Department of Psychiatry, St Luke's Hospital

ID Number: AC0037

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Department of Psychiatry
St. Luke's Hospital
Freshford Road
Kilkenny

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

Most Recent Registration Date: 1 March 2017

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee: Mr David Heffernan, General Manager, CHO 5 Mental Health Services

Inspection Team:
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Inspection Date: 19 – 22 September 2017
Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 6 – 8 July 2016

Date of Publication: 3 May 2018

2017 COMPLIANCE RATINGS

REGULATIONS

13
17
1

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

1
1
2

CODES OF PRACTICE

6

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.
Inspector of Mental Health Services

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 policies in relation to health and safety and a safety statement. A risk management policy was available. Managerial staff were trained in organisational risk management. Clinical staff had received training in individual risk management. The risk register was not audited at least quarterly to determine compliance with the approved centre’s risk management policy. Bed capacity was highlighted as a risk on the risk register; however, this risk had not been reviewed in the register since January 2017. The approved centre completed risk assessments for all residents at admission to identify individual risk factors. Changes in risk had occurred in relation to three risk assessment forms; however, these had not been updated in line with the approved centre’s risk management policy.

Person specific identifiers were used the provision of health care services. Food safety audits were completed periodically by the catering manager. Catering areas and associated equipment were clean. At the time of inspection, a number of ligature points were identified, but works were under way in relation to the minimisation of ligature points. A daily log of medication fridge temperatures was not being maintained on either ward.

The numbers and skill mix of staff were not appropriate to the assessed needs of residents and the size and layout of the approved centre, as indicated by a shortage of nursing staff and an insufficient number of psychologists in the service. Not all staff had up-to-date mandatory training in fire safety, Basic Life Support the management of aggression and violence, and the Mental Health Act 2001.

Appropriate care and treatment of residents

Residents’ individual care plans (ICP) were unsatisfactory. Not all ICPs were regularly reviewed with input from the multidisciplinary teams. Nine of the ICPs inspected did not contain specific and appropriate goals for the residents. One ICP did not identify the care and treatment required to meet the goals identified and three ICPs did not identify the resources required to provide the care and treatment identified. The range of available therapeutic services and programmes was appropriate and met the assessed needs of the
residents, and adequate and appropriate resources and facilities were available. Not all residents who had been in the approved centre for longer than six months had their general health needs monitored and assessed at least every six months.

There was compliance with Part 4 of the Mental Health Act 2001: Consent to Treatment.

The approved centre was not compliant with the rules governing the use of seclusion. It was non-compliant with eight elements of the code of practice on physical restraint. The approved centre admitted children in 2017 but age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. No staff had received training in support of the principles and guidance in the Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities. The approved centre was non-compliant with this code of practice.

There was non-compliance with 18 elements of the code of practice on admission, transfer and discharge. The approved centre was compliant with the code of practice on ECT except that the policy required review on an annual basis.

**AREAS REFERRED TO**
- Regulations 5, 14, 15, 16, 17, 18, 19, 23, 25, 27
- Part 4 of the Mental Health Act 2001
- Rule Governing the Use of Seclusion and Mechanical Means of Bodily Restraint
- Rule Governing the Use of ECT
- Code of Practice on Physical Restraint
- Code of Practice on the Admission of Children
- Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities
- Code of Practice on Admission, Transfer and Discharge
- Service user experience, and interviews with staff.

**Respect for residents’ privacy and dignity**

Residents were supported to keep and wear their personal clothing. All residents had an adequate supply of individualised clothing which were clean and appropriate to their needs. Residents could bring personal possessions into the approved centre and were supported to manage their own property and secure facilities were provided on both wards for the safekeeping of small sums of residents’ money.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors, and where residents shared a room, appropriate bed screening was in place to ensure that privacy was not compromised. Not all observation panels in bedrooms were appropriately screened. All windows that looked out onto public areas were fitted with opaque film.

The approved centre was frequently exceeded bed capacity, which led to residents using sitting rooms as bedrooms. Residents slept on mattresses on the floor which is unacceptable.

On Oak Ward, residents’ names and other personal information could be viewed by passers-by on whiteboards in the nurses’ office.

When searches were carried out, residents signed the search form, consenting to the search. There was lack of documentation of implementation of the search, despite a policy outlining how searches should be managed.

CCTV was used in a manner that respected residents’ dignity and privacy.
The approved centre provided a dedicated tribunal room. However, the door to the room was fitted with a clear glass panel and the patient and everyone else in the room could be seen from the corridor. As a result, it was not possible for tribunal sittings to be held in private, as required by the Mental Health Act.

**Responsiveness to residents’ needs**

Residents were provided with a variety of wholesome and nutritious food choices that took account of any special dietary requirements and food, including modified consistency diets, was presented in an appealing manner. The approved centre provided a range of recreational activities during the week and at weekends. There were two secure gardens, one at the back of each unit. Residents had access to multi-faith chaplains. There was a designated visitors’ room, where residents could meet visitors in private. Residents had access to external communications, including a cordless phone, mail, e-mail, and fax.

Required information was provided to residents at admission, in an information booklet and admission checklist. They received written and verbal information about their diagnosis and medications, including any possible side-effects.

The approved centre was dirty and badly maintained. A broken paper towel dispenser in the seclusion room bathroom was a potential hazard to residents. Toilet floors and bedroom floors were dirty, badly stained, damaged, and required replacing. There were broken tiles, dirty, stained and chipped skirting boards, stained and blocked air vents, handles missing from observation panels to bedrooms, a dirty and malodorous visitors’ toilet in the reception area, and the floor of the property room on Oak Ward was stained. There was a pile of rubbish on the ground in the cleaners’ room. The male toilets on the main corridor in Sycamore were malodorous. There were no laundry facilities, and residents were air-drying wet towels through the windows and on bushes outside.

New, brightly coloured sofas had been purchased for communal areas. Bedside chairs had been purchased for each resident, and the dining area had new tables and chairs.

**Governance of the approved centre**

The approved centre was under the management of Community Healthcare Organisation (CHO) 5. The CHO 5 area was divided into two executive management teams, Carlow/Kilkenny/South Tipperary and Waterford/Wexford. The approved centre was governed by the executive management team from Carlow/Kilkenny/South Tipperary.
The Executive Management Team (EMT) meeting was held monthly. The Quality and Safety Executive Committee (QSEQ) meeting was attended by a range of multi-disciplinary professionals and senior management. There was also a local operational management group meeting for the approved centre, which recently changed its terms of reference to the quality and patient safety committee.

The heads of disciplines met with staff on a regular basis and there were clear reporting systems in place. They had received training in risk management. There was service user input into the governance of the approved centre. Each head of discipline had strategic aims in relation to their department. Not all of the heads of discipline had performance management structures in place.

The management team had identified that overcrowding was a serious operational and health and safety risk. This risk had been escalated to a national level within the HSE. The approved centre had developed communication meetings with the local Gardaí and the staff in the emergency department to improve the processes around referral to the approved centre. A delayed discharge meeting was also established to expedite discharges where appropriate. Despite these measures, there was continued overcrowding in the approved centre. There was a lack of documentation in relation to the management of this in the minutes of the EMT, QSEC and the local operational management group meeting.

Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. Not all policies required by the regulations were reviewed every 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. New bedside chairs and sofas.
2. Refurbishment of the waiting room.
3. New blood pressure monitors and electrocardiogram machines.
4. Introduction of disposable curtains.
5. New chairs for the dining hall.
6. New hot serving counter for the dining hall.
7. Upgrade of staff alarms.
8. The introduction of new nursing handover book to improve communication.
9. The introduction of meetings with Gardaí and meetings with staff from St. Luke’s general hospital to improve communication between services.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was located on the grounds of St Luke’s General Hospital in Kilkenny city. There was prominent signage in the general hospital directing people to the approved centre.

The approved centre was made up of two units, Sycamore and Oak, which had 25 and 19 beds, respectively. There were three 6-bed rooms, four 4-bed rooms, and 10 single rooms. There was a high observation area in Oak Ward that accommodated the seclusion room and two single bedrooms. There was one dining room for both units that was located near the reception area. There were well-maintained gardens that were accessible to both units. The approved centre was frequently over occupied, which led to residents using sitting rooms as bedrooms.

There were 12 consultant-led teams that admitted residents to the approved centre from the community mental health teams. There was also a consultant with in-patient responsibility for residents from the South Tipperary sector.

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>44</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>47</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>10</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>1</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>7</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

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

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

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

4.4 Governance

The approved centre was under the management of Community Healthcare Organisation (CHO) 5. The CHO 5 area was divided into two executive management teams, Carlow/Kilkenny/South Tipperary and Waterford/Wexford. The approved centre was governed by the executive management team from Carlow/Kilkenny/South Tipperary.

Minutes of the executive management team (EMT) meeting for Carlow/Kilkenny/South Tipperary were provided. These meetings occurred monthly and were attended by heads of discipline, the executive clinical director, the general manager, and the area lead for mental health engagement. These outlined a clear agenda, actions, and review of governance. Minutes of the Quality and Safety Executive Committee (QSEC) meeting were also provided. These were attended by a range of multi-disciplinary professionals and senior management. There was also a local operational management group meeting for the approved centre, which recently changed its terms of reference to the quality and patient safety committee. In the minutes provided, there was a lack of clarity in relation to actions to be taken and who was responsible.

The management team had identified that overcrowding was a serious operational and health and safety risk. This risk had been escalated to a national level within the HSE. The approved centre had developed communication meetings with the local Gardaí and the staff in the emergency department to improve the processes around referral to the approved centre. A delayed discharge meeting was also established to expedite discharges where appropriate. Despite these measures, there was continued overcrowding in the approved centre and there was a lack of documentation in relation to the management of this in the minutes of the EMT, QSEC and the local operational management group meeting.
## 5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 6 – 8 July 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 8: Residents’ Personal Property and Possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</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>Non-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 Electro-Convulsive Therapy</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 the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
### 5.2 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 13: Searches</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</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 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 30: Mental Health Tribunals</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 34: Certificate of Registration</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X</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 Relating to Admission of Children under the Mental Health Act 2001</td>
<td>X</td>
<td>N/A</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 the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</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.

Three residents and a number of their families chose to speak with the inspection team. Six questionnaires were returned. Residents reported that the food was good and that they were involved in their individual care plans. Residents reported that showers were frequently blocked and not clean. Residents noted that nursing staff made efforts to engage with them but that nursing staff appeared very busy.

The IAN was contacted to obtain residents’ feedback about the approved centre. It was understood that the respective advocate was not available to meet with the inspection team on the days of the inspection.
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:

- Principal Social Worker
- Principal Psychologist
- Occupational Therapy Manager
- Acting Clinical Director
- Area Director of Nursing

The heads of disciplines visited the approved centre frequently. They met with staff on a regular basis and there were clear reporting systems in place. The heads of discipline had received training in risk management. There was service user input into the governance of the approved centre. Each head of discipline had strategic aims in relation to their department. Not all of the heads of discipline had performance management structures in place. There were procedures in place to support peer review. All disciplines except for nursing had supervision structures in place. There was a plan to commence nursing supervision in the next few months. There were systems in place to support quality improvements in each discipline.

The operational risks reported by the heads of discipline related to staffing, delayed discharges, and high bed occupancy. The staffing challenges included an increase in demand for one-to-one nursing observations, the use of medical and nursing agency staff, and the recent national change in accessing agency staff. The heads of discipline reported that the issues around the increased bed occupancy had been escalated as a risk to a national level within the HSE.
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:

- Assistant Director of Nursing
- Assistant Director of Nursing on behalf of Area Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 x 2
- Clinical Risk Manager
- Consultant Psychiatrist x 2
- Mental Health Act Administrator
- Principal Social Worker
- Senior Clinical Psychologist on behalf of Principal Psychologist
- Senior Occupational Therapist
- Occupational Therapy Manager
- Acting Clinical Director
- General Manager/Registered Proprietor

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

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

The following regulations are not applicable

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

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

## INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the identification of residents, which was last reviewed in April 2014. 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 interviewed were able to articulate the processes for identifying residents, as set out in the policy.

**Monitoring:** An annual audit had been undertaken to ensure that clinical files contained appropriate resident identifiers. Documented analysis had not 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. The 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. A red-sticker system was in place to alert staff to the presence of residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of appropriate food and nutrition to residents, which was last reviewed March 2017. It included requirements of the Judgement Support Framework, with the following exceptions:

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

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 food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans was undertaken 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 approved centre’s menus were developed by the catering manager with input from the dietitian. All food was prepared in St. Canice’s Hospital and delivered to the approved centre. Residents were provided with a variety of wholesome and nutritious food choices that took account of any special dietary requirements and were consistent with residents’ individual care plans. Menus were displayed on the wards and written up daily on a blackboard in the dining area.

Food, including modified consistency diets, was presented in an appealing manner, and hot meals were served daily. Residents were offered hot and cold drinks regularly, and they had access to a source of safe, fresh drinking water in water dispensers, which had been installed on both wards since the last inspection.

The approved centre did not use an evidence-based nutrition assessment tool to evaluate residents with special dietary needs. Residents did not have direct access to a dietician in the approved centre. Limited access was available through referral via medical outpatient services.

Residents, their representatives, family, and next of kin were educated about residents’ diets, if required. Nutritional and dietary needs were assessed, where necessary, and addressed in the 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 and evidence of implementation pillars.
**Regulation 6: Food Safety**

1. The registered proprietor shall ensure:
   - the provision of suitable and sufficient catering equipment, crockery and cutlery
   - the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and
   - 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:
   - the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;
   - any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and
   - the Food Safety Authority of Ireland Act 1998.

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to food safety, which was last reviewed in March 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 could articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date documented training in the application of Hazard Analysis and Critical Control Point (HACCP).

**Monitoring:** Food safety audits were completed periodically by the catering manager. Food temperatures were recorded 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, and the kitchen had been recently upgraded with the aim of promoting food safety.

**Evidence of Implementation:** There were appropriate hand-washing areas for catering staff. There was suitable and sufficient catering equipment. Appropriate facilities were available in the approved centre for the refrigeration, storage, preparation, cooking, and serving of food. The kitchen and dining area had been renovated, with the addition of a new fridge, bain marie (hot food servery), water boiler, stainless steel sink and serving area, extractor fan, and dining tables and chairs.

Hygiene was maintained to support food safety. Catering areas and associated equipment were appropriately cleaned. Food was not prepared on-site but was stored and served appropriately, in a manner that reduced the risk of contamination, spoilage, and infection. Residents were provided with a supply of suitable crockery and cutlery.

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 7: Clothing

The registered proprietor shall ensure that:

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in April 2014. It included requirements of the Judgement Support Framework, with the exception of the responsibility of the approved centre to provide clothing to residents, where necessary, with consideration of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices.

**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 residents’ clothing, as set out in the policy.

**Monitoring:** The availability of an emergency supply of resident clothing was monitored on an ongoing basis, and this was documented. A record of residents wearing nightclothes during the day was maintained and monitored.

**Evidence of Implementation:** Residents were supported to keep and wear their personal clothing. All residents had an adequate supply of individualised clothing. Residents’ clothing was observed to be clean and appropriate to their needs.

There was a supply of emergency clothing. The supply of clothing took account of residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Nightclothes were not worn by residents during the day, unless specified in a resident's individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 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 July 2014. 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 relating to residents’ property and possessions, as set out in the policy.

Monitoring: Personal property logs were not monitored. Documented analysis had not been completed to identify opportunities for improving the processes around residents’ personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their individual care plans (ICPs). Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided on both wards for the safekeeping of small sums of residents’ money. Residents were encouraged to send valuables home, where possible.

Signed property checklists were maintained, detailing each resident’s personal property and possessions. These were kept in the residents’ clinical files, stored separately to their ICPs. Access to and use of resident money was overseen by two members of staff and the residents or their representatives. Where any money belonging to residents was handled by staff, signed records of the staff issuing the money were retained. Where possible, these records were countersigned by the residents or their representatives.

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.
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 staff to read and understand. Relevant staff interviewed could articulate the processes relating to recreational activities in the approved centre.

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

**Evidence of Implementation:** The approved centre provided a range of recreational activities appropriate to the resident group profile. There was a communal TV room as well as recreational areas stocked with books, games, and art supplies. Arts and crafts classes were provided in a therapy room, yoga classes were held weekly, and various sporting activities were facilitated. There were two secure gardens, one at the back of each unit.

Activities were provided during the week and at weekends. A timetable of recreational activities was available to residents in an accessible format. Recreational activities were developed, maintained, and implemented with resident involvement. Where deemed appropriate, individual risk assessments were completed for residents in relation to the selection of appropriate activities.

Residents’ decisions on whether or not to participate in activities were respected and documented. Opportunities were available for outdoor exercise and physical activity. Records of resident attendance at events were maintained in the clinical files.

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

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

INSPECTION FINDINGS

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

- The procedure for respecting religious beliefs during the provision of services, care, and treatment.
- The process for ensuring that a resident’s religious beliefs and values were respected within the routines of daily living.

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 for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The policy’s implementation to support residents’ religious practices had not been reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. Chaplaincy services were provided to the approved centre by St. Luke’s General Hospital, where residents were supported to attend mass, if deemed appropriate following a risk assessment. Residents had access to multi-faith chaplains.

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 in residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and monitoring pillars.
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 September 2016. 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 were able to articulate the processes relating to visits, as set out in the policy.

Monitoring: At the time of inspection, no visiting restrictions were being implemented for residents. 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 in the approved centre.

There was a designated visitors’ room, where residents could meet visitors in private, unless there was an identified risk to the resident or to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children were welcome when accompanied by an adult to ensure their safety. The visiting room was suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in January 2014. 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 communication, as set out in the policy.

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

Evidence of Implementation: Residents had access to external communications, including a cordless phone, mail, e-mail, and fax. Individual risk assessments were completed for residents in relation to their external communication and documented in their individual care plans, where appropriate. At the time of inspection, no incoming or outgoing resident communication required examination by the consultant psychiatrist or a designated senior staff member.

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

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

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

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

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

**INSPECTION FINDINGS**

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

- The management and application of searches of a resident, their belongings, and the environment in which they were 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 process for communicating the approved centre’s search policies and procedures to residents.

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

**Monitoring:** A search log was maintained, but each search record was not systematically reviewed to ensure the requirements of the regulation were complied with. Documented analysis had not been completed to identify opportunities for improving search processes.

**Evidence of Implementation:** The resident search policy and procedure was communicated to residents at admission. One resident had been searched since the date of the last inspection, and the relevant clinical file was inspected. The search was recorded in the search log, and the clinical file contained a pro forma search form. The resident’s clinical notes did not refer to a search or indicate that the multi-disciplinary team had reviewed the search.
The search log indicated that risk was assessed prior to the search. The resident signed the search form, consenting to the search.

The clinical file contained no evidence that the resident was informed by those implementing the search of what was happening and why or that the search was implemented with due regard to the resident’s dignity and privacy. No information was provided in relation to why, where, and how the search was conducted and how many staff were in attendance.

There was no written record of environmental searches; the inspectors were informed that environmental searches were rarely undertaken.

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

a) The registered proprietor did not ensure that staff were aware of the policy and procedures on searches, 13(5).

b) There was no documented evidence that a minimum of two appropriately qualified staff were in attendance at all times when the search was being conducted, 13(6).

c) There was no documented evidence that the search was undertaken with due regard to the resident’s privacy and dignity, 13(7).

d) There was no documented evidence that the resident was informed by those implementing the search of what was happening and why, 13(8).

e) The reason for the search was not documented, 13(9).

f) There was no written record of every search conducted in the approved centre, 13(9).
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to care of the dying: a management of death policy dated June 2015 and guidelines relating to end of life care, dated January 2016. Together, the policies included requirements of the Judgement Support Framework, with the exception of 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 health care facility.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in June 2015. 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: Resident ICPs were audited on a quarterly basis to assess compliance with the regulation. Documented analysis had been undertaken to identify opportunities for improving the individual care planning process.

Evidence of Implementation: The ICPs of 20 residents were inspected. Each ICP was a composite set of documents stored in the clinical file and was identifiable and uninterrupted.

Each resident was assessed at admission and an initial care plan was put in place to address immediate needs. The ICPs were developed within seven days of admission, following assessment. There was limited MDT input into ICPs. Two ICPs recorded nursing and medical input only, and six had limited occupational therapy and social work involvement and no psychology input. The ICP was discussed, agreed where practicable, and drawn up with the participation of residents, their representatives, family, or next of kin.

Eight of the ICPs inspected did not identify the residents’ assessed needs, and nine did not contain specific and appropriate goals for the residents. One ICP did not identify the care and treatment required to meet the goals identified. Three ICPs did not specify appropriate resources to provide the care and treatment identified. Seven of the ICPs inspected did not include individual risk management plans, and not all of the ICPs included a preliminary discharge plan.

The ICPs were reviewed regularly in consultation with the resident. A key nurse was appointed in all cases, but there was no evidence that the approved centre operated a key worker system. Residents had access to their ICPs and were informed of any changes. Where a resident declined or refused a copy of the ICP, this was documented.

As there were no child residents in the approved centre at the time of inspection, educational requirements did not apply.
The approved centre was non-compliant with this regulation for the following reasons:

a) Not all ICPs were regularly reviewed with input from the MDT.
b) Nine of the ICPs inspected did not contain specific and appropriate goals for the residents.
c) One ICP did not identify the care and treatment required to meet the goals identified.
d) Three ICPs did not identify the resources required to provide the care and treatment identified.
Regulation 16: Therapeutic Services and Programmes

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.
(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

Processes: The approved centre did not have a current written policy in relation to the provision of therapeutic services and programmes to residents. There was a draft policy in place, which had not yet been approved by senior management.

Training and Education: There was no policy for clinical staff to read or understand. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes in the approved centre.

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

Evidence of Implementation: The range of available therapeutic services and programmes was appropriate and met the assessed needs of the residents, as indicated in their individual care plans. Therapeutic services and programmes provided by the approved centre were evidence-based and included a wide range of physical, creative, psychosocial, and skill-based groups.

Therapeutic services and programmes in the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. The programmes included relaxation, mindfulness, occupational therapy groups, art classes, walks, yoga, independent living skills, recovery, self-care, sleep hygiene, sports, gardening, walking, fitness, drama, and music therapy.

A list of therapeutic services and programmes was available to residents. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes. Where residents required therapeutic services or programmes such as physiotherapy, speech and language therapy, and dietetics, they were referred to the general hospital.

Records were maintained of the residents’ participation in, engagement with, and outcomes achieved in therapeutic services or programmes and documented in their clinical files.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
**Regulation 17: Children’s Education**

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

As none of the children admitted to the approved centre since the last inspection had educational requirements, this regulation was not applicable.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in October 2015. 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 the transfer process.
- Managing emergency transfers.

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.

Monitoring: The approved centre did not maintain a transfer log, and each transfer record was not systematically reviewed to ensure that all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical files of two residents who had been transferred to another facility were inspected. In each case, the communication records with the receiving facility were documented. Both files contained documented consent of the residents to the transfer.

All relevant information regarding the residents was transferred, including letters of referral listing current medications, resident transfer forms, and information on required medication for the residents during the transfer. The approved centre completed a checklist to ensure comprehensive resident records were transferred to the receiving facility. Copies of all records relating to the transfers were retained in the clinical files.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to general health and medical emergencies, which was last reviewed in February 2014. It included requirements of the Judgement Support Framework, with the exception of the following:

- The roles and responsibilities in relation to the provision of general health services to residents.
- The process for providing residents with access to a registered medical practitioner.
- The resource requirements for general health services, including equipment needs.
- The incorporation of general health needs into the resident individual care plan (ICP).
- The referral process for general health needs of residents.

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 providing general health services and responding to medical emergencies, as set out in the policy.

Monitoring: Resident take-up of national screening programmes was recorded and monitored, where applicable. A systematic review had not been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an emergency trolley and there was an Automated External Defibrillator on both units. Weekly checks were completed on emergency equipment. Records were maintained of any medical emergency in the approved centre and of the care implemented.

A registered medical practitioner (RMP) assessed residents at admission and on an ongoing basis. Residents received appropriate general health care interventions in line with their ICPs.

A review of the clinical files of seven residents who had been in the approved centre for longer than six months indicated that residents’ general health needs were not monitored and assessed at least every six months. Two residents did not have physical examinations within the required time frame. The relevant RMP was notified, and the physicals were completed by the end of the inspection.

Records were maintained of general health checks and associated results. Where relevant, residents had access to appropriate national screening programmes. No information regarding these programmes was available to residents in the approved centre.
The approved centre was non-compliant with this regulation because two residents had not received a physical examination within the required six-month time frame, 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 January 2014. It included requirements of the Judgement Support Framework, with the following exceptions:

- The process for identifying the residents’ preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.
- The interpreter and translation services available within the approved centre.
- The process for managing the provision of information to resident representatives, family, or next of kin.

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

Evidence of Implementation: Required information was provided to residents and/or their representatives at admission, in an information booklet and admission checklist. Residents were provided with information on housekeeping arrangements, arrangements for personal property, the complaints procedure, visiting times and arrangements, mealtimes, relevant advocacy and voluntary agencies, and residents’ rights. Residents were provided with verbal information on their 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 to the residents on the indications for use of medications, including any possible side-effects. The information provided by and within the approved centre was evidence-based.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in January 2017. It included requirements of the Judgement Support Framework, with the following exceptions:

- The method for identifying and ensuring, where possible, residents’ privacy and dignity expectations and preferences.
- The process applied when resident privacy and dignity were not respected by staff.

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

Monitoring: An annual review had not been undertaken 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 members were observed to interact with residents in a respectful manner. Staff were appropriately dressed and sought permission before entering residents’ rooms. They were discreet when discussing residents’ care and treatment. Residents were observed to be wearing clothing that respected their privacy and dignity.

Bathrooms, showers, toilets, and single bedrooms had locks on the inside of the doors, and these had an override facility. Where residents shared a room, appropriate bed screening was in place to ensure that privacy was not compromised. Residents were facilitated in making and taking private phone calls.

Not all observation panels in bedrooms were appropriately screened. The opaque film fitted to glass panels in four bedrooms on both Oak and Sycamore Wards was torn and needed to be replaced. All windows that looked out onto public areas were fitted with opaque film.

Sitting rooms were used to accommodate residents overnight when the approved centre was over occupied. Residents slept on mattresses on the floor. This did not respect their dignity.

At the time of inspection, a new noticeboard system had been recently implemented. Whiteboards were fitted in the nurses’ stations, but, on Oak Ward, residents’ names and other personal information could be viewed by passers-by.

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

a) The absence of appropriate screening on observation panels did not ensure that resident’s privacy was appropriately respected at all times.
b) The practice of residents sleeping on mattresses in sitting rooms did not ensure that resident's dignity was appropriately respected at all times.

c) Noticeboards displayed identifiable resident information, which did not ensure that resident's privacy was appropriately respected at all times.
Regulation 22: Premises

(1) The registered proprietor shall ensure that:
   (a) premises are clean and maintained in good structural and decorative condition;
   (b) premises are adequately lit, heated and ventilated;
   (c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the premises, which was last reviewed in June 2013. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- The approved centre’s premises maintenance programme.
- The approved centre's cleaning programme.
- The provision of adequate and suitable furnishings in the approved centre.
- The process for identifying hazards and ligature points.

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

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

Evidence of Implementation: Residents had access to personal space, and appropriately sized communal areas were available for each ward. Communal areas had adequate lighting to facilitate reading and other activities. Rooms were comfortably and sufficiently heated, and heating could be safely controlled in residents’ rooms. Appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including enclosed gardens for both wards.

A broken paper towel dispenser in the seclusion room bathroom was a potential hazard to residents. At the time of inspection, a number of ligature points were identified, but works were under way in relation...
to the minimisation of ligature points. According to the maintenance manager, these will be addressed on a phased basis to ensure minimal disruption to services.

Toilet floors and bedroom floors were dirty and badly stained, damaged, and required replacing. Broken tiles were observed in one shower room in Sycamore, and skirting boards throughout the approved centre were stained and chipped. Air vents in the rooms leading out to the gardens were stained and blocked. Air vents in a female bathroom in Oak Ward were stained. There was a broken shower door and broken paper dispenser in the bathroom of the seclusion room. A number of handles were missing from observation panels to bedrooms.

An extensive cleaning schedule was in place, but it was not fully implemented due to the size of the wards and the limited number of cleaning staff employed. As a result, the approved centre was not clean, hygienic, and free from offensive odours throughout.

On the first day of inspection, the visitors’ toilet in the reception area was dirty and malodourous, the floor of the property room on Oak Ward was stained, and walls and skirting boards were dirty. The cleaners’ room in Sycamore Ward was untidy and there was a pile of rubbish on the ground. The male toilets on the main corridor in Sycamore were malodorous at the time of inspection as stains were embedded in the flooring. A bath and shower chair were stained in Sycamore.

There was a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. Where faults or problems were identified, there was an appropriate maintenance reporting process, which had been introduced since the last inspection. There was no programme of decorative maintenance.

There were no laundry facilities, and residents were air-drying wet towels through the windows and on bushes outside. In addition, the limited number of cleaning staff meant that required cleaning was not effectively completed, which posed an infection control risk.

There was a sufficient number of toilets and showers for residents, including accessible facilities and wheelchair accessible facilities for use by visitors who required them. Residents reported that showers were frequently blocked and not clean. There were designated sluice, cleaning, and therapy/examination rooms.

Bedrooms were appropriately sized for resident needs, but the approved centre often exceeded bed capacity and residents had to sleep in sitting areas that were not suitable for use as bedrooms.

New, brightly coloured sofas had been purchased for communal areas. Bedside chairs had been purchased for each resident, and the dining area had new tables and chairs.

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

a) The premises were not clean throughout or maintained in good structural and decorative condition, 22(1)(a).

b) There was no programme of routine decorative maintenance of the premises, 22(1)(c).

c) Ligatures had not been mitigated. Residents were sleeping in areas that were not suitable for use as bedrooms. A broken paper towel dispenser in the seclusion room bathroom was a potential hazard to residents. Therefore, the physical structure and overall approved centre environment were not developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

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

- Medication reconciliation.
- Review of resident medication.

Training and Education: 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 had access to comprehensive, up-to-date information on all aspects of medication management. All clinical staff had received documented training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. There was no evidence that 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 30 of these were inspected. Two appropriate resident identifiers were used on each MPAR. Names of medications were written in full, the generic names of medications were recorded, and all medications administered to residents were documented. The frequency of administration, the dosage, and the administration route for medications were documented, and medications refused by or withheld from residents were noted.

In 11 of the MPARs examined, the Medical Council Registration Number (MCRN) of each medical practitioner prescribing medication to the residents was not included. The allergy section was not completed in seven MPARs.

Medication was reviewed at least six-monthly, and all medicines were administered by a registered nurse or registered medical practitioner. Medicinal products were appropriately administered, and the expiry dates of medications were checked prior to their administration. Good hand hygiene and cross-infection control techniques were observed during the dispensing of medications. Controlled drugs were checked by two staff members against the delivery form, and the details were appropriately entered in the controlled drug book. Directions to crush medication were only accepted from residents’ medical practitioners and administered in consultation with the pharmacist.
Medication arriving from the pharmacist was verified against the order to ensure that it was correct and accompanied by appropriate directions for use. Medication storage areas were clean and tidy, and food and drink was not stored in areas used for the storage of medication.

A daily log of medication fridge temperatures was not being maintained on either ward. During the inspection, medication in the fridge on Oak Ward was disposed of on the advice of the pharmacist because it may not have been stored at the appropriate temperature.

Medication was stored securely in a locked trolley in the clinical room on each ward. There was a separate secure storage area for scheduled controlled drugs. A system of stock rotation was implemented, and an inventory of medications was completed monthly. Medications that were no longer required or were out of date were disposed of appropriately.

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

a) In 11 of the MPARs inspected, the MCRN of every medical practitioner prescribing medication to the residents was not included.

b) Unsuitable practices in relation to the storage of medication requiring refrigeration were observed in Oak Ward.
**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 two policies in relation to health and safety, a health and safety policy dated March 2016 and a driving HSE vehicles policy dated March 2017. It also had a safety statement, which was dated September 2017. Together, the policies and safety statement addressed requirements of the *Judgement Support Framework*, with the exception of the following:

- Infection control measures, including
  - Raising awareness of residents and visitors to infection control measures.
  - The response to sharps or needle stick injuries.
  - Specific measures in relation to infections such as C. diff, MRSA, and Norovirus.
- First aid response requirements.
- Falls prevention initiatives.

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

**Monitoring:** The health and safety policies were monitored pursuant to Regulation 29: Operational Policies and Procedures.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of CCTV, which was last reviewed in June 2016. 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 relating to the use of CCTV, as set out in the policy.

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

Evidence of Implementation: There was prominent signage indicating the locations where CCTV cameras were situated in the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The inspection team was informed about the approved centre’s use of CCTV.

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

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 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the recruitment, selection, and vetting of staff, which was last reviewed in April 2016. It addressed requirements of the Judgement Support Framework, with the exception of the following:

- The methods for communicating the staff rota details to staff.
- The staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassigning staff in response to changing resident needs.
- The process for transferring responsibility between staff members.
- 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 not been reviewed annually. The numbers and skill mix of staff were assessed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability of staff in the approved centre. There was a planned staff rota but no actual rota in place. Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times.

The numbers and skill mix of staff were not sufficient to address resident needs. Frequent 1:1 nursing observation was required, which meant that there was a need for additional nursing staff. Completed incident report forms indicated that the number of nursing staff on duty in August was insufficient to meet resident’ needs. In addition, not all residents had access to a psychologist due to a shortage of psychology staff on community mental health teams.
The approved centre did not have a written 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 was completed by staff. Training records indicated that not all health care professionals had up-to-date, mandatory training in fire safety, Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act 2001.

At least one staff member was trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training completed in manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, resident rights, risk management, recovery-centred approaches to mental health care and treatment, incident reporting, and the protection of children and vulnerable adults. Not all training in risk management was documented.

The Mental Health Act 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in the nursing office and on the wards.

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>Oak Ward</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sycamore Ward</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Occupational Therapist x 2.0 WTE

*Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), WTE = Whole Time Equivalents.*

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

a) The numbers and skill mix of staff were not appropriate to the assessed needs of residents and the size and layout of the approved centre, as indicated by a shortage of nursing staff and an insufficient number of psychologists in the service, 26(2).

b) Not all staff had up-to-date mandatory training in fire safety, BLS, the management of aggression and violence, and the Mental Health Act 2001, 26(4) and 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 June 2015. It addressed requirements of the Judgement Support Framework, including policies and procedures relating to record retention periods.

The policy did not reference 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 review requirements.
- The destruction of records.
- The way in which entries in residents’ records were made, corrected, and overwritten.
- The process for making a retrospective entry in residents’ records.
- The retention of reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed the signature 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, as set out in the policy. 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, and this was documented. 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, and six clinical files were inspected. Residents’ records were physically stored together and secured from loss or destruction, tampering, and unauthorised access or use.
Records were constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and national guidelines and legislative requirements. There was a tab system in use in the files, but the documents were not always correctly filed, making it difficult to find information. Two files were observed to contain loose pages. In addition, in two clinical files inspected, errors in records were crossed out and not signed or dated.

The clinical files inspected indicated that records were reflective of residents’ current status and the care and treatment being provided. The records were maintained through the use of a resident-specific identifier. Residents’ records were accessible to authorised staff only. Records contained factual, consistent, and accurate entries. Documentation relating to health and safety, food safety, and fire inspections was maintained in the approved centre.

In three clinical files inspected, two appropriate resident identifiers were not recorded on all documentation. Where a member of staff made a referral to or consulted with another health care professional, this individual was not always clearly identified using full name and title. Entries were not consistently dated and time-stamped in three clinical files.

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

- The approved centre did not have written policies and procedures relating to the creation of, access to and destruction of records.
- Not all of the records were in good order, with two of the clinical files inspected containing loose pages, 27(1).
- Records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, 27(1):
  - Documentation was not always correctly filed, making it difficult to find information.
  - Errors in records were crossed out and not signed or dated in two clinical files.
  - Two appropriate resident identifiers were not recorded on all documentation in three clinical files.
  - Where a referral was made to another health care professional, this individual was not always clearly identified using full name and title.
Regulation 28: Register of Residents

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating MODERATE

(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. At the time of inspection, it did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Diagnosis on admission and on discharge were not consistently recorded as there was a three-month delay in recording these in the register.

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

   a) The register of residents was not up to date, 28(1).
   b) The register of residents did not include all of the information specified in schedule 1. Specifically, diagnosis on admission and on discharge were not consistently recorded as there was a three-month delay in recording these, 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 on the development and review of operating policies and procedures, which was last reviewed in June 2017. It included requirements of the Judgement Support Framework, with the following exceptions:

- The process for training on operating policies and procedures, including the training requirements following the release of a new or updated operating policy and procedure.
- The standardised operating policy and procedure layout used by the approved centre.

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

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. 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. The policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved before being implemented. Generic policies in use were suitable to the approved centre and the resident group profile and were appropriately adopted.

Not all of the operating policies and procedures required by the regulations had been reviewed within three years, specifically policies relating to Regulation 8: Residents’ Personal Property and Possessions, Regulation 12: Communication, Regulation 19: General Health, Regulation 20: Provision of Information to Residents, and Regulation 31: Complaints Procedures.

Obsolete versions of operating policies and procedures were not removed from possible access by staff and were evident in the policy folder. The format of the policies and procedures used by the approved centre did not reference the document owner or the date of implementation.

The approved centre was non-compliant with this regulation because not all policies and procedures required by the regulations had been reviewed at least every three years, specifically those relating to Regulation 8: Residents’ Personal Property and Possessions, Regulation 12: Communication, Regulation 19: General Health, Regulation 20: Provision of Information to Residents, and Regulation 31: Complaints Procedures.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of Mental Health Tribunals. It addressed requirements of the Judgement Support Framework, with the exception of the provision of information to the patient about the Mental Health Tribunals.

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 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 dedicated tribunal room. However, the door to the room was fitted with a clear glass panel and the patient and anyone else in the room could be seen from the corridor. As a result, it was not possible for tribunal sittings to be held in private, as required by the Mental Health Act 49(9).

Adequate resources were provided in support of the process, and staff assisted and supported residents to attend and participate in Mental Health Tribunals, where necessary.

The approved centre was non-compliant with this regulation because the clear glass panel in the door of the tribunal room prevented tribunal sittings from being held in private. As a result, the registered proprietor did not ensure that the approved centre cooperated fully with Mental Health Tribunals, 30(1).
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 April 2014. It also used the HSE’s Your Service, Your Say policy. Together, the policies addressed all of the requirements of the Judgement Support Framework.

Training and Education: 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 had not been completed. A log of complaints had been completed and sent to senior management and analysis had commenced at the end of July 2017. Required actions had been identified to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated individual responsible for dealing with all complaints who was available to the approved centre. 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. Details of the complaints policy and procedure were included in the resident information booklet.

The complaints log and database were reviewed by the inspector and evidenced clear, systematic complaints management processes and procedures. 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. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives.
Complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. A procedure for addressing minor complaints was in place, and all minor complaints were logged, including complaints that had been addressed on the spot by staff.

Where minor complaints could not be addressed locally, they were escalated to the nominated person. All complaints that were not minor were dealt with by the nominated person and recorded in the complaints log. Details of the complaints, subsequent investigations, and the outcomes were recorded and kept separately from the resident’s individual care plan.

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 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 June 2016. It addressed requirements of the Judgement Support Framework, including the following:

- The process of identification, assessment, treatment, reporting, and monitoring of
  - Organisational risks.
  - Structural risks such as ligature points.
  - Health and safety risks to the 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.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The policies did not specify the following:

- The responsibilities of the registered proprietor.
- The person responsible for the completion of six-monthly incident summary reports.
- The process of identification, assessment, treatment, reporting, and monitoring of capacity risks relating to the number of residents in the approved centre.
- The process for notifying the Mental Health Commission about incidents involving residents of the approved centre.
**Training and Education:** No documentation was provided by the approved centre to verify whether relevant staff had received training in the identification, assessment, and management of risk or in health and safety risk management. Managerial staff were trained in organisational risk management. Clinical staff had received training in individual risk management.

No documentation was provided by the approved centre to verify whether all staff had been trained in incident reporting. Not all staff had signed the signature log to indicate that they had read and understood the policy. Staff interviewed were able to articulate the risk management processes, as set out in the policy. No evidence was provided to the inspectors in relation to the documentation of risk management training.

**Monitoring:** The risk register was not 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. No evidence was provided to the inspectors in relation to the analysis of incident reports to identify opportunities for improving risk management processes.

**Evidence of Implementation:** The person with responsibility for risk was known by all staff in the approved centre, and responsibilities were allocated at management level to ensure the effective implementation of risk management.

Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Bed capacity was highlighted as a risk on the risk register; however, this risk had not been reviewed in the register since January 2017. Where any works to the premises were ongoing, the approved centre implemented a plan to reduce risks to residents.

Ligature points, had not been removed or effectively mitigated. Numerous ligature points were observed in the approved centre. There were works ongoing to minimise ligature points.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors. Risk assessments were completed before and during the use of seclusion, physical restraint, and specialised treatments such as Electro-Convulsive Therapy and before a transfer or discharge. Changes in risk had occurred in relation to three risk assessment forms, however these had not been updated in line with the approved centre’s risk management policy.

Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of risk management processes, as did residents and/or their representatives. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated using the National Incident Management System (NIMS). All clinical incidents were reviewed by the MDT at their regular meeting, but a record was not maintained of this review or of recommended actions. There was a delay in review of these incident forms by the MDT of up to three months in some cases. There was a further administrative delay in the incident forms being uploaded onto the NIMS database.

A six-monthly summary report of all incidents occurring in the approved centre was sent to the Mental Health Commission in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. The approved centre had an emergency plan that incorporated a fire evacuation plan.
The approved centre was non-compliant with this regulation because risk assessment forms were not updated or reviewed in line with the approved centre’s risk management policy, 32(1).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre did not have an up-to-date certificate of registration. The second page of the certificate on display was dated March 2014. This was rectified during the course of the inspection. The conditions attached to the certificate of registration were documented and displayed.

The approved centre was non-compliant with this regulation because the current certificate was not displayed.

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating LOW

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

Section 59

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT), which was last reviewed in February 2016. The policy, which had not been reviewed annually, included provisions in relation to the following:

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

Training and Education: Staff involved in delivering ECT were trained in line with best international practice and had up-to-date Basic Life Support training.

As no patient in the approved centre had been prescribed Electro-Convulsive Therapy since the last inspection, the evidence of implementation pillar for this rule was not inspected against.

The approved centre was non-compliant with this rule because the policy in relation to the use of ECT had not been reviewed annually, 12.2.
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of seclusion, which was last reviewed in March 2016. The policy, which had not been reviewed annually, identified those who were authorised to initiate seclusion, referenced the provision of information to the resident, and addressed ways of reducing rates of the use of seclusion. There was a policy in relation to the use of closed circuit television (CCTV).

The policy did not identify staff training requirements in relation to the use of seclusion, with reference to the following:

- Who will receive training.
- Areas to be addressed in training, including alternatives to seclusion.
- The frequency of training.
- The identification of appropriately trained staff to deliver training.
- The mandatory nature of training for staff involved in the use of seclusion.

Training and Education: All staff involved in the use of seclusion had signed the signature log to indicate that they had read and understood the policy. Records were maintained of staff attendance at training and were made available to the inspector.

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

Evidence of Implementation: The clinical files relating to two episodes of seclusion were inspected. The residents in seclusion had access to adequate toilet and washing facilities, and the seclusion room was furnished, maintained, and cleaned to ensure that resident dignity and privacy were respected, as far as was practicable. There was a broken shower door and broken paper towel dispenser in the bathroom of the seclusion room. The broken paper towel dispenser was as a potential hazard.

Both episodes were initiated by a registered medical practitioner or registered nurse, and the consultant psychiatrist was notified of the use of seclusion as soon as was practicable. This was recorded in the clinical...
files. A comprehensive assessment, including a risk assessment, was completed in advance of the use of seclusion. The use of CCTV to monitor the seclusion room was appropriate.

Seclusion was used in rare, exceptional circumstances and best interests, when the residents posed an immediate and serious threat of harm to self or others and after all other interventions to manage unsafe behaviour had been first considered. Residents were under the direct observation of a registered nurse for the first hour.

In each case, residents were informed of the ending of seclusion and the reasons for ending seclusion. All episodes of seclusion were reviewed by the multi-disciplinary team. All uses of seclusion were clearly recorded in the clinical files and documented in the seclusion register. Cultural awareness and gender sensitivity were demonstrated in each episode.

In one case, the seclusion order was for a period of more than eight hours, and one seclusion order did not include the time at which the period of seclusion ended.

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

a) The policy in relation to seclusion had not been reviewed annually, 10.2(a).
b) The policy did not address the requirements for training staff in the use of seclusion, 11.1.
c) The broken paper towel dispenser did not ensure patient safety, 8.3.
d) One seclusion order was for a period of more than eight hours, 3.3(e).
e) One seclusion order did not include an end time, 3.3(e).
Section 69: The Use of Mechanical Restraint

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

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

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

56. In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where –
   a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
   b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

60. Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either –
   a) the patient gives his or her consent in writing to the continued administration of that medicine, or
   b) where the patient is unable to give such consent –
      i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
      ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

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

61. Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –
   a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and
   b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist.

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

INSPECTION FINDINGS

The clinical files of four patients who had been in the approved centre for more than three months and in continued receipt of medication were examined. In two cases, the patients had been assessed as capable of consenting to treatment and a Consent to Treatment form was completed. The patients had signed the consent form, which contained confirmation of their ability to understand the nature, purpose, and likely effects of the medication(s) administered. The forms specified the following:

- The names of the medications prescribed.
- Details of the discussion with the patient in terms of the nature and purpose and effects of the medication.
- Supports provided to the patient in terms of the discussion and their decision-making process.

In two other cases, a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed and a copy of the form was retained in the relevant clinical files. Each Form 17 documented the assessment of the patients’ ability to understand the nature, purpose, and likely effects of the medication.
The forms also contained details of the following:

- The names of the medication prescribed.
- Discussions with the patient in terms of the nature and purpose and effects of the medication.
- Views expressed by the patient.
- Supports provided to the patient in terms of the discussion and their decision-making process.
- Authorisation by a second consultant psychiatrist.

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.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint, which was last reviewed in June 2016. The policy, which had not been reviewed annually, addressed all the requirements of this code of practice.

Training and Education: Not all staff involved in the use of physical restraint had signed the signature log to indicate that they had read and understood the policy. A record of attendance at training was maintained. 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 of three residents were examined in relation to physical restraint. 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. The episodes of physical restraint were not prolonged beyond the period necessary.

In one case, there was no documented evidence that gender sensitivity was demonstrated during the use of restraint or that a same sex staff member was in attendance. In one case, it was not documented that the consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. In one episode, a registered medical practitioner did not complete a medical examination within three hours of the start of the physical restraint. In one case, it was not documented that members of the multi-disciplinary team (MDT) reviewed the use of physical restraint within two working days.

The residents were informed of the reasons, likely duration, and circumstances leading to the discontinuation of physical restraint. In the three episodes examined, the consultant psychiatrist signed and dated the clinical practice forms within 24 hours and the use of physical restraint was recorded in the clinical files.

The clinical practice form book for physical restraint was examined. Four separate clinical practice forms were not signed by the consultant psychiatrist within 24 hours and they were not placed in the relevant clinical file.

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

a) The physical restraint policy had not been reviewed annually, 9.2(d).
b) There was no record to indicate that all staff involved in the use of physical restraint had read and understood the policy, 9.2(b) and (c).
c) In one episode of restraint, there was no documented evidence that gender sensitivity was demonstrated, 1.9, or that a same sex staff member was in attendance, 6.3.
d) In one episode, it was not documented that the consultant psychiatrist was notified of the use of restraint as soon as was practicable, 5.3.
e) In one episode, it was not documented that the registered medical practitioner completed a medical examination of the resident within three hours of the start of the physical restraint, 5.4.

f) In one episode, it was not documented that members of the MDT reviewed the use of physical restraint within two working days, 9.3.

g) Four separate clinical practice forms were not signed by the consultant psychiatrist within 24 hours, 5.7(c).

h) Four separate clinical practice forms were not placed in the relevant clinical file, 8.3.
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 Health Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

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

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

Evidence of Implementation: The clinical files relating to two child admissions were reviewed. Provisions were in place to ensure the safety of the child, to respond to each child’s special needs as a young person in an adult setting, and to ensure the right of the children to have their views heard. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. All children admitted were referred to the occupational therapist for a determination of educational needs.

Appropriate accommodation was available for children in the approved centre, who were accommodated in a single en suite room. Gender sensitivity was demonstrated in each case. The children had their rights explained and were provided with information about the available facilities in a form and language that they could understand. Advice from the Child and Adolescent Mental Health Service was available when necessary. Consent for treatment was obtained from one or both parents.

Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. All staff having contact with the child had undergone Garda vetting. The MHC was notified of the child admissions to an approved centre for adults within the required 72-hour time frame.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5(b).
Notification of Deaths and Incident Reporting

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

INSPECTION FINDINGS

Processes: The approved centre had a risk management policy that covered the notification of deaths and incident reporting to the Mental Health Commission (MHC). It identified the risk manager and specified 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 policy did include the roles and responsibilities in relation to completing six-monthly incident summary reports.

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

The approved centre was non-compliant with this code of practice because:

(a) The policy did not specify the roles and responsibilities in relation to completing six-monthly incident summary reports, 4.3.
(b) The approved centre was non-compliant 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 dated June 2013. 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: No staff had received training in support of the principles and guidance in this code of practice.

Monitoring: The policy had not been reviewed within the required three-year time frame. Restrictive practices were 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, the resident’s assessed needs, environmental considerations, and available resources and supports.

The resident received an assessment, which included a mental state examination; a medical, psychiatric, and psychosocial history; a risk assessment; details of past and current medication; and a determination of performance capacities and difficulties. The assessment did not include consideration of communication difficulties or of social, interpersonal, and physical environment-related issues.

A key worker was appointed, and family members were involved. Opportunities were made available for resident engagement in meaningful activities.
The resident’s preferred ways of receiving and giving information had not been established. The clinical file did not contain any documentation as to the resident’s understanding of information. The approved centre did not represent the least restrictive environment to meet the resident’s needs and the resident was not accommodated in a single en suite room, as per the approved centre’s policy. The clinical team were actively pursuing alternative accommodation for this resident.

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

a) No staff had received education and training to support the principles and guidance in the code of practice, 6 and 6.1.
b) 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.
c) The policy had not been reviewed within the required three-year time frame, 5.4.
d) The resident assessment did not address communication difficulties or social, interpersonal, and physical environment-related issues, 8.2.
e) The resident’s preferred ways of receiving and giving information had not been established, 9.1.
f) The clinical file did not contain documentation as to the resident’s understanding of information, 9.6.
g) The approved centre did not represent the least restrictive environment to meet the resident’s needs, 10.1.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT), which was last reviewed in February 2016. The policy, which had not been reviewed annually, included provisions in relation to the following:

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

Training and Education: Staff involved in delivering ECT were trained in line with best international practice and had up-to-date Basic Life Support training.

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

Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were displayed, but they were in a small format and were not easy to read. A named consultant and named consultant anaesthetist had responsibility for ECT, and a designated ECT nurse and a registered psychiatric nurse were in the ECT suite at all times when treatment was being delivered. The designated ECT nurse was responsible for checking emergency equipment and drugs on a weekly basis.

The clinical file of one resident was examined in relation to two episodes of ECT. The records indicated that appropriate information about ECT was provided by the consultant psychiatrist, including details of likely adverse effects of the treatment. The information provided was in clear and simple language that the resident could understand. The resident was informed of their rights to an advocate and had the opportunity to raise questions at any time. The resident was assessed by the consultant psychiatrist as capable of giving informed consent for ECT, and the assessment was documented in the clinical file. Consent was given for each programme of ECT.

The programmes of ECT were prescribed by the responsible consultant psychiatrist and recorded. Pre-anaesthetic assessments were documented in the clinical files, and anaesthetic risk assessments were recorded. The consultant psychiatrist in conjunction with the resident reviewed progress and the need for continuation of ECT. The ECT records were retained in the clinical file, along with all post-ECT assessments.

The approved centre was non-compliant with this code of practice because the policy in relation to the use of ECT for voluntary patients had not been reviewed annually, 13.2.
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 last reviewed in June 2015, included a procedure for involuntary admission and a protocol for planned admission, with reference to pre-admission assessments, eligibility for admission, and referral letters. There was also a policy on confidentiality, privacy, and consent.

The admission policy did not include protocols for urgent referrals, self-presenting individuals, and timely communication with primary care and community mental health teams. It did not reference the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment.

Transfer: The transfer policy, which was last reviewed in October 2015, included procedures for involuntary transfer and outlined the roles and responsibilities of staff in relation to the transfer of residents. It detailed how a transfer was arranged and addressed the safety of the resident and staff during a transfer. The policy did not include provisions for emergency transfer or transfer abroad.

Discharge: The discharge policy, which was last reviewed in July 2015, included procedures for the discharge of involuntary patients and the management of discharge against medical advice. The policy referenced prescriptions and supply of medication on discharge and included protocols for discharging homeless people and older persons. It did not include a protocol for discharging people with intellectual disability. The follow-up policy did not reference crisis management plans.

Training and Education: There was no documented evidence that all staff had read and understood the policies on admission, transfer, and discharge.

Monitoring: There was no documented 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: One clinical file was reviewed in relation to admission. The approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. The decision to admit was taken by the registered medical practitioner (RMP) and made on the basis of a mental illness or disorder. An admission assessment was completed and all assessments were documented in the clinical file. There was evidence of the involvement of family members/carers in the admission process. The resident was admitted to the unit most appropriate to their needs.
The approved centre’s admission process was compliant under the following regulations associated with this 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. The clinical files of two residents who had been transferred to another health care facility were inspected. The decision to transfer was made by the RMP and documented, and it was agreed with the receiving facility in each case. Residents’ family members/carers/advocates were involved in the transfer process. The residents were assessed prior to the transfer, and an effort was made to respect the residents’ wishes and obtain consent.

In one of the clinical files inspected, there was no evidence of MDT involvement in the transfer. One clinical file did not contain a copy of the referral letter. Neither clinical file contained evidence that residents’ property was returned in accordance with the approved centre’s policy.

**Discharge:** Three clinical files was inspected in relation to discharge. The decision to discharge was made by the RMP, and a discharge plan was in place as part of each residents’ individual care plan. In one case, the discharge plan did not refer to early warning signs of relapse.

A discharge meeting attended by the resident, key worker, relevant members of the MDT, and family members/carers/advocates was documented in the clinical files. The residents were assessed prior to discharge, but assessments did not address information needs. In one of the files examined, there was inadequate MDT input into discharge planning.

In one of the files examined, the resident did not receive two days’ notice of the discharge.

Efforts were made to inform primary care/community mental health teams of the discharges within 24 hours. None of the files examined contained evidence that a preliminary discharge summary was issued within 3 days or that a comprehensive discharge summary followed within 14 days. Timely follow-up appointments were recorded in the clinical files.

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

a) The admission policy did not include protocols for
   - Urgent referrals, 4.4.
   - Individuals who self-present, 4.5.
   - Timely communication with primary care and community mental health teams, 4.9.

b) The admission policy did not indicate the roles and responsibilities of MDT staff in relation to post-admission assessment, 4.7.

c) The transfer policy did not include provisions for emergency transfer or transfer abroad, 4.13.


e) The discharge policy did not include a protocol for discharging people with intellectual disability, 4.16.

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

g) There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission and discharge policies, 4.19.

h) The approved centre was non-compliant with Regulation 32: Risk Management Procedures, 7.1.

i) The admission process was non-compliant because the approved centre did not comply with the following regulations associated with this code of practice: Regulation 15: Individual Care Plan, 17.1, and Regulation 27: Maintenance of Records, 22.6.
j) There was no evidence of MDT involvement in the transfer process in one of the clinical files examined, 29.1.

k) A copy of the referral letter was not retained in one of the clinical files inspected in relation to transfer, 31.2.

l) There was no evidence that residents’ property was returned in accordance with the approved centre’s transfer policy, 32.3.

m) One discharge plan did not reference early warning signs of relapse, 34.2.

n) In one file, there was no evidence that a discharge meeting took place, attended by the resident, key worker, relevant members of the MDT, and family/carer/advocate, 34.4/42.1.

o) Pre-discharge assessments did not include informational needs, 35.1.

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

q) There was no evidence that a comprehensive discharge summary was issued within 14 days, 38.3(b).

r) In one file examined, the resident did not receive two days’ notice of the discharge, 40.1.
Appendix 1 – Corrective and Preventative Action Plans

Regulation 13: Searches

Report reference: Page 30-31

<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>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring(^1) or New(^2) area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>1. The registered proprietor did not ensure that staff were aware of the policy and procedures on searches.</td>
<td>New</td>
<td>Corrective Action(s): All staff are now aware of the policy and procedures relating to searches. Post-Holder(s) responsible: Heads of Disciplines</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Awareness of policies and procedures relating to searches will continue to form part of staff Induction process and at staff meeting. Post-Holder(s) responsible: Heads of Disciplines</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td>2. There was no documented evidence that a minimum of two appropriately qualified staff were in attendance</td>
<td>New</td>
<td>Corrective Action(s): Staff are reminded to document that a minimum of two appropriately qualified staff are in attendance when a search is initiated. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
</tbody>
</table>

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\(^1\) Area of non-compliance reoccurring from 2016
\(^2\) Area of non-compliance new in 2017
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<tr>
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<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>
<td><strong>Provide the timeframe of the completion of the action(s)</strong></td>
</tr>
<tr>
<td>at all times when the search was being conducted.</td>
<td>Preventative Action(s): Awareness of policies and procedures relating to searches will continue to form part of staff Induction process and at staff meeting. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td>3. There was no documented evidence that the search was undertaken with due regard to the resident’s privacy and dignity.</td>
<td>New Corrective Action(s): Staff are reminded to document in the Health Care Record evidence that the search are undertaken with due regard to the resident’s privacy and dignity. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Awareness of policies and procedures relating to searches will continue to form part of the staff Induction process and at staff meeting. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td>4. There was no documented evidence that the resident was informed by those implementing the search of what was happening and why.</td>
<td>New Corrective Action(s): Staff are reminded to document in the Health Care Record evidence that a resident is informed by those implementing the search of what was happening and why. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Awareness of policies and procedures relating to searches will continue to form part of staff Induction process and at staff meeting. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
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<td>Area(s) of non-compliance</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>5. The reason for the search was not documented.</td>
<td>New</td>
<td>Corrective Action(s): A search log is in place in the Approved Centre. The reason for the search will be recorded in the HCR and in the search log. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td>6. There was no written record of every search conducted in the approved centre.</td>
<td></td>
<td>Preventative Action(s): Awareness of policies and procedures relating to searches will continue to form part of staff Induction process and at staff meeting. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed.</td>
<td>Achievable and Realistic</td>
</tr>
</tbody>
</table>
### Regulation 15: Individual Care Plan

*Report reference: Page 33-34*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<tr>
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<td><strong>Reoccurring or New area of non-compliance</strong></td>
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<tr>
<td>7. Not all ICPs were regularly reviewed with input from the MDT.</td>
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<tr>
<td>8. Nine of the ICPs inspected did not contain specific and appropriate goals for the residents.</td>
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<tr>
<td>9. One ICP did not identify the care and treatment required to meet the goals identified.</td>
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<tr>
<td>10. Three ICPs did not identify the resources required to provide the care and treatment identified.</td>
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</tbody>
</table>

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3 To ensure adherence to *Regulation 15: Individual Care Plan*, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.
### Regulation 19: General Health


<table>
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<tr>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>11. Two residents had not received a physical examination within the required six-month time frame.</td>
<td>New</td>
<td><strong>Corrective Action(s):</strong> All residents have now had a physical examination within the required six-month time frame. Post-Holder(s) responsible: Clinical Director</td>
<td>Documentation review</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Preventative Action(s):</strong>  A log for monitoring physical examination time frames is in place on both units. Post-Holder(s) responsible: Clinical Director/Clinical Nurse Manager</td>
<td>Documentation review</td>
<td>Achievable and Realistic</td>
</tr>
</tbody>
</table>
Regulation 21: Privacy
Report reference: Page 42-43

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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</tr>
<tr>
<td>12. The absence of appropriate screening on observation panels did not ensure that resident’s privacy was appropriately respected at all times.</td>
<td>Corrective Action(s): Appropriate screening on all observation panels is now in place to ensure that resident’s privacy is appropriately respected at all times. Post-Holder(s) responsible: Clinical Nurse Manager and Technical Services</td>
<td>Walk through review</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Defective screening will be reported to technical services for priority repair. Post-Holder(s) responsible: Clinical Nurse Manager and Technical Services</td>
<td>Walk through review</td>
<td>Achievable and Realistic</td>
<td>As required</td>
</tr>
<tr>
<td>13. The practice of residents sleeping on mattresses in sitting rooms did not ensure that resident’s dignity was appropriately respected at all times.</td>
<td>Corrective Action(s): The resident’s dignity is appropriately respected at all times. Post-Holder(s) responsible: Heads of Disciplines</td>
<td>Walk through review</td>
<td>Achievable and Realistic</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): The resident’s dignity is appropriately respected at all times. Regular delayed discharge meetings and weekly bed management meetings are scheduled to address overcapacity. Post-Holder(s) responsible: Heads of Disciplines</td>
<td>Walk through review</td>
<td>Achievable and Realistic</td>
<td>Ongoing</td>
</tr>
<tr>
<td>14. Noticeboards displayed identifiable resident information, which did not ensure that</td>
<td>Corrective Action(s): Blinds are fitted to noticeboards to ensure that resident’s privacy is appropriately respected at all times. Post-Holder(s) responsible: Technical Services</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
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</tr>
<tr>
<td>resident's privacy was appropriately respected at all times.</td>
<td>Preventative Action(s): Blinds are fitted to noticeboards to ensure that resident's privacy is appropriately respected at all times. Post-Holder(s) responsible: Technical Services</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
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</tbody>
</table>

Preventive Action(s): Blinds are fitted to noticeboards to ensure that resident's privacy is appropriately respected at all times. Post-Holder(s) responsible: Technical Services

Action is completed

Achievable and Realistic

Completed
### Regulation 22: Premises

Report reference: Page 44-45

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

15. The premises were not clean throughout or maintained in good structural and decorative condition.
16. There was no programme of routine decorative maintenance of the premises.
17. Ligatures had not been mitigated. Residents were sleeping in areas that were not suitable for use as bedrooms. A broken paper towel dispenser in the seclusion room bathroom was a potential hazard to residents. Therefore, the physical structure and overall approved centre environment were not developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents.

Reoccurring

To be monitored as per Condition 4

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4 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.
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

Report reference: Page 46-47

<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>18. In 11 of the MPARs inspected, the MCRN of every medical practitioner prescribing medication to the residents was not included.</td>
<td><strong>Reoccurring</strong></td>
<td>Corrective Action(s): The MCRN of every medical practitioner prescribing medication to residents is now recorded in all MPARs.. Post-Holder(s) responsible: Clinical Director</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): MPARs and need to record MCRN is included in induction programme for all new medical staff. Highlight to all staff the requirement to adhere to the Drug Administration Policy Post-Holder(s) responsible: Clinical Director</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td>19. Unsuitable practices in relation to the storage of medication requiring refrigeration were observed in Oak Ward.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Storage of medication requiring refrigeration are now in accordance to the Drug Administration Policy. Refrigeration temperature log is recorded daily. Post-Holder(s) responsible: Clinical Nurse Manager/Technical Services</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Daily recording of refrigeration temperature in Oak ward. Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Report reference: Page 50-51**

<table>
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<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>20. The numbers and skill mix of staff were not appropriate to the assessed needs of residents and the size and layout of the approved centre, as indicated by a shortage of nursing staff and an insufficient number of psychologists in the service.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Agreed nursing complement and skill mix is in place. Additional nursing resources are provided for 1:1 specials and where clinical indicated. Psychology vacancies remain as priority post for filling. Senior clinical psychologist is now based in DOP 2/3 days per week Post-Holder(s) responsible:Nurse Management/Psychology Manager.</td>
<td>QSEC minutes</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): As above Post-Holder(s) responsible: Nurse Management/Psychology Manager.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Not all staff had up-to-date mandatory training in fire safety, BLS, the management of aggression and violence, and the Mental Health Act 2001.</td>
<td><strong>Recurring</strong></td>
<td>Corrective Action(s):Staff of the approved centre are prioritised for for spring 2018 and autum 2018 mandatory training. Post-Holder(s) responsible: Heads of Discipline</td>
<td>Audit of staff training records</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Staff of the approved centre are prioritised for for spring 2018 and autum 2018 mandatory training. Post-Holder(s) responsible: Heads of Discipline</td>
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## Regulation 27: Maintenance of Records

*Report reference: Page 52-53*

<table>
<thead>
<tr>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>22. The approved centre did not have written policies and procedures relating to the creation of, access to and destruction of records.</strong></td>
<td>Corrective Action(s): This policy is referred to the CHOS policy group to include procedures relating to the creation of, access to and destruction of records are included. Post-Holder(s) responsible: CHOS Policy Group</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
<td>June 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): All policies will be updated on a three yearly basis or more frequently if required Post-Holder(s) responsible: CHOS Policy Group</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
<td>June 2018</td>
</tr>
<tr>
<td><strong>23. Not all of the records were in good order, with two of the clinical files inspected containing loose pages.</strong></td>
<td>Corrective Action(s): An additional administration post is in place to assist with the maintenance of records. All clinical files are maintained as per HSE policy. Post-Holder(s) responsible: Heads of Discipline Service Manager, Ward Clerk</td>
<td>Clinical file inspection</td>
<td>Achievable and realistic</td>
<td>June 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): An additional administration post is in place to assist with the maintenance of records. Staff are reminded of HSE policy Post-Holder(s) responsible: Heads of Discipline</td>
<td>Clinical file inspection</td>
<td>Achievable and realistic</td>
<td>June 2018</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Measureable</td>
<td>Achievable / Realistic</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>24. Records were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval:</td>
<td>Reoccuring</td>
<td>Corrective Action(s): An additional administration post is in place to assist with the maintenance of records. Staff are reminded of the requirement to adhere to Good Record Keeping Guidelines. Two appropriate resident identifiers are now recorded on all clinical files. All referrals are now identified using full name and title. Post-Holder(s) responsible. MDT, Heads of Department</td>
<td>Clinical file inspection</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>– Documentation was not always correctly filed, making it difficult to find information.</td>
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<tr>
<td>– Errors in records were crossed out and not signed or dated in two clinical files.</td>
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</tr>
<tr>
<td>– Two appropriate resident identifiers were not recorded on all documentation in three clinical files.</td>
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</tr>
<tr>
<td>– Where a referral was made to another health care professional, this individual was not always clearly identified using full name and title.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Preventative Action(s): An additional administration post is in place to assist with the maintenance of records. Post-Holder(s) responsible: MDT Heads of Department</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 28: Register of Residents

*Report reference: Page 54*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring 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>25. The register of residents was not up to date.</td>
<td>New</td>
<td>Corrective Action(s): An additional administration post is in place to assist with the maintenance of the register of residents. Post-Holder(s) responsible: Ward clerk</td>
<td>Inspection of the register of residents.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>26. The register of residents did not include all of the information specified in schedule 1. Specifically, diagnosis on admission and on discharge were not consistently recorded as there was a three-month delay in recording these.</td>
<td></td>
<td>Preventative Action(s): An additional administration post is in place to assist with the maintenance of the register of residents. Post-Holder(s) responsible: Ward clerk</td>
<td>Inspection of the register of residents.</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
Regulation 29: Operation Policies and Procedures

Report reference: Page 55

<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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<tr>
<td>Taken from the inspection report</td>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>27. Not all policies and procedures required by the regulations had been reviewed at least every three years, specifically those relating to Regulation 8: Residents’ Personal Property and Possessions, Regulation 12: Communication, Regulation 19: General Health, Regulation 20: Provision of Information to Residents, and Regulation 31: Complaints Procedures.</td>
<td>Corrective Action(s): Policies requiring review are referred to the CHOS Policy Group to ensure compliance with their review requirements. Post-Holder(s) responsible: CHOS Policy Group</td>
<td>Policy Review</td>
<td>Achievable</td>
<td>June 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Policies requiring review are referred to the CHOS Policy Group to ensure compliance with their review requirements. Post-Holder(s) responsible: CHOS Policy Group</td>
<td>Policy Review</td>
<td>Achievable</td>
<td>June 2018</td>
</tr>
</tbody>
</table>
### Regulation 30: Mental Health Tribunals

*Report reference: Page 56*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</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 the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>28. The clear glass panel in the door of the tribunal room prevented tribunal sittings from being held in private.</td>
<td>Corrective Action(s): Window screening is fitted to the door panels of the tribunal room. Post-Holder(s) responsible: Technical Services</td>
<td>Action is completed</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Window screening is fitted to the door panels of the tribunal room. Post-Holder(s) responsible: Technical Services</td>
<td>Action is completed</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
</tbody>
</table>
## Regulation 32: Risk Management Procedures (and Code of Practice: Notification of Deaths and Incident Reporting)

Report reference: Page 59-61 and 76

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tr>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>29.</strong> Risk assessment forms were not updated or reviewed in line with the approved centre’s risk management policy.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Risk assessment forms are now updated and reviewed in line with the approved centre’s risk management policy. Post-Holder(s) responsible: MDT Quality Patient Safety Group</td>
<td>Documentation review.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Risk assessment forms are now updated and reviewed in line with the approved centre’s risk management policy. Post-Holder(s) responsible: MDT + Quality Patient Safety Group</td>
<td>Documentation review.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td><strong>30.</strong> The policy did not specify the roles and responsibilities in relation to completing six-monthly incident summary reports.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): This policy is referred to the CHOS Policy Group to include the roles and responsibilities in relation to completing six-monthly incident summary reports. Post-Holder(s) responsible: Post-Holder(s) responsible: CHOS policy Group</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): This policy is referred to the CHOS Policy Group to ensure compliance with completing six-monthly incident summary reports. Post-Holder(s) responsible: CHOS policy Group</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>

### Regulation 34: Certificate of Registration
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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<tr>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>31. The current certificate was not displayed.</td>
<td>New</td>
<td>Corrective Action(s): The current certificate is now displayed in the approved centre Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): The current certificate is now displayed in the approved centre Post-Holder(s) responsible: Clinical Nurse Manager</td>
<td>Action is completed</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
## Section 59: The Use of Electro-Convulsive Therapy (and Code of Practice: Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

*Report reference: Page 65 and 79*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<tr>
<td>Taken from the inspection report</td>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
</tbody>
</table>

| 32. The policy in relation to the use of ECT had not been reviewed annually. | Reoccuring | Corrective Action(s): This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements. Post-Holder(s) responsible: CHOS Policy Group | Policy review | Achievable and realistic | June 2018 |

| 33. The policy in relation to the use of ECT for voluntary patients had not been reviewed annually. | Reoccuring | Preventative Action(s): This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements. Post-Holder(s) responsible: CHOS Policy Group | Policy review | Achievable and realistic | June 2018 |
### Section 69: The Use of Seclusion


<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>
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<td></td>
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</tr>
<tr>
<td><strong>Reoccurring or New area of non-compliance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>34.</strong> The policy in relation to seclusion had not been reviewed annually.</td>
<td>Corrective Action(s): This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements.</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
<td>June 2018</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: CHOS Policy Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>35.</strong> The policy did not address the requirements for training staff in the use of seclusion.</td>
<td>Preventative Action(s): This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements.</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
<td>June 2018</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: CHOS Policy Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>36.</strong> The broken paper towel dispenser did not ensure patient safety.</td>
<td>Corrective Action(s): The broken paper towel dispenser has been replaced</td>
<td>Action is completed</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Technical Services</td>
<td></td>
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</tr>
<tr>
<td><strong>37.</strong> One seclusion order was for a period of more than eight hours.</td>
<td>Corrective Action(s): All staff have been educated on the rules governing the use of seclusion</td>
<td>Action is Completed</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>38.</strong> One seclusion order did not include an end time.</td>
<td></td>
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</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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</tr>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>Preventative Action(s):</td>
<td></td>
<td>All staff have been educated on the rules governing the use of seclusion. Rules governing the use of seclusion are included in the induction programme for medical staff. Post-Holder(s) responsible: Clinical Nurse Manager Clinical Director</td>
<td>Action is Completed</td>
<td>Achievable and Realistic</td>
</tr>
</tbody>
</table>
## Code of Practice: The Use of Physical Restraint

*Report reference: Page 73-74*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring 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>39. The physical restraint policy had not been reviewed annually.</td>
<td>New</td>
<td>Corrective Action(s): This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements Post-Holder(s) responsible: CHOS Policy Group</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>Preventative Action(s): This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements Post-Holder(s) responsible: CHOS Policy Group</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>40. There was no record to indicate that all staff involved in the use of physical restraint had read and understood the policy.</td>
<td>New</td>
<td>Corrective Action(s): All staff have been reminded to record that they had read and understood the policy. Post-Holder(s) responsible: Clinical Nurse Manager Heads of Department</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td></td>
<td>New</td>
<td>Preventative Action(s): All staff have been reminded to record that they had read and understood the policy. Included in induction programme for new staff. Post-Holder(s) responsible: Clinical Nurse Manager. Heads of Department</td>
<td>Action is completed</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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</tr>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>41. In one episode of restraint, there was no documented evidence that gender sensitivity was demonstrated or that a same sex staff member was in attendance.</td>
<td>Corrective Action(s): <em>All staff have been educated on the policy relating to Physical Restraint and specifically in relation to:</em>  <em>Gender sensitivity, documenting that the Consultant Psychiatrist has to be notified of the use of restraint as soon as was practicable.</em>  <em>Document that the registered medical practitioner completed a medical examination of the resident within three hours of the start of the physical restraint.</em>  <em>Members of the MDT review the use of physical restraint within two working days.</em>  <em>Clinical practice forms are signed by the consultant psychiatrist within 24 hours.</em>  <em>Clinical practice forms are placed in the relevant clinical file.</em> Post-Holder(s) responsible: Clinical Nurse Manager. Clinical Director</td>
<td>Twice yearly audit</td>
<td>Achievable and realistic</td>
<td>July 2018</td>
</tr>
<tr>
<td>42. In one episode, it was not documented that the consultant psychiatrist was notified of the use of restraint as soon as was practicable.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>43. In one episode, it was not documented that the registered medical practitioner completed a medical examination of the resident within three hours of the start of the physical restraint.</td>
<td>New</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. In one episode, it was not documented that members of the MDT reviewed the use of physical restraint within two working days.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. Four separate clinical practice forms were not signed by the consultant psychiatrist within 24 hours.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Four separate clinical practice forms were not placed in the relevant clinical file.</td>
<td></td>
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</tr>
</tbody>
</table>

Preventative Action(s): As outlined above  Post-Holder(s) responsible: Clinical Nurse Manager. Clinical Director  Twice yearly audit | Achievable and realistic | December 2018? |
## Code of Practice: Admission of Children

**Report reference: Page 75**

<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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<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>47. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.</td>
<td>Corrective Action(s): Every effort is made to source age appropriate facilities and programmes of activities for all children requiring admission. Post-Holder(s) responsible: MDT</td>
<td>KPI’s and HSE monitoring process</td>
<td>Achievable and realistic</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Every effort is made to source age appropriate facilities and programmes of activities for all children requiring admission. Post-Holder(s) responsible: MDT</td>
<td>KPI’s and HSE monitoring process</td>
<td>Achievable and realistic</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
## Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

### Report reference: Page 77-78

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</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>

### 48. No staff had received education and training to support the principles and guidance in the code of practice.

- **Corrective Action(s):**
  - Staff are requested to complete the e-learning programme in relation to education and training to support the principles and guidance in the code of practice.
  - Post-Holder(s) responsible: Head of Discipline

- **Preventative Action(s):**
  - Staff are requested to complete the e-learning programme in relation to education and training to support the principles and guidance in the code of practice.
  - Post-Holder(s) responsible: Heads of Discipline

### 49. 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

- **Corrective Action(s):**
  - This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements
  - Post-Holder(s) responsible: CHOS Policy Group

- **Preventative Action(s):**
  - Staff training records

### Reoccurring

- **Policy review Group**

### Achievable and Realistic

- **Ongoing**

- **June 2018**
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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<td><strong>Measureable</strong></td>
<td><strong>Achievable / Realistic</strong></td>
<td><strong>Time-bound</strong></td>
</tr>
<tr>
<td>- Areas to be addressed in training</td>
<td>Preventative Action(s):</td>
<td>Policy review</td>
<td>Achievable and realistic</td>
<td>June 2018</td>
</tr>
<tr>
<td>- Frequency of training.</td>
<td>This policy is referred to the CHOS Policy Group to ensure compliance with their review requirements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Identification of appropriately qualified people to deliver training</td>
<td>Post-Holder(s) responsible: CHOS Policy Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Evaluation of training programmes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. The policy had not been reviewed within the required three-year time frame.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51. The resident assessment did not address communication difficulties or social, interpersonal, and physical environment-related issues.</td>
<td>Corrective Action(s):</td>
<td>Checked on admission</td>
<td>Achievable and realistic</td>
<td>Ongoing</td>
</tr>
<tr>
<td>52. The resident’s preferred ways of receiving and giving information had not been established.</td>
<td>Preventative Action(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Each service user with Intellectual Disability will have a communication passport completed whilst an inpatient in the approved centre.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: MDT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53. The clinical file did not contain documentation as to the resident’s understanding of information.</td>
<td>Corrective Action(s):</td>
<td>Checked on admission</td>
<td>Achievable and realistic</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>The clinical file will contain documentation as to the resident’s understanding of information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: MDT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
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<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>Preventative Action(s): The clinical file will contain documentation as to the resident’s understanding of information. Post-Holder(s) responsible: MDT</td>
<td>Checked on admission</td>
<td>Achievable and realistic</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>Corrective Action(s): The approved centre will endeavour to provide an environment that is least restrictive having due regarding to the individuals assessed needs and clinical risk factor. Post-Holder(s) responsible: MDT</td>
<td>Walk through inspection</td>
<td>Achievable and realistic</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Preventative Action(s): As above Post-Holder(s) responsible: MDT</td>
<td>Walk through inspection</td>
<td>Achievable and realistic</td>
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<td></td>
</tr>
</tbody>
</table>
## Code of Practice: Admission, Transfer and Discharge

**Report reference:** Page 81-82

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<td><strong>Reoccurring or New area of non-compliance</strong></td>
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<td><strong>Provide the timeframe of the completion of the action(s)</strong></td>
</tr>
</tbody>
</table>
| **55.** The admission policy did not include protocols for:  
- Urgent referrals  
- Individuals who self-present  
- Timely communication with primary care and community mental health teams. **Reoccurring (#55, #57, #58 and #59)** | Corrective Action(s): This policy is referred to the CH05 Policy Group to ensure compliance with the policy requirements.  
Post-Holder(s) responsible: Policy Review Group | Policy review Group | Acheivable and realistic | June 2018 |
| **56.** The admission policy did not indicate the roles and responsibilities of MDT staff in relation to post-admission assessment. | Preventative Action(s): This policy is referred to the CH05 Policy Group to ensure compliance with the policy requirements  
Post-Holder(s) responsible: Policy Review Group | Policy review | Acheivable and realistic | June 2018 |
| **57.** The transfer policy did not include provisions for emergency transfer or transfer abroad. **New** | Corrective Action(s): Staff have been advised to sign that they have read and understood the policies on admission, transfer, and discharge.  
Post-Holder(s) responsible: Heads of Discipline. | Documentation review | Achievable and realistic | Completed |
<p>| <strong>58.</strong> The post-discharge follow-up policy did not reference crisis management. | | | | |
| <strong>59.</strong> The discharge policy did not include a protocol for discharging people with intellectual disability. | | | | |
| <strong>60.</strong> There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge. | | | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Preventative Action(s):</strong></td>
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<td><strong>Corrective Action(s):</strong></td>
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<tr>
<td><strong>New</strong></td>
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<td>Preventative Action(s): Preventive Actio Staff have been advised to sign that they have read and understood the policies on admission, transfer, and discharge.</td>
<td>Documentation review</td>
<td>Achievable and Realistic</td>
<td>Completed</td>
</tr>
<tr>
<td><strong>New</strong></td>
<td>New</td>
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</tbody>
</table>

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

   Corrective Action(s):
   Preventative Action(s):
   New

   Post-Holder(s) responsible: Heads of Discipline

   - Preventative Action(s):
   - New

   Documentation of MDT involvement will take place in the transfer process of a service user where appropriate.

   Copies of referral letter will be retained in the health care record.

   There will be documentary evidence that residents’ property will be returned in accordance with the policies.

   Post-Holder(s) responsible: CPC

   Yearly Audit

   Achievable and Realistic

   December 2018

62. There was no evidence of MDT involvement in the transfer process in one of the clinical files examined.

63. A copy of the referral letter was not retained in one of the clinical files inspected in relation to transfer.

64. There was no evidence that residents’ property was returned in accordance with the policies.

   Post-Holder(s) responsible: CPC

   Yearly Audit

   Achievable and Realistic

   December 2018

   New

   New
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<td>with the approved centre’s transfer policy.</td>
<td>returned in accordance with the approved centre’s transfer policy.</td>
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<td></td>
<td>Post-Holder(s) responsible: MDT</td>
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<tr>
<td>Preventative Action(s):</td>
<td>Evidence of MDT involvement will take place in the transfer process of a service user</td>
<td>Documentation review</td>
<td>Achievable and Realistic</td>
<td>June 2018</td>
</tr>
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<td></td>
<td>Copies of referral letter will be retained in the health care record</td>
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<td></td>
<td>There will be documentary evidence that residents’ property will be returned in accordance with the approved centre’s transfer policy.</td>
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<tr>
<td><strong>65.</strong> One discharge plan did not reference early warning signs of relapse.</td>
<td>Corrective Action(s): All discharge plan now reference early warning signs of relapse. MDT meeting will take place and will be attended by the resident, key worker, relevant members of the MDT, and family/carer/advocate where possible Pre-discharge assessments will now include informational needs. MDT teams will strive to ensure that preliminary discharge summaries are sent to primary care/community mental health teams within three days. MDT teams will strive to ensure that a comprehensive discharge summary is issued within 14 days.</td>
<td>Post-Holder(s) responsible: MDT</td>
<td>Documentation review</td>
<td>Achievable and Realistic</td>
</tr>
<tr>
<td><strong>66.</strong> In one file, there was no evidence that a discharge meeting took place, attended by the resident, key worker, relevant members of the MDT, and family/carer/advocate.</td>
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<td><strong>67.</strong> Pre-discharge assessments did not include informational needs.</td>
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<td><strong>68.</strong> There was no evidence that preliminary discharge summaries were sent to primary care/community mental health teams within three days.</td>
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<td><strong>69.</strong> There was no evidence that a comprehensive discharge summary was issued within 14 days.</td>
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<tr>
<td><strong>70.</strong> In one file examined, the resident did not receive two days’ notice of the discharge.</td>
<td></td>
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</tbody>
</table>

**Reoccurring (#69 only)**

| Corrective Action(s): All discharge plan now reference early warning signs of relapse. MDT meeting will take place and will be attended by the resident, key worker, relevant members of the MDT, and family/carer/advocate where possible Pre-discharge assessments will now include informational needs. MDT teams will strive to ensure that preliminary discharge summaries are sent to primary care/community mental health teams within three days. MDT teams will strive to ensure that a comprehensive discharge summary is issued within 14 days. In the event of a resident not given two days notice reasons will be documented in the file. residents file. | **Preventative Action(s):** As above | Documentation review | **Achievable and Realistic** |