>Ongoing process 6 months</td>
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<td><strong>35.</strong> The policy in relation to training staff did not address alternatives to physical restraint.</td>
<td>Corrective Action(s): This policy has been amended at regional level to address this area and is awaiting sign off. Preventative Action(s): Audit Annually</td>
<td>Audit as per Code</td>
<td>Achievable</td>
<td>3 months</td>
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<td><strong>36.</strong> In two episodes, the registered medical practitioner did not conduct a physical examination of the residents within three hours.</td>
<td>Corrective Action(s): Provide feedback to medical staff. Ensure staff involved in physical restraint request physical examination within 3 hours of the event. Further training in the documentation needed with physical restraint.</td>
<td>Audit as per Code of practice</td>
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<tr>
<td>Area(s) of non-compliance</td>
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<td>hours of the start of physical restraint.</td>
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<td>CNMIII, C Director</td>
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<td>Preventative Action(s):</td>
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<td></td>
<td>Audit Ensure post physical restraint check list is complete and audit 6 monthly</td>
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<td>Post-Holder(s) responsible: CNMIII and Medical staff</td>
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<td>37. In one episode, next of kin were not informed of the use of physical restraint and no justification for this was documented in the clinical file.</td>
<td>Corrective Action(s): Provide a physical restraint checklist and further training to relevant staff</td>
<td>Audit as per Code</td>
<td>MDT meetings occur weekly having a full MDT review within 2 days can be a challenge</td>
<td>6 months</td>
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<td></td>
<td>Post-Holder(s) responsible: A Fitzpatrick, CNMIII, C Director</td>
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<td>Preventative Action(s):</td>
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<td>Audit and ongoing training Ensure post physical restraint check list is complete and audit 6 monthly</td>
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<td>Post-Holder(s) responsible: As for corrective action</td>
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<td>38. In two episodes, members of the MDT did not review and document the use of physical restraint within two working days.</td>
<td>Corrective Action(s): Provide a physical restraint checklist and further training to relevant staff</td>
<td>Audit as per Code</td>
<td>MDT meetings occur weekly having a full MDT review within 2 days can be a challenge</td>
<td>6 months</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>Mental Health Act Facilitator, CNMIII, C Director</td>
<td>New</td>
<td>Corrective Action(s): Ensure procedures documentation of same on all episodes of physical restraint are compliant with code of practice</td>
<td>Use of checklist for each episode Quaterely Audit as per Code</td>
<td>Achievable</td>
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<td>Preventative Action(s): Ongoing Audit and Training</td>
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<td>Post-Holder(s) responsible: All relevant line managers and Consultants</td>
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<td>Post-Holder(s) responsible: A Fitzpatrick, CNMIII, C Director</td>
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</table>

In one case, the resident did not have an opportunity to discuss the episode with members of the MDT as soon as was practicable.
<table>
<thead>
<tr>
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</table>
| **40.** There was no policy for training staff in working with people with intellectual disability that addressed the following:  
  • Induction training for new staff  
  • Who should receive training  
  • Areas to be addressed in training  
  • Frequency of training.  
  • Identification of appropriately qualified people to deliver training  
  • Evaluation of training programmes. | Reoccurring: Corrective Action(s):  
  This policy is under review at Regional level by Policy and Procedure committee  
  Post-Holder(s) responsible:  
  A Fitzpatrick, Galway/Roscommon  
  Policy and Procedure commitee  
  Preventative Action(s):  
  Audit as per Code  
  Post-Holder(s) responsible:  
  CNMIII, Local audit committee members | Audit as per Code | Achievable | 6 Months |
| **41.** Not all staff had received training in support of the principals and guidance in this code of practice. | New: Corrective Action(s):  
  Training Program for all staff on this code of practice  
  Post-Holder(s) responsible:  
  P Lavin, A Fitzpatrick | Audit against COP Audit training register 6 monthly | achievable | 12 months |
| **42.** The use of restrictive practices was not reviewed periodically. | Reoccurring: Corrective Action(s):  
  Ensure clear documentary evidence provided by relevant staff of review  
  Post-Holder(s) responsible:  
  The relevant MDT and | Audit of this code of practice | Achievable | 6 months |
<table>
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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>All potentially Relevant MDT’s and CNMIIIC Director</td>
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<td>Preventative Action(s): Audit of COP 6 monthly audit</td>
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<td>Post-Holder(s) responsible: Local audit group</td>
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<tr>
<td>43. The resident’s individual care plan did not address environmental considerations or list available resources and supports.</td>
<td>Corrective Action(s): Relevant MDT to address documentation of proactive work in this area</td>
<td>Audit as per code of practice</td>
<td>Achievable</td>
<td>6 months</td>
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<td>Post-Holder(s) responsible: Residents MDT,</td>
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<td>Preventative Action(s): Further training and audit on this COP Ensure regular input from all appropriate disciplines within the MDT. Insure all input is documented.</td>
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<td></td>
<td>Post-Holder(s) responsible: A Fitzpatrick, members of Local audit group</td>
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</table>
### Code of Practice: Admission, Transfer and Discharge

**Report reference: Page 78-79**

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<td>Reoccurring or New area of non-compliance</td>
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<tr>
<td>44. The discharge policy did not include a method for following up and managing missed appointments.</td>
<td>Corrective Action(s): This policy is under review by Regional Policy Group Post-Holder(s) responsible: A Fitzpatrick</td>
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<td>Preventative Action(s): Audit 6 monthly Post-Holder(s) responsible: A Fitzpatrick, P Lavin</td>
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<td>6 months</td>
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<td>Reoccurring</td>
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<tr>
<td>45. The discharge policy did not include a protocol for discharging people with an intellectual disability.</td>
<td>Corrective Action(s): This regional policy is currently under review by Galway/Roscommon policy group Post-Holder(s) responsible A Fitzpatrick, N Creighton</td>
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<td>Preventative Action(s): Template of review dates to prompt reviews Post-Holder(s) responsible: A Fitzpatrick</td>
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<td>46. The discharge policy had not been reviewed within the required three-year time frame.</td>
<td>Corrective Action(s): Ensure documentary evidence is recorded Post-Holder(s) responsible: CNMIII</td>
<td>Audit</td>
<td>Achievable</td>
<td>6 months</td>
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<td></td>
<td>Preventative Action(s): Audit of Same 6 monthly Post-Holder(s) responsible: CNMIII</td>
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<td>47. There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge.</td>
<td>Corrective Action(s): Ensure documentary evidence is recorded Post-Holder(s) responsible: CNMIII</td>
<td>Audit</td>
<td>Achievable</td>
<td>6 months</td>
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<td>Preventative Action(s): Audit of Same 6 monthly Post-Holder(s) responsible: CNMIII</td>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
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<tr>
<td>48. The implementation of and adherence to the admission and discharge policies had not been audited.</td>
<td>Corrective Action(s): This has been referred to local and regional Audit groups and will be addressed by same Post-Holder(s) responsible: CNMIII, C Director, Local Audit group</td>
<td></td>
<td>Achievable with staff being freed from routine duties to participate in audit as JSF and COP require very significant staff time input</td>
<td>8 months</td>
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<td>Preventative Action(s): Audit of this COP</td>
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<td>Post-Holder(s) responsible: CNMIII, Local audit group</td>
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<td>49. There was no reference to early warning signs of relapse in one discharge plan inspected.</td>
<td>Corrective Action(s): Further training and audit feedback to relevant staff in this area A review of the Discharge plan/summaries is currently taking place with a review to improving the template to prompt/aid compliance Post holders responsible A Fitzpatrick, CNMIII, C Director, Local governance group</td>
<td>Audit of this COP 6 monthly audits</td>
<td>Achievable</td>
<td>6 months</td>
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<td>Preventative Action(s): Development of new template</td>
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<td>Post-Holder(s) responsible: As per corrective action</td>
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<td>50. Two discharge summaries did not include a mental state examination.</td>
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<td>51. One discharge summary did not reference outstanding health or social issues or the names and contact details of key people for follow-up.</td>
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<td>52. In one file inspected, two days' notice was not given of the discharge.</td>
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