Sligo/Leitrim Mental Health In-patient Unit

ID Number: AC0014

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Sligo/Leitrim Mental Health In-patient Unit
Sligo/Leitrim Mental Health Services
Clarion Road
Ballytivnan
Sligo

Conditions Attached: Yes

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

Registered Proprietor: HSE

Most Recent Registration Date: 1 March 2017

Approved Centre Type:

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Noeleen Byrne
David McGuinness
Leon Donovan
Dr Susan Finnerty

Inspection Date: 26 – 29 September 2017

Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 28 – 30 June 2016

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

Date of Publication: 5 April 2018

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

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

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

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

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

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

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

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

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

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

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

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

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

### 2.0 Inspector of Mental Health Services – Summary of Findings

The following ratings are assigned to areas inspected. COMPLIANCE RATINGS are given for all areas inspected. QUALITY RATINGS are given for all regulations, except for 28, 33 and 34. RISK RATINGS are given for any area that is deemed non-compliant.
Inspector of Mental Health Services  
Dr Susan Finnerty

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

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

Safety in the approved centre

There was a written policy in place in relation to the health and safety of residents, staff, and visitors. The approved centre had a series of written policies available in relation to risk and incident management processes. Training in the identification, assessment, and management of risk was ongoing in the approved centre at the time of the inspection. All incidents in the approved centre were recorded and risk-rated, but there was no review incidents for any trends or patterns occurring in the services. There was no fire evacuation emergency plan in place in the approved centre.

Resident identifiers were checked when staff administered medications, undertook medical investigations and provided other health care services. Food safety audits were carried out regularly and there were proper facilities for the storage and serving of food. Hygiene was maintained to support food safety requirements. Anti-ligature works were in progress at the time of the inspection; however, numerous ligature points remained. There were discrepancies in prescribing and administering medication and quarterly audits had not been conducted on residents’ Medication Prescription and Administration Records. Not all health care professionals were trained in fire safety, Basic Life Support, the management of violence and aggression and the Mental Health Act 2001.

AREAS REFERRED TO
Regulations 4, 6, 22, 23, 24, 26, 32, Rule Governing the Use of Seclusion, Code of Practice on the Use of Physical Restraint, the Rule and Code of Practice on the Use of ECT, service user experience, and interviews with staff.

Appropriate care and treatment of residents

Individual care plans (ICP) were not audited on a quarterly basis to assess compliance with the regulation and there were a number of deficits in the ICPs observed on inspection: the ICP was not discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next-of-kin, as appropriate; the residents did not have access to their ICP and were not kept informed of any changes and were not offered a copy of their ICP; multidisciplinary teams (MDTs) were not involved in developing and reviewing ICPs; ICPs did not identify (a) appropriate goals for the residents, (b) care and treatment required to meet the goals identified and (c) responsibilities for implementing the care and treatment; the ICPs were not consistently updated following review as indicated by the residents’ changing needs, condition, circumstances, and goals.
The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. However, residents’ assessed needs were not documented in the residents’ individual care plans (ICPs), making it difficult to establish as to whether the therapeutic services and programmes were appropriate to meet the needs of residents.

Residents received general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. An evidence-based nutritional assessment tool, the Malnutrition Universal Screening Tool (MUST), was used for residents with special dietary needs.

The approved centre was compliant with Part 4 of the Mental Health Act 2001 Consent to Treatment. It was not compliant with the Rule Governing the Use of Seclusion.

Resident records were not developed and maintained to a logical sequence. There were pages on medical notes that did not contain any resident identifiers and records were not maintained appropriately, were not in good order, and contained loose pages. Records were appropriately secured throughout the approved centre.

**AREAS REFERRED TO**


**Respect for residents’ privacy and dignity**

Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs. Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions. However, as residents’ monies were kept in a safe in the administration building, they had no access to their own money at the weekend.

Residents’ consent was sought prior to any searches. Searches were implemented with due regard to residents’ dignity, privacy and gender, and residents were informed of what was happening during a search and why it was being carried out.

All bathrooms, showers, and toilets had locks on the inside of the door, and each of these locks had an override function. However, single bedrooms did not have locks. Rooms were not overlooked by public areas. Not all observation panels on doors of treatment rooms and bedrooms had blinds, curtains, or opaque glass. There was no privacy curtain or opaque glass in the clinical room.

The CCTV monitor in the high observation unit was facing out into a public area, making it possible for anybody passing along a public footpath to see the seclusion room on the monitor. Female residents, in order to enter the seclusion room of the high observation area, had to walk through the male ward.
Noticeboards detailed resident full names and were visible from outside the office areas. Blinds were in place to cover the noticeboards, however, they were not in use during the time of inspection.

**Responsiveness to residents’ needs**

The approved centre provided access to recreational activities but opportunities were not provided for indoor and outdoor exercise and physical activity. While there were some walking groups, there was no outdoor space around the approved centre for residents to engage in outdoor activity.

Residents’ rights to practice religion were facilitated within the approved centre and residents had access to multi-faith chaplains. Appropriate and reasonable visiting times were displayed and residents could meet their visitors in private. There was access to mail, fax, e-mail, internet and telephone.

Residents were provided with menus offering a variety of wholesome and nutritious food choices.

Residents were provided with an information handbook which included information on housekeeping arrangements. Information about diagnosis and medications, including potential side-effects, was provided to each resident. The approved centre adopted the HSE *Your Service Your Say* complaints policy and there was a robust complaints procedure in place.

The approved centre was adequately lit and heated, and areas of the approved centre had been freshly painted. The corridors and communal areas were clean and bright. There were no outdoor spaces apart from the smoking areas. The approved centre was not kept in a good state of repair externally and internally. While a cleaning schedule was implemented, the approved centre was not clean, hygienic, and free from offensive odours throughout. Rooms were not ventilated and residents could not control the heating in their own rooms. The windows were bolted shut to facilitate the removal of handles in relation to anti-ligature works. There was evidence of a programme of ongoing general maintenance in the approved centre.
Governance of the approved centre

The approved centre was part of the Community Healthcare Organisation (CHO) 1, which included Donegal, Sligo/Leitrim/West Cavan, and Cavan/Monaghan Mental Health Services and was governed by the Sligo Leitrim Mental Health Service area mental health management team. The clinical director chaired a monthly area management team meeting. Agenda items included maintenance of the approved centre, regulatory compliance and corrective actions, recruitment, finance, and operational matters. The Quality and Risk Group addressed risk management, complaints/compliments, and Corrective and Preventative Actions updates.

The clinical director and the occupational therapy manager visited the approved centre on a weekly basis and the area director of nursing and the principle psychologist visited at least once a fortnight. The team leader social work visits when required. Clear lines of responsibility were evident in all departments, with heads of discipline attending regular meetings with staff and departments providing supervision to their staff. All heads of discipline identified strategic goals for their staff and discussed potential operational risks with their departments, including difficulties in covering leave and future planning for the move to the new centre when it has been completed.

The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. All operating policies and procedures required by the regulations were reviewed within three years. An annual audit had been undertaken to determine compliance with review time frames.

AREAS REFERRED TO

Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.
The following quality initiatives were identified on this inspection:

1. Plans were progressing for the development of a new acute unit on the campus of the Sligo University Hospital.

2. The approved centre was currently being refurbished, i.e., painted, new curtains and furniture, and new windows.

3. Significant work had begun to mitigate ligature points within the approved centre.

4. The approved centre had begun training staff in cultural awareness and person-centred models of care.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was located on the Clarion Road, Ballytivnan, on the outskirts of Sligo town. The building dated from the 1930s and was situated on its own grounds, next to the former psychiatric hospital. Plans were progressing for the development of a new acute unit on the campus of Sligo University Hospital.

The approved centre was a two-story building; residents were accommodated on the ground floor with therapy rooms, a training room, and offices on the first floor. The unit was divided into female (14 beds) and male (14 beds), with a high-observation area off the male ward. The observation area had the capacity for four beds; however, only two were in use at the time of inspection. The approved centre was being refurbished, and significant work had begun to mitigate ligature points throughout the unit areas.

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>32</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>16</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>4</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>3</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 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

**Condition 2:** To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training 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 governed by the Sligo Leitrim Mental Health Service area mental health management team. It was part of the Community Healthcare Organisation (CHO) 1, which included Donegal, Sligo/Leitrim/West Cavan, and Cavan/Monaghan Mental Health Services. The clinical director chaired a monthly team meeting. Agenda items included maintenance of the approved centre, regulatory compliance and corrective actions, recruitment, finance, and operational matters. The minutes of monthly Quality and Risk Group meetings addressed risk management, complaints/compliments, and Corrective and Preventative Actions updates. Minutes of these meetings were available to the inspection team.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 28 – 30 June 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 13: Searches</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 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>Regulation 32: Risk Management Procedures</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 Relating to Admission of Children under the Mental Health Act 2001</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice - Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on 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 15: Individual Care Plan</td>
<td>✓</td>
<td>X</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>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</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 for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice - Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>X</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>✓</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

5.3 Areas of compliance rated Excellent on this inspection

No areas of compliance were rated excellent on this inspection.
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.

Six residents met with the inspection team and two residents completed the service user experience questionnaire. Residents were generally complimentary about the staff in the in-patient unit and they were very complimentary about the food in the approved centre. Three residents understood the purpose of their individual care plans and the multi-disciplinary team meetings. The residents felt that there were enough activities to choose from during the day; many enjoyed the art classes provided for the residents. When asked how often they felt safe in the approved centre, two residents responded via the service user experience questionnaire by saying “sometimes”. Two residents also stated that they never felt able to give feedback to staff or to make complaints when not satisfied with any part of their stay in the approved centre. Residents felt that their privacy and dignity was respected and that they could communicate freely with their family/friends/advocate.

The inspection team did not receive any feedback with regard to the Sligo/Leitrim Mental Health In-Patient Unit from the IAN.
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:

- Area Director of Nursing
- Clinical Director
- Occupational Therapy Manager
- Principle Psychologist
- Team Leader, Social Work

Heads of discipline from medical, nursing, and health and social care professionals provided an overview of the governance within their respective departments. The clinical director and the occupational therapy manager visited the approved centre on a weekly basis and the area director of nursing and the principle psychologist visited at least once a fortnight. The team leader, social work visits when required. Clear lines of responsibility were evident in all departments, with heads of discipline attending regular meetings with staff and departments providing supervision to their staff. All heads of discipline identified strategic goals for their staff and discussed potential operational risks with their departments, including difficulties in covering leave and future planning for the move to the new centre when it has been completed.
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:

- Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Team Leader, Social Work
- Support Services Supervisor
- Finance Compliance Staff Officer
- Clinical Nurse Manager 1
- Compliance, Quality and Patient Safety Officer
- Clinical Nurse Manager 3
- Consultant Psychiatrist
- Assistant Director of Nursing
- Acting Clinical Nurse Manager 1
- General Manager Mental Health Services and 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. Discussion followed with regard to the progression of the plans for the new acute unit on the campus of Sligo University Hospital. It was hoped that the building would be completed in 2019. The inspection team recognised and acknowledged the overall improvement since the last inspection, particularly with regard to the continued refurbishment of the current approved centre and the commencement of staff training concerning a person-centred culture of care.
EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

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

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

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Processes:</strong> The approved centre had a policy in place dated November 2016 on the identification of residents. The policy included all of the requirements of the <em>Judgement Support Framework</em>.</td>
</tr>
<tr>
<td><strong>Training and Education:</strong> 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 for identifying residents, as set out in the policy.</td>
</tr>
<tr>
<td><strong>Monitoring:</strong> The approved centre had undertaken an annual audit to ensure that there were appropriate resident identifiers on resident clinical files. Documented analysis had been completed to identify opportunities for improving resident identification processes.</td>
</tr>
<tr>
<td><strong>Evidence of Implementation:</strong> A minimum of two resident identifiers appropriate to the resident group profile were used. Residents wore identity wristbands, which detailed their name, date of birth, and hospital number. The identifiers, detailed in each resident’s clinical file, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.</td>
</tr>
<tr>
<td>The identifiers used were person-specific and were appropriate to the residents’ needs and communication abilities. There was an alert system in place to assist staff in distinguishing between residents of the same or a similar name.</td>
</tr>
<tr>
<td><strong>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 <em>Judgement Support Framework</em> under the training and education pillar.</strong></td>
</tr>
</tbody>
</table>
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 policy in place on food and nutrition, dated November 2016. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Menus were systematically reviewed to ensure that residents were provided with a variety of wholesome and nutritious food in line with their needs. Documented analysis was completed to improve the food and nutrition processes.

Evidence of Implementation: The approved centre’s menus had been approved by a dietitian to ensure nutritional adequacy in accordance with the residents’ dietary needs. Residents were provided with menus offering a variety of wholesome and nutritious food choices. Hot meals were served daily. Meals were attractively presented. Both hot and cold drinks were offered regularly to residents. Residents had adequate supplies of safe and fresh drinking water in easily accessible locations throughout the approved centre.

The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. An evidence-based nutritional assessment tool, the Malnutrition Universal Screening Tool (MUST), was used for residents with special dietary needs. Nutritional and dietary needs were assessed, where necessary, and addressed and documented 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 training and education pillar.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in place on food safety, dated February 2017. The policy included the requirements of the Judgement Support Framework, with the following exceptions:

- Food disposal controls.
- The process for adhering to the relevant food safety legislative requirements.
- The management of catering and food safety equipment.

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

Monitoring: Food temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored. Food safety audits were carried out based on the Judgement Support Framework (JSF). Documented analysis was completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was appropriate and sufficient catering equipment, crockery, and cutlery to meet the needs of residents in the approved centre. Food was cooked and prepared in St. John’s Hospital and transported to the approved centre. There were proper facilities for the storage and serving of food. Hygiene was maintained to support food safety requirements.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
### Regulation 7: Clothing

The registered proprietor shall ensure that:

1. when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
2. night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

#### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy, dated January 2017, in relation to residents’ clothing. The policy included all of the requirements of the *Judgement Support Framework*.

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

**Monitoring:** The availability of a supply of emergency clothing was monitored regularly. A record of residents wearing night clothes during the day was kept and monitored in both wards of the approved centre.

**Evidence of Implementation:** No resident was wearing night clothing during daytime hours over the course of the inspection. Residents were supported to keep and use their personal clothing, which was clean and appropriate to their needs. Residents had an adequate supply of individualised clothing. Residents were provided with emergency personal clothing that was appropriate to them and considered their preferences, dignity, bodily integrity, and religious and cultural practices.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Process: The approved centre had a written operational policy, dated May 2017, relating to residents’ personal property and possessions. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on residents’ personal property and possessions. Relevant staff interviewed were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis was not completed to identify opportunities to improve the processes for managing residents’ personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safe-keeping of the residents’ monies, valuables, personal property, and possessions, as necessary. The approved centre maintained a signed property checklist detailing each resident’s personal property and possessions. The property checklist was kept separate from the resident’s individual care plan (ICP). Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

The access to and use of resident monies was overseen by two members of staff and the resident or their representative. Where any money belonging to the resident was handled by staff, signed records of the staff issuing the money were retained. Where possible, this was countersigned by the resident or their representative. However, residents’ monies were kept in a safe in the administration building, they had no access to their own money at the weekend.

The approved centre was compliant with this regulation. The quality assessment was rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the staff training and education, and monitoring pillars.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy dated March 2017 in relation to the provision of recreational activities. The policy included requirements of the Judgement Support Framework with the exception of

- The facilities available for recreational activities, including the identification of suitable locations for recreational activities within and external to the approved centre.
- The process to support resident involvement in planning and reviewing recreational activities.

Training and Education: There was no documented evidence to indicate that relevant staff had read and understood the policy on recreational activities. Relevant staff interviewed could articulate the recreational activities processes, as set out in the policy.

Monitoring: There was a record of the occurrence of planned recreational activities, including a record of resident uptake and attendance. Documented analysis had been completed to identify opportunities to improve the processes relating to recreational activity.

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. Residents had opportunities to share their perspectives and contribute ideas to recreational activities development.

There was a timetable available, which detailed recreational activities. The activities available in the approved centre included yoga, baking, art, word wheel, books, walking groups, beauty therapy, mass, bingo, television, DVDs, and games. On the male ward, there was table tennis, a magnetic dart board, a regular newspaper, a current affairs discussion, and an exercise bike.

Individual risk assessments were not completed for residents, where deemed appropriate, in relation to the selection of appropriate activities. Opportunities were not provided for indoor and outdoor exercise and physical activity. While there were some walking groups, there was no outdoor space around the approved centre for residents to engage in outdoor activity. Despite it being an open unit where residents could go outside, the male ward was locked throughout the inspection.

Communal spaces were available throughout the approved centre, which were suitable for recreational activities. There was a games room and a television room. Attendance at recreational activities was documented in each resident’s clinical file.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and evidence of implementation pillars.
Regulation 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 policy in place dated November 2016 on the facilitation of religious practices. The policy included all the requirements of the Judgement Support Framework.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on religion. 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 implementation of the policy to support residents’ religious practices had been reviewed to ensure that it reflected the identified needs of the residents. This was documented.

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable, with facilities available to support their religious practices. Mass was celebrated every Sunday at 10am on the female admission area. Residents had access to multi-faith chaplains, including the names and numbers of the Methodist minister and a Church of Ireland minister. Residents were facilitated to observe or abstain from religious practice in accordance with their own free will.

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

(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 operational policy, dated August 2016, and protocols in place in relation to visits. The policy and protocols included the requirements of the Judgement Support Framework, with the exception of the availability of appropriate locations for resident visits and the required visitor identification methods.

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

Monitoring: There were no restrictions on residents’ rights to receive visitors at the time of the inspection. Documented analysis of the processes relating to visits had been completed.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed on the entrance to the wards and throughout other ward areas. Residents could meet their visitors in private, unless there was an identified risk to the resident or others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit, if accompanied by an adult and supervised at all times. The visiting rooms, spaces, and facilities available in the approved centre were suitable for visiting children.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillar.
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 policy in relation to resident communication, dated February 2017. This policy included requirements of the Judgement Support Framework, with the exception of

- The communication services and methods available to the resident.
- The assessment of resident communication needs.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy. Staff interviewed were able to articulate the processes for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions were monitored on an ongoing basis. Documented analysis had been completed to identify opportunities to improve the communication processes.

Evidence of Implementation: Individual risk assessments were completed for residents on admission and on an ongoing basis, as deemed appropriate, in relation to any risks associated with their external communication and documented in their individual care plans. No residents had their communications monitored by senior staff at the time of the inspection.

Residents had access to mail, fax, e-mail, Internet (where available), and telephone for the purposes of sending or receiving messages or goods unless otherwise risk assessed with due regard to the residents’ well-being, safety, and health. Residents had access to their own mobile phones. Access to the Internet was limited to supervised sessions when the occupational therapist was on duty on weekdays and weekends. There was a new room with four computers.

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 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: There was a written policy in place, dated January 2017, in relation to the searching of a resident, his or her belongings, and the environment in which he or she was accommodated. The policy included the complete requirements of the Judgement Support Framework, including:

- The management and application of all types of searches.
- The process for the finding of illicit substances during a search.
- The consent requirements of a resident regarding searches and the process for implementing searches in the absence of consent.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on searches. Relevant staff interviewed articulated the searching processes, as set out in the policy.

Monitoring: A log of searches was maintained and each search record was systematically reviewed to ensure the requirements of the regulation had been complied with. Documented analysis was completed to identify opportunities for improvement of the search processes.

Evidence of Implementation: The files of three current residents who had been searched for illicit substances were inspected. Risk had been assessed prior to the search, and resident consent was sought and documented. Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches was being conducted.

Searches were implemented with due regard to residents’ dignity, privacy and gender; at least one of the staff members conducting the search was the same gender as the resident being searched.
A written record of every search of a resident and every property search was available (i.e. a record of the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search). Policy requirements were implemented when illicit substances were found as a result of a search.

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy, dated November 2015, in relation to care of the dying. The policy 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 elsewhere (e.g. for general health care services).

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

Monitoring: End of life care provided to residents was systematically reviewed to ensure section 2 of the regulation was complied with. Systems analysis was undertaken in the event of a sudden or unexpected death in the approved centre. Analysis was not completed to identify opportunities to improve the processes for the care of the dying.

Evidence of Implementation: One resident had died suddenly within the approved centre since the last inspection. A second resident had died, but not suddenly. This resident received end of life palliative care and had been transferred to Sligo General Hospital in advance of their death. Representatives, family, next of kin and friends were involved, supported, and accommodated during the resident’s end of life care. Support was given to other residents and staff following both residents’ deaths, and the Mental Health Commission was notified within 48 hours of the deaths occurring.

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 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: There was a policy on individual care plans (ICPs) dated May 2015. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Individual care plans were not audited on a quarterly basis to assess compliance with the regulation. Documented analysis was completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: 16 resident ICPs were inspected. The ICP documentation was stored within each resident’s clinical file, was identifiable, uninterrupted, and not amalgamated with progress notes. A key worker was identified to ensure continuity in the implementation of the resident’s ICP. All key workers were nurses. The ICP included an individual risk management plan.

The following discrepancies were found on inspection:

- One resident admitted the day before the inspection had not received an initial assessment and did not have an initial care plan.
- The ICP was not discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next-of-kin, as appropriate.
- Three residents had not signed their ICPs and only one ICP stated why this was the case.
- MDTs were not involved in developing ICPs.
- The ICPs were not reviewed by the MDT in consultation with the resident. Instead, progress updates were addressed by the MDT.
- ICPs did not identify appropriate goals for the residents.
- The ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.
- The ICPs did not identify all of the multi-disciplinary resources required to provide the care and treatment identified. Nursing staff were predominantly identified as the resources and were assigned responsibility for goals.
- The ICPs were not consistently updated following review as indicated by the residents’ changing needs, condition, circumstances, and goals. The ICP of a resident on section 26 leave was not updated.
- The ICPs did not include a preliminary discharge plan, where deemed appropriate.

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH
• The resident did not have access to their ICP and was not kept informed of any changes. The residents were not offered a copy of their ICP, including any reviews.
• When a resident declined or refused a copy of their ICP, this was not recorded, including any given reason.

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

a) ICPs were not developed by the MDT.
b) ICPs were not reviewed by the MDT.
c) ICPs did not identify necessary resources.
d) ICPs did not specify appropriate goals for the resident.
e) The ICPs were not always discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next-of-kin, as appropriate.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to therapeutic services and programmes, dated April 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log to indicate that they had read and understood the policy on therapeutic services and programmes. Not all clinical staff were able to articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: There was no evidence of ongoing monitoring of the range of therapeutic services and programmes provided to ensure that they met the assessed needs of residents. Documented analysis was not completed to improve the processes relating to therapeutic services and programmes.

Evidence of Implementation: The therapeutic services and programmes provided by the approved centre were evidence-based and reflective of good practice guidelines. Residents’ assessed needs however were not documented in the residents’ individual care plans (ICPs) making it difficult to establish as to whether the therapeutic services and programmes were appropriate to meet the needs of residents.

All therapeutic programmes and services were provided by staff trained in accordance with their care delivery roles, and these programmes and services were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Adequate resources and facilities were available.

A list of therapeutic services and programmes provided within the approved centre was available to residents through a weekly schedule of activities, which was displayed on the unit. Therapeutic services and programmes were provided in a separate, dedicated consultation room.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. A record was maintained of participation, engagement, and outcomes achieved in therapeutic services or programmes within each resident’s clinical file but not within each residents ICP.

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

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

INSPECTION FINDINGS

As no child had been admitted to the approved centre since the last inspection, 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 operational policy in place, dated May 2017, and procedures in relation to the transfer of residents. The policy detailed all of the requirements of the Judgement Support Framework.

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

Monitoring: A log of transfers from the approved centre was maintained. Transfer records were systematically reviewed to ensure all relevant information was provided to the receiving facility. Analysis of transfers had been completed.

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre to receive treatment in a general hospital was inspected. Prior to transfer, the resident was assessed; this assessment included an individual risk assessment relating to the transfer and an assessment of the resident’s needs. This was documented and provided to the receiving facility.

Communications between the approved centre and the receiving facility were documented and followed up by a written referral. The resident’s consent to transfer was documented. Full and complete written information regarding the resident was transferred when the resident moved from the approved centre.

The clinical file recorded the documentation released to the receiving facility as part of the transfer, including the letter of referral, a list of current medications, the resident transfer form, and the required medication for the resident during the transfer process. The approved centre completed checks to ensure comprehensive resident records were transferred to the receiving facility.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
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 written operational policies and procedures for responding to medical emergencies and in relation to general health, dated January 2017. The policies included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff had signed a log to indicate that they had read the policies on the provision of general health services and for responding to medical emergencies. All clinical staff interviewed were able to articulate the processes for the provision of general health services and for responding to medical emergencies, as set out in the policies.

Monitoring: Resident take-up of national screening programmes was recorded and monitored, where applicable. Documented analysis was completed to identify opportunities to improve general health processes. A systematic review to ensure six-monthly reviews of general health needs was completed.

Evidence of Implementation: The approved centre had an emergency trolley, and staff had access at all times to an Automated External Defibrillator (AED). Staff checked the AED weekly. Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and when indicated by the residents’ specific needs, but not less than every six months. Adequate arrangements were in place for residents to access general health services and be referred to other health services, as required. Information and access was provided to residents on national screening programmes.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education pillar.
Regulation 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: There were written policies in place, dated April 2015 and May 2017, in relation to the provision of information to residents. The policies included requirements of the Judgement Support Framework, with the following exceptions:

- The information provided to residents on an ongoing basis.
- The process for identifying the residents’ preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.

Training and Education: Not all staff had signed a log to indicate that they had read and understood the policies on the provision of information to residents. Staff interviewed were able to articulate the processes for providing information to residents, as set out in the policies.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure the information was appropriate and accurate. Documented analysis was completed to identify opportunities to improve the processes for providing information to residents.

Evidence of Implementation: Residents were provided with an information handbook at admission, and this included information on housekeeping arrangements, including the process for managing personal property, mealtimes within the approved centre, the complaints procedure, visiting times and arrangements, and details of relevant advocacy and voluntary agencies. The handbook detailed some but not all of residents’ rights. Residents were provided with details of their multi-disciplinary team (MDT).

Diagnosis-specific information about medications, including potential side-effects, was provided to each resident. Medication information sheets, as well as verbal information, were provided to residents in a format that was suitable to the residents’ needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident.
Residents were provided with written and verbal information regarding their diagnosis unless their treating psychiatrist believed that the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and evidence of implementation pillars.
Regulation 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 policy dated January 2017 in relation to privacy. The policy included the requirements of the *Judgement Support Framework*, with the exception of the roles and responsibilities for the provision of resident privacy and dignity and the method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.

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

Monitoring: An annual review was undertaken to check that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis was completed to identify opportunities to improve the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Staff were observed to be respectful and courteous with residents throughout the inspection process. Staff and residents wore clothes which assured resident privacy and dignity. All bathrooms, showers, and toilets had locks on the inside of the door, and each of these locks had an override function. However, single bedrooms did not have locks on the inside of the door.

Rooms were not overlooked by public areas. Resident’s privacy was not assured as not all observation panels on doors of treatment rooms and bedrooms had blinds, curtains, or opaque glass. The observation panel in the door of one single room on the female ward was frosted but not enough to afford privacy to the resident. Some opaque stickers on the bedroom windows in the male ward had been peeled off with small holes appearing. The shower door in the high-observation area had an observation panel, and the sticker was peeling off. As a result, it was possible to see into the shower cubicle, which had no curtain.

There was no privacy curtain or opaque glass in the clinical room on the female ward, which was used for phlebotomy purposes, making it possible for residents to be seen during these procedures. The CCTV monitor in the high observation unit was facing out into a public area, making it possible for anybody passing to see the seclusion room on the monitor. For female residents to enter the seclusion room of the high observation area, they had to walk through the male ward. Noticeboards detailed resident full names and were visible from outside the office areas. Blinds were in place to cover the noticeboards however, they were not in use during the time of inspection. Residents were facilitated to make private phone calls. They had access to a cordless phone and could use meeting rooms to make private calls.

The approved centre was non-compliant with this regulation because residents’ privacy and dignity was not appropriately respected for the following reasons:

a) The observation panel in the door of one single room on the female ward was frosted but not enough to afford privacy to the resident, and sufficiently obscure residents. Some opaque stickers on the bedroom windows in the male ward had been peeled off with small holes appearing.

b) The shower cubicle in the high-observation area was not appropriately screened to ensure resident privacy. Single bedrooms did not have any locks.
c) For female residents to enter the seclusion room of the high observation area, they had to walk through the male ward.

d) There was no privacy curtain or opaque glass in the clinical room of the female ward, which was used for phlebotomy purposes, making it possible for residents to be seen during these procedures.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre did not have a policy in place in relation to the premises.

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

Monitoring: The approved centre had completed separate ligature and hygiene audits. Documented analysis was completed to identify opportunities to improve the premises.

Evidence of Implementation: The approved centre was adequately lit and heated. Areas of the approved centre had been freshly painted. The corridors and communal areas were clean and bright.

There was a sufficient number of toilets and shower facilities for residents in the approved centre. Suitable furnishings were provided to support resident independence and comfort. Rooms were not ventilated; the windows were bolted shut to facilitate the removal of handles in relation to anti-ligature works. Appropriate signage and sensory aids were not provided to support resident orientation needs. Signs on doors were not sufficiently noticeable. Sufficient spaces were not provided for residents to move about, including outdoor spaces. There were no outdoor spaces apart from the smoking areas. Despite it being an open unit, the male ward was locked on the first and second day of the inspection and the female ward was locked on the second day.

Anti-ligature works were in progress at the time of the inspection; however, numerous ligature points remained. The approved centre was not kept in a good state of repair externally and internally. The bathroom in the male ward was in poor condition. The doors had holes and veneers were peeled back. A number of areas were recently painted and there were plans to paint other sections of the approved centre.
While a cleaning schedule was implemented, the approved centre was not clean, hygienic, and free from offensive odours throughout. Some rooms lacked ventilation, and one single room in particular was malodorous due to the lack of ventilation. Residents could not control the heating in their own rooms. The approved centre did not have dedicated therapy/examination rooms, as appropriate. Back-up power was available in the approved centre.

Remote or isolated areas of the approved centre were not monitored. Rooms at the male corridor were remote and a long distance away from the nurses’ station. These rooms were adjacent to the high-observation unit. There was evidence of a programme of ongoing general maintenance in the approved centre.

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

a) The premises were not adequately ventilated, 22(1)(b).

b) There were no outdoor spaces apart from smoking shelters, 22(3)

c) The condition of the physical structure and the overall approved centre environment was not 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. Many areas required painting and decorative maintenance. There were numerous ligature points, 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 operational policy dated May 2017 on the ordering, prescribing, storing and administration of medicines. The policy detailed requirements of the Judgement Support Framework, with the exception of the process for medication reconciliation, and the process to review resident medication.

Training and Education: Not all nursing, medical, and pharmacy staff had signed a log to indicate that they had read and understood the policy on ordering, prescribing, storing, and administering medicines. Staff interviewed were able to articulate the processes relating to 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. Not all nursing, medical, and pharmacy staff, where applicable, had received training on the importance of reporting medication incidents, errors, or near misses and this was documented.

Monitoring: (MPARs). Incident reports were recorded for medication errors and near misses, which were then forwarded to the risk manager. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR, and 13 MPARs were inspected. The Medical Council Registration Number of the prescribing medical practitioner was recorded within each resident’s MPAR. All medication was stored in an appropriate and secure environment.

The following discrepancies were found on inspection:

- Two prescriptions were illegible, which increased the risk of medication errors.
- One resident’s MPAR had one resident identifier instead of two.
- Two MPARS recorded trade names for medication and not the generic name of the medication.
- One MPAR contained a blank administration record and not a record of all medications administered to the resident.
- One MPAR did not have a discontinuation date for each medication.

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

a) Two prescriptions were illegible, which increased the risk of medication errors.
b) One MPAR did not have two resident identifiers ensuring suitable and appropriate practices.
c) One MPAR contained a blank administration record and not a record of all medications administered to the resident.
d) One MPAR did not have a discontinuation date for each medication.
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: There was a written policy, dated August 2017, in place in relation to the health and safety of residents, staff, and visitors. There was also an associated safety statement. The policy and safety statement included requirements of the Judgement Support Framework, with the exception of vehicle controls and the allocation and documentation of safety representative roles.

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

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

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

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

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: There were policies and procedures in the approved centre on the use of CCTV. The CCTV policy was dated September 2015. The policies included the requirements of the Judgement Support Framework with the exception of the roles and responsibilities for the use of CCTV in the approved centre.

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

Monitoring: The quality of CCTV images was checked regularly to ensure they were operating appropriately, and this was documented. Analysis was completed to identify opportunities for the improvement of the use of CCTV.

Evidence of Implementation: There was clear signs in prominent positions, which conveyed where CCTV cameras were located throughout the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The Mental Health Commission had been informed about the approved centre’s use of CCTV. Cameras were incapable of recording or storing a resident’s image on a tape, disc, or hard drive or in any other format.

CCTV cameras used to observe a resident transmitted images to a monitor that could be seen by individuals other than the health professional responsible for the resident. The monitor in the high-observation area could be seen clearly from the footpath outside, which meant that members of the public could potentially observe a resident in seclusion.

The approved centre was non-compliant with this regulation because the CCTV monitor in the high-observation unit was visible to people not responsible for the welfare of a resident in seclusion, 25(1)(a).
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 dated August 2017 in relation to the recruitment, selection and vetting of staff. The policy included all of regulatory-based policy requirements and requirements of the Judgement Support Framework, with the exception of the following:

- The staff performance and evaluation requirements.
- The required qualifications of training personnel.

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

Monitoring: The implementation and effectiveness of staff training plans were not reviewed on an annual basis. The number and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis was completed to identify opportunities to improve staffing processes and to respond to the changing needs and circumstances of residents.

Evidence of Implementation: The approved centre had an organisational chart, which identified the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. A planned and actual staff rota, showing the staff on duty at any one time in the approved centre, was maintained. The number and skill mix of staffing was sufficient to meet resident needs.

Staff were recruited and selected in accordance with the approved centre’s policy and procedure for recruitment and appointment of staff. All staff, including permanent, contract, and volunteers, were vetted in accordance with HSE policies. Staff had appropriate qualifications to do their job. An appropriately qualified staff member was on duty and in charge at all times.

There was a written staffing plan for the approved centre, which addressed the level of acuity of psychiatric illness and the age profile of the residents.
Annual staff training plans were completed to identify staffs’ required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training was completed for all staff.

Training records were not available for all disciplines and not all health care professionals were trained in the following:

- Fire safety.
- Basic Life Support (BLS).
- The management of violence and aggression.
- The Mental Health Act 2001.

At least one staff member was trained in Children First. Training had been completed in the areas of infection control and recovery-centred approaches to mental health care and treatment. Training had not been completed in manual handling, dementia care or end of life care.

Opportunities were made available to staff for further education. Where available, in-service training was completed by trained and competent individuals. Facilities and equipment were available for staff in-service education.

The Mental Health Act 2001, the associated regulation (S.I. No 551 of 2006), and the Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were made available to staff throughout the approved centre through the online information portal.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Unit</td>
<td>CNM1/2</td>
<td>1</td>
<td>CNM3 0.5</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapists</td>
<td>2 across both units</td>
<td>0</td>
</tr>
<tr>
<td>Female Unit</td>
<td>CNM1/2</td>
<td>1</td>
<td>CNM1 0.5</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
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<td></td>
<td>HCA</td>
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</tr>
<tr>
<td></td>
<td>Occupational Therapists</td>
<td>2 across both units</td>
<td>0</td>
</tr>
</tbody>
</table>

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

The approved centre was non-compliant with this regulation because not all staff had received training in the management of violence and aggression, BLS, and fire safety, 26(4) and the Mental Health Act (2001), 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 operational policy dated February 2017 in relation to the maintenance of records. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Not all clinical staff and other relevant staff had signed a log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed could articulate the processes for the creation of, access to, retention of, and destruction of records, as set out in the policy. All clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. Analysis was completed to identify opportunities to improve the maintenance of records process.

Evidence of Implementation: Resident records were reflective of the residents’ current status and the care and treatment being provided. Records were not maintained through the use of an identifier that was unique to the resident, there were pages on medical notes that did not contain any resident identifiers. All records were physically stored together, where possible.

Resident records were not developed and maintained to a logical sequence. The records were not maintained appropriately, were not in good order, and contained loose pages. Entries were factual, consistent, and accurate but each entry did not record the date and time using the 24-hour clock. Hand-written records were legible and written in black ink. Correction tape was used on the register of residents.

Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was non-compliant with section 1 of this regulation for the following reasons:
  a) There were medical continuation pages without any resident identifiers.
  b) Resident records contained loose pages.
  c) Correction tape was used on the register of residents.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented and up-to-date register of residents. It was available to the Mental Health Commission on inspection. The register did not include all of the information specified in Schedule 1 to the Mental Health Act 2001, as follows:

- Residents’ next of kin were not documented in three instances.
- Residents’ diagnosis on admission was not documented in 12 instances.
- Residents’ diagnosis on discharge was not documented in 52 instances.

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

a) Residents’ next of kin were not documented in three instances.
b) Residents’ diagnosis on admission was not documented in 12 instances.
c) Residents’ diagnosis on discharge was not documented in 52 instances.
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 an up-to-date written policy and associated guidelines in relation to the development, management, and review of operating policies and procedures. The policy and guidelines, combined, included the requirements of the Judgement Support Framework with the exception of the standardised operating policy and procedure layout used by the approved centre.

Training and Education: Not all relevant staff had signed a log to indicate that they had read and understood the policy on developing and reviewing operating policies. Relevant staff were trained 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 been undertaken to determine compliance with review time frames. Analysis of operating policies and procedures was conducted to identify opportunities to improve the processes for developing and reviewing policies.

Evidence of Implementation: The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users, as appropriate. Operating policies and procedures were communicated to all relevant staff. All operating policies and procedures required by the regulations were reviewed within three years.

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 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 policy in place on Mental Health Tribunals, dated January 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

**Monitoring:** Documented analysis was completed to identify opportunities to improve the processes for facilitating Mental Health Tribunals.

**Evidence of Implementation:** The approved centre provided facilities and adequate resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend a tribunal, when necessary.

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

**COMPLIANT**

**Quality Rating**

**Satisfactory**
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 operational policy dated October 2015 relating to the making, handling and investigating of complaints. The approved centre also adopted the HSE’s Your Service, Your Say complaints policy. The process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre, was detailed in the policy. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: All relevant staff were trained in the complaints management process. Not all staff had signed a log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: An audit of the complaints log and related records was completed. Complaints data were analysed and discussed by senior management on a quarterly basis. Required actions were identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: The approved centre adopted the HSE’s Your Service, Your Say complaints policy. There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. Residents were provided with a resident information booklet at admission, which detailed the complaints policy.

The complaints procedure, including the process for contacting the nominated complaints person and the appeals process, was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. All complaints, including the outcomes of these complaints, were documented. The registered proprietor ensured that the quality of
the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made.

All complaints (that were not minor complaints) were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept separate 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 pillar.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies available in relation to risk and incident management processes. The policies included the requirements of the Judgement Support Framework and the policy-related regulatory requirements, with the exception of the following:

- The responsibilities of the registered proprietor and the multi-disciplinary team in relation to risk management and risk policy implementation in the approved centre.
- Capacity risks relating to the number of residents in the approved centre.
- The methods for controlling the following specified risks: assault and accidental injury to residents or staff.
- The process for learning from incidents.

Training and Education: Training in the identification, assessment, and management of risk was ongoing in the approved centre at the time of the inspection, and this training was documented. Clinical staff were trained in individual risk management processes. Management staff were not trained in organisational risk management. All staff were trained in incident reporting and documentation. Staff were trained in health and safety risk management. Not all staff had signed a log to indicate that they had read and understood the risk management policy. All staff interviewed were able to articulate the risk management processes, as set out in the policy.

Monitoring: All incidents in the approved centre were recorded and risk-rated. The risk register was audited to determine compliance with the approved centre’s risk management policy. There was no documented analysis of incident reports to identify opportunities for improvement of risk management processes.
Evidence of Implementation: Risk management responsibilities were allocated at management level and throughout the approved centre. The person with responsibility for risk was identified and known by all staff. Clinical risks and health and safety risks were identified, assessed, treated, reported, monitored, and were documented in the risk register as appropriate.

Structural risks, including ligature points, were not removed or effectively mitigated. Since the last inspection work had commenced to mitigate ligature points, but ligature points remained in areas of the approved centre. Multi-disciplinary teams were not involved in the development, implementation, and review of the individual risk management processes.

Residents and/or their representatives were not involved in the individual risk management processes. All clinical incidents were not reviewed by the multi-disciplinary team at their regular meeting. A record was not maintained of this review and recommended actions. The person with responsibility for risk management did not review incidents for any trends or patterns occurring in the services. There was no fire evacuation emergency plan in place in the approved centre.

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

a) The policies did not include the precautions in place to control for the following specified risks: assault and accidental injury to residents or staff, as required by the regulation, 32 (c).

b) The policy did not include the process for learning from incidents, 32 (d).

c) There was no fire evacuation emergency plan in place in the approved centre. 32 (e).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

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

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

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

Section 59

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

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

INSPECTION FINDINGS

Processes: An operational policy and procedures were in place in the approved centre on the use of Electro-Convulsive Therapy (ECT) for patients. All elements of the policy complied with the ECT rules. The policies were reviewed annually. The protocols in place included the following:

- How and where Dantrolene was stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hyperthermia.
- Obtaining consent for the maintenance and continuation of ECT.

Training and Education: All staff involved in ECT were trained in line with international best practice. All staff involved in ECT had appropriate training, including Basic Life Support.

As no patient in the approved centre was receiving ECT treatment at the time of the inspection, the approved centre was inspected under the two pillars of processes and training and education only.

The approved centre was compliant with this rule.
Section 69: The Use of Seclusion

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. There was a policy in place on the use of CCTV in the seclusion room. The policies addressed the requirements specified in the Rules Governing the Use of Seclusion. The seclusion policy detailed the areas to be addressed in training, including the Professional Management of Aggression and Violence, and the mandatory nature of training for those involved. It did not identify appropriate staff to give training or the required frequency of training.

Training and Education: Not all relevant staff had read and understood the policy. A record of attendance at training was maintained. Thirty-one staff had up-to-date training in the therapeutic management of aggression and violence.

Monitoring: There was a documented annual report on the use of seclusion in the approved centre.

Evidence of Implementation: There was one seclusion room in the approved centre, which was monitored using CCTV. Viewing of CCTV was not restricted to designated personnel. Resident privacy could potentially be compromised as the CCTV monitor could be viewed through the window, which overlooked a footpath used by members of the public, who could potentially view the seclusion room.

The seclusion room had been maintained and cleaned to ensure resident dignity and safety. Adequate toilet and washing facilities were available in the seclusion room. All furniture and fittings in the seclusion facility were of such a design and quality as not to endanger patient safety.

The clinical files of four residents who had been secluded were inspected. Seclusion had been used in rare and exceptional circumstances to ensure the safety of the resident and others. The use of seclusion was based on a thorough risk assessment and was initiated by a registered medical practitioner (RMP) or registered nurse. There was a documented record that the consultant psychiatrist was notified of the use of seclusion as soon as was practicable.
A staff nurse was assigned to continuously monitor each resident in seclusion. In two seclusion episodes there was no documented record of direct observation of each resident by the registered nurse for the first hour.

Resident notes were updated by the nurse every 15 minutes, and this included their level of distress and behaviour. Following risk assessment, a nursing review took place every two hours, with a minimum of two staff (with one registered nurse) entering the seclusion room. In one seclusion episode there was no documented evidence to show that a medical review took place within the required four-hour time frame.

In one case, the reason for ending seclusion was not recorded in the clinical file. Each resident had the opportunity to discuss the seclusion episode with members of the multi-disciplinary team (MDT).

All uses of seclusion were clearly recorded in the residents’ clinical files. A copy of the seclusion register was placed in the four clinical files and was available to the inspector. There were records to indicate that the next of kin had been informed as required.

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

a) The training policy did not identify appropriate staff to give training or the required frequency of training, 11.1(d).

b) Not all relevant staff had read and understood the policy, 10.2(b).

c) The CCTV monitor could be viewed through the window, which overlooked a footpath used by members of the public, who could potentially view the seclusion room, 12.2(a).

d) In two seclusion episodes, there was no documented record of direct observation of each resident by the registered nurse for the first hour, 5.1(a).

e) In one seclusion episode, there was no evidence that a medical review took place within the required four-hour time frame, 5.4.

f) In one seclusion episode, the reason for ending seclusion was not recorded in the clinical file, 3.6.
Section 69: The Use of Mechanical Restraint

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

INSPECTION FINDINGS

As mechanical restraint was not used in the approved centre, this rule was not applicable.
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 psychiatrists 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

At the time of the inspection, there was one involuntary patient in the approved centre for longer than three months. Their individual clinical file was inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. The clinical file evidenced the following:

- The responsible consultant psychiatrist had undertaken a capacity assessment, which was documented.
- There was a record of the patient’s consent that contained
  - A written record of the name of specific medications prescribed.
  - Confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s).
- Details were provided of discussions with the patient, including
  - The nature and purpose of the medication(s).
  - The effects of medication(s), including risks and benefits and views expressed by the patient.
  - Any supports provided to the patient in relation to the discussion and their decision-making.
The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
12.0 Inspection Findings – Codes of Practice

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

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

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

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: There was a written policy in place dated January 2017 in relation to the use of physical restraint. The policy was reviewed annually. There was a separate policy and procedures in relation to staff training on physical restraint. The policies included all of the guidance criteria of this code of practice.

Training and Education: There was no documented evidence to indicate that all staff involved in physical restraint had read and understood the policy. A record of attendance at training was not maintained. Physical restraint was not used to ameliorate staff shortages.

Monitoring: The approved centre forwarded the relevant annual report to the Mental Health Commission.

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. The approved centre complied with the code of practice on physical restraint across all episodes, with one exception: there was no documented evidence to show that a medical examination of the resident by a registered medical practitioner had taken place.

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

a) There was no documented evidence to indicate that all staff involved in physical restraint had read and understood the policy. A record of attendance at training was not maintained, 9.2(b) and 9.2(c).

b) There was no documented evidence to show that a medical examination of the resident by a registered medical practitioner had taken place, 5.4.
Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

**INSPECTION FINDINGS**

As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
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: There was a risk management policy and an end of life care policy which covered the notification of deaths and incident reporting to the Mental Health Commission (MHC). The policies included all of the items of the code of practice.

Monitoring: Deaths and incidents were not reviewed to identify and correct any problems and improve the quality of processes.

Evidence of Implementation: The approved centre was non-compliant with article 32 of the regulations. There was a national incident reporting system in place and a standardised incident report form was used and made available to inspectors. There had been two deaths in the approved centre since the last inspection, and the Mental Health Commission had been notified of both deaths. A six-monthly summary of all incidents was provided to the MHC.

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

a) The approved centre was non-compliant with article 32 of the regulations, 3.1.
b) Deaths and incidents were not reviewed to identify and correct any problems and improve the quality of processes, 6.1.
INSPECTION FINDINGS

Processes: There was a policy and protocols for staff working with people with intellectual disabilities. The policy reflected person-centred treatment planning and presumption of capacity. Least restrictive interventions were detailed in the policy. There was a separate policy and procedures for training of staff working with people with an intellectual disability, which included who should receive training. The training policy did not include the following:

- Induction training for new staff.
- Areas to be addressed in training.
- Frequency of training.
- The identification of appropriately qualified people to give training.
- Evaluation of training programmes.

Training and Education: The education and training provided supported the principles and guidance in the code of practice.

As no resident in the approved centre had been diagnosed with an intellectual disability at the time of the inspection, this code of practice was assessed under the two pillars of processes and training and education only.

The approved centre was non-compliant with this regulation because the training policy did not include induction training for new staff, areas to be addressed in training, frequency of training, the identification of appropriately qualified people to give training, and the evaluation of training programmes, 6.2.
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

### INSPECTION FINDINGS

**Processes:** An operational policy and procedures were in place in the approved centre on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. All elements of the policy complied with the code of practice. The policies were reviewed annually. The protocols in place included

- How and where Dantrolene was stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hyperthermia.
- Obtaining consent for the maintenance and continuation of ECT.

**Training and Education:** All staff involved in ECT were trained in line with international best practice. All staff involved in ECT had appropriate training, including Basic Life Support.

As there was no resident in the approved centre receiving ECT treatment at the time of the inspection, the approved centre was inspected under the two pillars of processes and training and education only.

The approved centre was compliant with this code of practice.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: There were written and up-to-date admission, transfer, and discharge policies in place. The policies included all of the items of the code of practice, with the exception of the following: The follow-up on discharge policy did not include reference to relapse prevention strategies or crisis management plans.

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

Monitoring: An audit was not undertaken to monitor the admission and discharge processes.

Evidence of Implementation:


The clinical files of two residents were inspected against in relation to the admission process. Each resident was assigned a key worker. The admission assessment was comprehensive in each case. All assessments and examinations were documented within both clinical files. A family member/carer/advocate was involved in the admission process (with the residents’ consent).

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical file of one resident was inspected. The registered medical practitioner had made the decision to transfer, the decision to transfer was agreed with the receiving facility, and an assessment, including a risk assessment, was completed. The resident’s family was informed and consent was obtained from them. A copy of the referral letter was retained in the resident’s clinical file.

Discharge: The clinical file of one resident who had been discharged was inspected. The decision to discharge was made by a registered medical practitioner. A discharge plan was not in place as a component of the resident’s individual care plan. The resident underwent a comprehensive assessment prior to being discharged.

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

a) The follow-up on discharge policy did not include reference to relapse prevention strategies or crisis management plans, 4.14.

b) An audit was not undertaken to monitor the admission and discharge processes, 4.19.

c) There was no documented evidence that all staff had read and understood the policies on admissions, transfer, and discharge, 9.1.

e) A discharge plan was not in place as a component of the resident’s individual care plan, 34.1.
### Appendix 1: Corrective and Preventative Action Plan Template – Sligo Leitrim Mental Health In-patient Unit

#### Regulation 15: Individual Care Plan

*Report reference: Page 32-33*

<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>Reoccurring¹ or New² 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. ICPs were not developed by the MDT.</td>
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<tr>
<td>2. ICPs were not reviewed by the MDT.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): ICP training for all Multi Disciplinary teams. Following Quality and Risk January 2018 all MDT reviews to be centred around ICP. Governance for audit results to be maintained by Quality. Risk Heads of Service to ensure compliance with policy HM61 for all their staff. Post-Holder(s) responsible: All MDT members Compliance, quality and patient safety (CQPS) Quality and Risk</td>
<td>3 monthly audits to be completed by MDT</td>
<td>Realistic and Achievable</td>
</tr>
<tr>
<td>Preventative Action(s): Regular training for MDT 3 monthly audits to be completed by MDT Post-Holder(s) responsible: All MDT members, CQPS</td>
<td></td>
<td>Compliance will be monitored via 3 monthly audits and non compliance will be managed through Quality and Risk</td>
<td>Achievable and Realistic</td>
<td>Training 9th of March and 15th of June. Feb 2018, May 2018, August 2018, November 2018</td>
</tr>
</tbody>
</table>

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>
<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>Reoccurring1 or New2 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>3. ICPs did not identify necessary resources.</td>
<td>Corrective Action(s):</td>
<td>3 monthly audits to be completed by MDT</td>
<td>Realistic and Achievable</td>
<td>Complete December 2017</td>
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<tr>
<td></td>
<td>ICP template amended December 2017 to reflect requirements to identify resources</td>
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<td></td>
<td>Post-Holder(s) responsible:</td>
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<td></td>
<td>Preventative Action(s):</td>
<td>3 monthly audits to be completed by MDT</td>
<td>Realistic and Achievable</td>
<td>Training 9th of March and 15th of June.</td>
</tr>
<tr>
<td></td>
<td>Regular training for MDT</td>
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<td>Feb 2018, May 2018, August 2018, November 2018</td>
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<td></td>
<td>3 monthly audits to be completed by MDT</td>
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<td></td>
<td>Post-Holder(s) responsible:</td>
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<td></td>
<td>All MDT members</td>
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<tr>
<td>4. ICPs did not specify appropriate goals for the resident.</td>
<td>Corrective Action(s):</td>
<td>3 monthly audits to be completed by MDT</td>
<td>Realistic and Achievable</td>
<td>Training 9th of March and 15th of June.</td>
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<td></td>
<td>ICP training for all Multi Disciplinary teams</td>
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<td>Monthly Q&amp;R meetings</td>
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<td></td>
<td>Governance for audit results to be maintained by Quality and Risk Heads of Service to ensure compliance with policy and regulation for all their staff</td>
<td></td>
<td></td>
<td>Feb 2018, May 2018, August 2018, November 2018</td>
</tr>
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<td></td>
<td>Post-Holder(s) responsible:</td>
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<td></td>
<td>MDT members, CQPS</td>
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<tr>
<td></td>
<td>Preventative Action(s):</td>
<td>3 monthly audits to be completed by MDT</td>
<td>Realistic and Achievable</td>
<td>Training 9th of March and 15th of June.</td>
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<tr>
<td></td>
<td>Regular training for MDT</td>
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<td></td>
<td>3 monthly audits to be completed by MDT</td>
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<td>Feb 2018, May 2018, August 2018, November 2018</td>
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<td></td>
<td>Post-Holder(s) responsible:</td>
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<tr>
<td></td>
<td>MDT members, CQPS</td>
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<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<tr>
<td>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>5. The ICPs were not always discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next-of-kin, as appropriate.</td>
<td>Corrective Action(s):  Regular training for MDT  Residents to be included in discussion, drawing up and participating in their ICP as per policy HM61.  Post-Holder(s) responsible:  MDT members</td>
<td>3 monthly audits to be completed by MDT</td>
<td>Realistic and Achievable</td>
<td>Training 9th of March and 15th of June.  31st March 2018</td>
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<td></td>
<td>Preventative Action(s):  Regular training for MDT  3 monthly audits to be completed by MDT  Post-Holder(s) responsible:  MDT members, CQPS</td>
<td>3 monthly audits to be completed by MDT</td>
<td>Realistic and Achievable</td>
<td>Training 9th of March and 15th of June.  Feb 2018, May 2018, August 2018, November 2018</td>
</tr>
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</table>
### Regulation 21: Privacy

**Report reference: Page 40-41**

<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>
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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>6. The observation panel in the door of one single room on the female ward was frosted but not enough to afford privacy to the resident, and sufficiently obscure residents. Some opaque stickers on the bedroom windows in the male ward had been peeled off with small holes appearing.</td>
<td>Corrective Action(s): Maintenance to replace frosted coverings immediately with frosted shatter proof glass panel. Post-Holder(s) responsible: Maintenance</td>
<td>Maintenance to meet with ward managers monthly to update maintenance schedule 6 monthly premises audit 6 monthly privacy audit</td>
<td>Achievable and Realistic</td>
<td>28/2/18</td>
</tr>
<tr>
<td>New</td>
<td>Preventative Action(s): Maintenance to meet with ward managers monthly to update maintenance schedule 6 monthly premises audit 6 monthly privacy audit Post-Holder(s) responsible: Maintenance Ward managers CQPS Quality and Risk Domestic Supervisor</td>
<td>Maintenance to meet with ward managers monthly to update maintenance schedule 6 monthly premises audit 6 monthly privacy audit</td>
<td>Achievable and Realistic</td>
<td>28/2/18</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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</tr>
<tr>
<td><strong>New</strong></td>
<td><strong>Corrective Action(s):</strong></td>
<td><strong>Preventative Action(s):</strong></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Screening for shower cubicle to be put in place</td>
<td>Maintenance to meet with ward managers monthly to update maintenance schedule</td>
<td>Achievable and Realistic</td>
<td>28/2/18</td>
</tr>
<tr>
<td></td>
<td>Locks to be placed on single bedrooms doors with an override feature</td>
<td>6 monthly premises audit</td>
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<tr>
<td></td>
<td>Post-Holder(s) responsible: Maintenance</td>
<td>6 monthly privacy audit</td>
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<td><strong>Achievable and Realistic</strong></td>
<td><strong>Achievable and Realistic</strong></td>
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<td><strong>28/2/18</strong></td>
<td><strong>28/2/18</strong></td>
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</tbody>
</table>

### 7. The shower cubicle in the high-observation area was not appropriately screened to ensure resident privacy. Single bedrooms did not have any locks.

**Corrective Action(s):**
- Screening for shower cubicle to be put in place
- Locks to be placed on single bedrooms doors with an override feature

**Post-Holder(s) responsible:** Maintenance

**Achievable and Realistic:**
- 28/2/18

### 8. For female residents to enter the seclusion room of the high observation area, they had to walk through the male ward.

**Corrective Action(s):**
- SLMHS to move to new build Q1 2020.
- Female ward staff to notify male unit prior to a transfer to seclusion to ensure male patients are not on corridor and privacy is maintained.

**Post-Holder(s) responsible:**
- AMHMT, Nursing staff

**Achievable and Realistic:**
- immediately

**Preventative Action(s):**
- Maintenance to meet with ward managers monthly to update maintenance schedule
- 6 monthly premises audit
- 6 monthly privacy audit

**Post-Holder(s) responsible:**
- AMHMT, Nursing staff

**Achievable and Realistic:**
- immediately
<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>Preventative Action(s): SLMHS to move to new build Q1 2020. Female ward staff to notify male unit prior to a transfer to seclusion to ensure male patients are not on corridor and privacy is maintained. Post-Holder(s) responsible: AMHMT, Nursing staff</td>
<td>6 monthly seclusion audits and 6 monthly privacy audits will monitor compliance with this.</td>
<td>Achievable and Realistic</td>
<td>immediately</td>
<td></td>
</tr>
<tr>
<td>9. There was no privacy curtain or opaque glass in the clinical room of the female ward, which was used for phlebotomy purposes, making it possible for residents to be seen during these procedures.</td>
<td>Corrective Action(s): Opaque glass to be put in place Post-Holder(s) responsible: Maintenance</td>
<td>Maintenace to meet with ward managers monthly to update maintenance schedule 6 monthly premises audit 6 monthly privacy audit</td>
<td>Achievable and Realistic</td>
<td>28/2/18</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Maintenace to meet with ward managers monthly to update maintenance schedule 6 monthly premises audit 6 monthly privacy audit Post-Holder(s) responsible: Maintenance Ward managers CQPS Quality and Risk, Domestic Supervisor</td>
<td>Maintenace to meet with ward managers monthly to update maintenance schedule 6 monthly premises audit 6 monthly privacy audit</td>
<td>Achievable and Realistic</td>
<td>28/2/18</td>
</tr>
</tbody>
</table>
## Regulation 22: Premises

Report reference: Page 42-43

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Reoccurring or New area of non-compliance</td>
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<tr>
<td>10. The premises were not adequately ventilated.</td>
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<tr>
<td>11. There were no outdoor spaces apart from smoking shelters.</td>
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<tr>
<td>12. The condition of the physical structure and the overall approved centre environment was not 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. Many areas required painting and decorative maintenance. There were numerous ligature points.</td>
<td>Reoccurring since 2015 (#12 presence of ligature points)</td>
<td>To be monitored as per Condition³</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

³ To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>13. Two prescriptions were illegible, which increased the risk of medication errors.</td>
<td>Corrective Action(s): Memo from ECD regarding prescribing requirements Memo for nurses regarding correct completion of administration record 3 monthly audits to be completed by prescribers and presented to Quality and Risk Post-Holder(s) responsible: Nurses Prescribers Quality and Risk</td>
<td>3 monthly audits to be completed by prescribers and presented to Quality and Risk</td>
<td>Achievable and Realistic</td>
<td>28/2/18 Audits: Feb 2018, May 2018, August 2018, November 2018</td>
</tr>
<tr>
<td>14. One MPAR did not have two resident identifiers ensuring suitable and appropriate practices.</td>
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<tr>
<td>15. One MPAR contained a blank administration record and not a record of all medications administered to the resident.</td>
<td>Preventative Action(s): 3 monthly audits to be completed by prescribers and presented to Quality and Risk Post-Holder(s) responsible: Prescribers Quality and Risk Nurses</td>
<td>3 monthly audits to be completed by prescribers and presented to Quality and Risk</td>
<td>Achievable and Realistic</td>
<td>28/2/18 Audits: Feb 2018, May 2018, August 2018, November 2018</td>
</tr>
<tr>
<td>16. One MPAR did not have a discontinuation date for each medication.</td>
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</tbody>
</table>

Report reference: Page 44
### Regulation 25: The Use of Closed Circuit Television

**Report reference: Page 46**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
</tbody>
</table>

#### 17. The CCTV monitor in the high-observation unit was visible to people not responsible for the welfare of a resident in seclusion.

**Corrective Action(s):**
- Frosted glass to be put on window to ensure privacy
- Post-Holder(s) responsible: Maintenance

**Preventative Action(s):**
- Frosted glass to be put on window to ensure privacy
- Post-Holder(s) responsible: Maintenance

**Measureable:**
- 6 monthly audit to ensure compliance with regulation 25

**Achievable / Realistic:**
- Achievable and Realistic

**Time-bound:**
- Immediate and complete
### Regulation 26: Staffing

*Report reference: Page 47-48*

<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>
</thead>
<tbody>
<tr>
<td>18. Not all staff had received training in the management of violence and aggression, BLS, and fire safety and the Mental Health Act (2001).</td>
<td>Reoccurring</td>
<td>To be monitored as per Condition⁴</td>
<td></td>
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</tr>
</tbody>
</table>

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⁴ To ensure adherence to *Regulation 26(4): Staffing*, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.
### Regulation 27: Maintenance of Records

**Report reference: Page 49**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td>19. There were medical continuation pages without any resident identifiers.</td>
<td>Reoccurring (#19-#20)</td>
<td>Corrective Action(s): All members of MDT to complete maintenance of records training on hseland.ie. This will be monitored by heads of service and governed by Quality and Risk</td>
<td>6 monthly maintenance of records audit to be completed by MDT</td>
<td>Realistic and Achievable</td>
</tr>
<tr>
<td>20. Resident records contained loose pages.</td>
<td></td>
<td>6 monthly maintenance of records audit to be completed by MDT</td>
<td></td>
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<tr>
<td>21. Correction tape was used on the register of residents.</td>
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</tbody>
</table>

#### Preventative Action(s):

- **Corrective Action(s):**
  - All members of MDT to complete maintenance of records training on hseland.ie. This will be monitored by heads of service and governed by Quality and Risk.
  - 6 monthly maintenance of records audit to be completed by MDT.

- **Preventative Action(s):**
  - 6 monthly maintenance of records audit to be completed by MDT.

**Post-Holder(s) responsible:**

- All MDT members
- CQPS
- Quality and Risk

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### Regulation 28: Register of Residents

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<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
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<th>Achievable / Realistic</th>
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<tbody>
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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>22. Residents’ next of kin were not documented in three instances.</td>
<td>Corrective Action(s):</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>23. Residents’ diagnosis on admission was not documented in 12 instances.</td>
<td>Memo re correct procedure for maintaining register of residents to be</td>
<td></td>
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<tr>
<td>24. Residents’ diagnosis on discharge was not documented in 52 instances.</td>
<td>sent to relevant staff</td>
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<td></td>
<td>Post-Holder(s) responsible: Quality and Risk</td>
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<td></td>
<td>Preventative Action(s):</td>
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<td></td>
<td>6 monthly audit of register of residents</td>
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<td></td>
<td>Post-Holder(s) responsible: ADON</td>
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</table>

February 28th 2018

February 2018, August 2018
Regulation 32: Risk Management Procedures

Report reference: Page 55-56

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

25. The policies did not include the precautions in place to control for the following specified risks: assault and accidental injury to residents or staff, as required by the regulation.

Corrective Action(s):
Risk Management Policy HM52 and HM 7 to be amended to include all requirements of the JSF
Post-Holder(s) responsible: PPG

Preventative Action(s):
Annual review of policy to ensure it meets all requirements of the JSF
Post-Holder(s) responsible: CQPS

Achievable and Realistic
28/2/18 (HM52)
31/3/18 (HM7)

26. The policy did not include the process for learning from incidents.

Preventative Action(s):
Annual review of policy to ensure it meets all requirements of the JSF
Post-Holder(s) responsible: CQPS

Achievable and Realistic
June 2018

27. There was no fire evacuation emergency plan in place in the approved centre.

Preventative Action(s):
Annual review of policy to ensure it meets all requirements of the JSF
Post-Holder(s) responsible: CQPS

Achievable and Realistic
June 2018
## Section 69: The Use of Seclusion


<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>28. The training policy did not identify appropriate staff to give training or the required frequency of training.</td>
<td><strong>Corrective Action(s):</strong> Policy HM4 to be amended to include all requirements of the JSF  Post-Holder(s) responsible: PPG  Preventative Action(s): Annual review of policy to ensure it meets all requirements of the JSF  Post-Holder(s) responsible: CQPS</td>
<td>Annual review of policy to ensure it meets all requirements of the JSF</td>
<td>Achievable and Realistic</td>
<td>31/3/18</td>
</tr>
<tr>
<td>29. Not all relevant staff had read and understood the policy.</td>
<td><strong>Corrective Action(s):</strong> Memo to all staff reminding of importance of reading and signing to say they have read the policy  Post-Holder(s) responsible: Quality and Risk  Preventative Action(s): 6 monthly audit to ensure SLMHS practise for seclusion is compliant with the Rules for Seclusion as per MHC</td>
<td>6 monthly audit to ensure SLMHS practise for seclusion is compliant with the Rules for Seclusion as per MHC</td>
<td>Achievable and Realistic</td>
<td>31/3/18</td>
</tr>
<tr>
<td>30. The CCTV monitor could be viewed through the window, which overlooked a footpath used by</td>
<td><strong>Corrective Action(s):</strong> Frosted glass to be put on window to ensure privacy  Post-Holder(s) responsible: Maintenance</td>
<td>6 monthly audit to ensure compliance with the Rules for Seclusion</td>
<td>Achievable and Realistic</td>
<td>Immediate and complete  March 2018, September 2018,</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>members of the public, who could potentially view the seclusion room.</td>
<td>Preventative Action(s): Frosted glass to be put on window to ensure privacy Post-Holder(s) responsible: Maintenance</td>
<td>6 monthly audit to ensure compliance with Rules for Seclusion</td>
<td>Achievable and Realistic</td>
<td>Immediate and complete March 2018, September 2018,</td>
</tr>
<tr>
<td>31. In two seclusion episodes, there was no documented record of direct observation of each resident by the registered nurse for the first hour.</td>
<td>Corrective Action(s): Memo to nurses reminding them of requirement to ensure the first hour of direct observation is recorded Post-Holder(s) responsible: Quality and Risk Preventative Action(s): Regular seclusion audits to ensure compliance with the Rules for Seclusion Post-Holder(s) responsible: MHA administrator</td>
<td>6 monthly seclusion audits to ensure compliance with the Rules for Seclusion</td>
<td>Achievable and Realistic</td>
<td>March 2018, September 2018, Memo:28/2/18</td>
</tr>
<tr>
<td>32. In one seclusion episode, there was no evidence that a medical review took place within the required four-hour time frame.</td>
<td>Corrective Action(s): Memo from ECD reminding all medical staff of need to complete medical review within 4 hours Post-Holder(s) responsible: ECD Preventative Action(s): Regular seclusion audits to ensure compliance with the Rules for Seclusion Post-Holder(s) responsible: MHA administrator</td>
<td>Regular seclusion audits to ensure compliance with the Rules for Seclusion</td>
<td>Achievable and Realistic</td>
<td>Memo:February 2018 March 2018, September 2018,</td>
</tr>
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<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
</tbody>
</table>
| **33.** In one seclusion episode, the reason for ending seclusion was not recorded in the clinical file. | New                                                                       | Corrective Action(s):  
Memo to nursing and medical staff reminding staff of the requirement to document reason for ending seclusion  
Post-Holder(s) responsible: Quality and Risk | Regular seclusion audits to ensure compliance with the Rules for Seclusion | Achievable and Realistic  
Memo: February 2018  
March 2018, September 2018, |
|                                                                                         | Preventative Action(s):  
Regular seclusion audits to ensure compliance with the Rules for Seclusion  
Post-Holder(s) responsible: MHA Administrator | Regular seclusion audits to ensure compliance with the Rules for Seclusion | Achievable and Realistic  
March 2018, September 2018, | |
### Code of Practice: Use of Physical Restraint

Report reference: Page 68

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
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<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td><strong>34.</strong> There was no documented evidence to indicate that all staff involved in physical restraint had read and understood the policy. A record of attendance at training was not maintained.</td>
<td><strong>New</strong> Corrective Action(s): Record of attendance at training to be maintained and monitored by each Head of Service Memo to all staff regarding the requirement of reading and understanding the policy Post-Holder(s) responsible: Quality and Risk All staff, Heads of service</td>
<td>Heads of service to maintain record of staff attendance at training and that staff have read and understood the policy</td>
<td>Realistic and Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td>Preventative Action(s): Heads of service to maintain record of staff attendance at training and that staff have read and understood the policy Post-Holder(s) responsible: Heads of service</td>
<td></td>
<td>Heads of service to maintain record of staff attendance at training and that staff have read and understood the policy</td>
<td>Realistic and Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>35.</strong> There was no documented evidence to show that a medical examination of the resident by a registered</td>
<td><strong>New</strong> Corrective Action(s): ECD to send memo to all staff regarding the requirement to ensure medical examination is complete Post-Holder(s) responsible: ECD</td>
<td>Regular physical restraint audits to ensure compliance with Code of Practise for Physical Restraint</td>
<td>Realistic and Achievable</td>
<td>28/2/18</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
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<tr>
<td>medical practitioner had taken place.</td>
<td>Preventative Action(s): Regular physical restraint audits to ensure compliance with Code of Practise for Physical Restraint Post-Holder(s) responsible: MHA administrator</td>
<td>Regular physical restraint audits to ensure compliance with Code of Practise for Physical Restraint</td>
<td>Realistic and Achievable</td>
<td>January 2018, June 2018, Dec 2018</td>
</tr>
</tbody>
</table>
36. Deaths and incidents were not reviewed to identify and correct any problems and improve the quality of processes.

**New**

**Corrective Action(s):**
- Monthly report from NIMs regarding deaths and incidents to be presented at Quality and Risk for review
- Post-Holder(s) responsible: Business Manager, CQPS

**Preventative Action(s):**
- Monthly report from NIMs regarding deaths and incidents to be presented at Quality and Risk for review
- Post-Holder(s) responsible: Business Manager, CQPS

**Measureable:**
- Monthly report from NIMs regarding deaths and incidents to be presented at Quality and Risk for review

**Achievable / Realistic:**
- Realistic and Achievable

**Time-bound:**
- 31/3/18
### Area(s) of non-compliance

<table>
<thead>
<tr>
<th>Taken from the inspection report</th>
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</thead>
<tbody>
<tr>
<td>37. The training policy did not include induction training for new staff, areas to be addressed in training, frequency of training, the identification of appropriately qualified people to give training, and the evaluation of training programmes.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): Policy on Guidance for persons working in Mental Health Services with people with Intellectual Disabilities in SLMHS to be amended to include all requirements of the JSF as outlined in the Code of Practise: Guidance for people working in mental health services with people with intellectual disabilities</td>
<td>6 monthly audit to ensure compliance with the code of practise</td>
<td>Realistic and Achievable</td>
<td>28/4/18</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): 6 monthly audit to ensure compliance with the code of practise</td>
<td>Post-Holder(s) responsible: CQPS</td>
<td>Post-Holder(s) responsible: PPG</td>
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</tr>
</tbody>
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**Preventative Action(s):**
- 6 monthly audit to ensure compliance with the code of practise
- Realistic and Achievable
- March 2018, September 2018
# Code of Practice: Admission, Transfer and Discharge

**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>
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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>
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<td>38. The follow-up on discharge policy did not include reference to relapse prevention strategies or crisis management plans.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Policy HM2 to be amended to include all requirements of the JSF as outlined in the Code of Practise: Admission, transfer, discharge</td>
<td>6 monthly audit of admission, transfer, discharge practises to ensure SLMHS is in compliance with the code of practice.</td>
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<td>Preventative Action(s): 6 monthly audit of admission, transfer, discharge practises to ensure SLMHS is in compliance with the code of practice.</td>
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<td>Realistic and Achievable</td>
</tr>
<tr>
<td>39. An audit was not undertaken to monitor the admission and discharge processes.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): 6 monthly audit of admission, transfer, discharge practises to ensure SLMHS is in compliance with the code of practice.</td>
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<tr>
<td><strong>40.</strong> There was no documented evidence that all staff had read and understood the policies on admissions, transfer, and discharge.</td>
<td><strong>New</strong> Corrective Action(s): Memo to all staff regarding the requirement of reading and understanding the policy Post-Holder(s) responsible: Quality and Risk</td>
<td>6 monthly audit of admission, transfer, discharge practises to ensure SLMHS is in compliance with the code of practice.</td>
<td>Realistic and Achievable</td>
<td>January 2018, June 2018</td>
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<td>6 monthly audit of admission, transfer, discharge practises to ensure SLMHS is in compliance with the code of practice.</td>
<td>Realistic and Achievable</td>
<td>Completed Dec 2017 January 2018, June 2018</td>
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<tr>
<td><strong>41.</strong> A discharge plan was not in place as a component of the resident’s individual care plan.</td>
<td>Corrective Action(s): ICP template to be amended to include requirement for discharge planning Post-Holder(s) responsible: PPG</td>
<td>6 monthly audit of admission, transfer, discharge practises to ensure SLMHS is in compliance with the code of practice.</td>
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