Admission Unit & St. Edna's Unit, St. Loman's Hospital

ID Number: AC0006

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Admission Unit & St. Edna's Unit
St. Loman's Hospital
Delvin Road
Mullingar
Co. Westmeath

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care/ Long Stay

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Dervila Eyres, General Manager, CHO 8

Inspection Team:
Siobhán Dinan, Lead Inspector
Dr Ann Marie Murray
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The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
7 – 10 November 2017

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
15 – 18 November 2016

Date of Publication:
5 April 2018

2017 COMPLIANCE RATINGS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

REGULATIONS

Non-compliant

Compliant

NOT APPLICABLE

CODES OF PRACTICE

Not applicable

Compliant

Non-compliant
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

Chart 2 – Comparison of overall risk ratings 2015 – 2017
## Contents

1.0 Introduction to the Inspection Process ................................................................. 5  
2.0 Inspector of Mental Health Services – Summary of Findings .................................. 7  
3.0 Quality Initiatives ..................................................................................................... 11  
4.0 Overview of the Approved Centre ........................................................................... 12  
   4.1 Description of approved centre .............................................................................. 12  
   4.2 Conditions to registration ...................................................................................... 12  
   4.3 Reporting on the National Clinical Guidelines ......................................................... 12  
   4.4 Governance ............................................................................................................ 13  
5.0 Compliance .............................................................................................................. 14  
   5.1 Non-compliant areas from 2016 inspection ............................................................ 14  
   5.2 Non-compliant areas on this inspection .................................................................. 15  
   5.3 Areas of compliance rated Excellent on this inspection ......................................... 15  
6.0 Service-user Experience ........................................................................................... 16  
7.0 Interviews with Heads of Discipline ....................................................................... 17  
8.0 Feedback Meeting ..................................................................................................... 18  
9.0 Inspection Findings – Regulations .......................................................................... 19  
10.0 Inspection Findings – Rules .................................................................................... 63  
11.0 Inspection Findings – Mental Health Act 2001 ....................................................... 68  
12.0 Inspection Findings – Codes of Practice ............................................................... 71  
Appendix 1 – Corrective and Preventative Action Plan ................................................ 80
1.0 Introduction to the Inspection Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspector of Mental Health Services  
Dr Susan Finnerty

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

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

Safety in the approved centre

The approved centre had a written policy in relation to health and safety and in relation to risk and incident management. Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. The risk register was audited at least quarterly. Responsibilities were allocated at management level to ensure the effective implementation of risk management. The approved centre completed risk assessments for all residents to identify individual risk factors.

Two person-specific identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. Catering areas and associated equipment were appropriately cleaned but food safety audits were not completed periodically. The approved centre had not completed a hygiene audit. Clinical waste bins were stored out in the open space on the Admission Unit. Current national infection control guidelines were not followed.

Ligatures had not been minimised, and a number of ligature points were observed in both units, some of which had not been identified in the most recent ligature audit. Refrigerated medication was not appropriately stored. However, ordering, prescribing and administration of medication was carried out in a safe manner.

The numbers and skill mix of staff were not sufficient to address the assessed needs of residents at the time of inspection. Although efforts had been made, not all health care professionals had up-to-date mandatory training in fire safety, Basic Life Support, the management of aggression and violence, and the Mental Health Act 2001.

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

Appropriate care and treatment of residents

All residents had an individual care plan (ICP) but some ICPs did not meet the requirements of the regulation. The range of therapeutic services and programmes available in the approved centre was not appropriate to the assessed needs of residents, as documented in their individual care plans. Not all residents had access
to a social worker and further occupational therapy resources were required to meet the identified needs of the residents. Nursing groups were timetabled in the Admission Unit but often did not take place due to staff shortages. The rationale, design and evaluation of the group therapeutic programmes were not always evidence-based and directed.

A registered medical practitioner assessed residents’ general health needs at admission and on an ongoing basis as indicated by their specific needs but not less than every six months. Adequate arrangements were in place for residents to access general health services. Residents had access to applicable national screening programmes, but information regarding screening programmes available was not provided. Resident records were developed and maintained in a logical sequence and in good order, and entries were written legibly and were factual and accurate.

One child had been admitted to the approved centre since the previous inspection. Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre and there was no access to age-appropriate advocacy services.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment. The approved centre was not compliant with Rule Governing the Use of Seclusion: one of the seclusion rooms in the Admission Unit included a blind spot that prevented nursing staff from directly observing residents for the first hour of seclusion, the seclusion room in St. Edna’s Unit was not maintained and cleaned and the seclusion policy did not address ways of reducing the use of seclusion. There was non-compliance with the Code of Practice on Physical Restraint in significant number of areas.

AREAS REFERRED TO

Respect for residents’ privacy and dignity

In St. Edna’s Unit, six residents were diagnosed with psychogenic polydipsia, with the result that their fluid intake was monitored and restricted in accordance with treatment protocols and with their ICPs. However, this involved a restriction of water sources throughout the unit, and all residents had to request fluids and access to bathroom and bedroom areas. This was a blanket highly restrictive practice which does not conform to the least restrictive practice principle and should not continue.

On St. Edna’s Unit, residents could use mobile phones as long as they did not include cameras; on the Admission Unit, residents could use their phones for the duration of calls/texts, after which the phones had to be returned to staff. Again, this was a highly restrictive practice.

Residents were supported to keep and wear their personal clothing. Clothing was observed to be clean and appropriate to their needs. Residents could bring personal possessions into the approved centre and secure facilities were provided in each unit and in the central administration area for each resident to store monies, valuables, personal property, and possessions.
When a search of residents was carried out the residents’ consent was sought, the residents were informed by those implementing the search of what was happening and why, and the searches were completed with due regard to the residents' dignity, privacy, and gender.

All bathrooms, showers, toilets, and single room had locks on the inside of their doors and all observation panels on doors of treatment rooms and bedrooms were appropriately screened. Residents had access to other outdoor areas that were not overlooked by the public. Resident accommodation was mainly in single, en suite bedrooms.

There was prominent signage to indicate the locations where CCTV cameras were operating throughout the approved centre. The CCTV cameras and monitors were incapable of recording or storing a resident’s image in any format, and monitors could only be viewed by the health professionals responsible for the residents.

**AREAS REFERRED TO**

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

### Responsiveness to residents’ needs

Residents were not always provided with foods that involved an element of choice and residents with special dietary requirements did not always receive appropriate meals. Food, including modified consistency diets, was presented in an appealing manner.

The approved centre provided a range of recreational activities during the week and at weekends. Opportunities were provided for residents to engage in indoor and outdoor exercise and physical activity but these were dependent on the availability of nursing staff. Residents were facilitated in the practice of their religion and a list of multi-faith chaplains was available. Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre and there were designated rooms in the approved centre where residents could meet visitors in private. Residents had access to external communications, including mail and telephone but did not have access to the Internet.

Residents were provided with an information booklet at admission, which contained information on housekeeping arrangements. There was access to written and verbal information regarding their diagnosis and medication, including adverse effects of treatments, including risks and other potential side-effects.

Residents had access to personal space and to appropriately sized communal areas. The approved centre was not in a good state of repair, externally and internally. Some walls needed painting, there was graffiti in some areas, windows were dirty, some handles were missing from the doors leading to internal courtyard areas and the toilet in the seclusion room in St. Edna’s Unit was dirty. In addition, conservatory areas, including the dining area of the Admission Unit, leaked during heavy rain. There was no programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was not comfortably heated at the time of inspection.

**AREAS REFERRED TO**

Regulations 5, 9, 10, 11, 12, 20, 22, 30, 31, Code of Practice on the Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, service user experience, and interviews with staff.
Governance of the approved centre

The approved centre was part of the Community Healthcare Organisation (CHO) 8 area. Governance was well developed in St. Loman’s, in terms of both structures and processes. The governance structures included an area management team, a local management team, a quality and safety committee, a health and safety committee, a drugs and therapeutics committee, and a policies and procedures committee. Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders and all of the operating policies and procedures required by the regulations had been reviewed within three years.

The area management team meetings occurred monthly and were attended by heads of discipline, the general manager, the risk and patient safety advisor, the peer advocate, and the area lead for mental health engagement. Both individual and operational risks were monitored. There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre.

Defined lines of responsibility were evident in each department. Each head of discipline met with staff on a regular basis, and there were clear processes for escalating issues of concern to heads of discipline and to the area management team. All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments. Staffing shortages were acknowledged as the biggest operational risk by all departments. All heads of discipline had training in risk management. None of the disciplines operated staff performance appraisals. Clear systems were in place to support quality improvement.

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. The approved centre had developed a training plan, which encompassed all disciplines.
2. The clinical nurse manager had received Quality Service User Safety (QSUS) training.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was a standalone premises on the grounds of St. Loman’s Hospital, Mullingar. The approved centre was well signposted and was accessed via a reception area, which was staffed during office hours. There were two units providing accommodation for up to 44 residents. These were the Admission Unit and St. Edna’s Unit. The Admission Unit catered for male and female residents. St. Edna’s Unit was a continuing care ward for male residents only.

The profile of residents in St. Edna’s Unit was high dependency and many had been residing in the approved centre for several years. Both units had locked doors. In St. Edna’s, all accommodation consisted of single, en suite bedrooms. In the Admission Unit, accommodation consisted of single and two-bed en suite rooms. During the inspection, there were 38 residents in the approved centre. Eight of these were involuntarily detained and four had Ward of Court status. Four community mental health teams, a psychiatry of later life team, a rehabilitation and recovery team, and the Community Alcohol and Drugs Service admitted residents to the approved centre.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>44</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>38</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>8</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>4</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>18</td>
</tr>
</tbody>
</table>

There were no patients on approved leave at the time of inspection.

4.2 Conditions to registration

At the time of this inspection there was one condition attached to the registration.

**Condition 1:** 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 part of the Community Healthcare Organisation (CHO) 8 area. Governance was well developed in St. Loman’s, in terms of both structures and processes. The governance structures included an area management team, a local management team, a quality and safety committee which met quarterly, a health and safety committee, a drugs and therapeutics committee, and a policies and procedures committee. The area management team meetings occurred monthly and were attended by heads of discipline, the general manager, the risk and patient safety advisor, the peer advocate, and the area lead for mental health engagement. These outlined a clear agenda, actions, and review of governance. The minutes of the area management team meetings demonstrated an action-oriented focus with clear time lines. Both individual and operational risks were monitored, as were pertinent staffing issues. There was an organisational chart to identify the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 15 – 17 November 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>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 for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
5.2 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 5: Food and Nutrition</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children under the Mental Health Act 2001</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>✓</td>
<td>✓</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.
6.0 Service-user Experience

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

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

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

Nine residents met with the inspection team. Residents were complimentary of staff and stated that they were helpful, supportive, and understanding. Residents were also complimentary of the food and said they had a good selection of food to choose from. Residents stated that they would like access to exercise equipment and to go on more group walks.

Residents were invited to complete a questionnaire about their experience in the Admission Unit and in St. Edna’s Unit. In total, three questionnaires were returned. Two residents reported that they understood what their individual care plan was and one resident reported that they did not. Two residents knew who their multi-disciplinary health care team members were and one did not. All residents surveyed felt able to give feedback to staff and to make complaints if they were not satisfied with any part of their stay in the approved centre. Two residents felt that they had sufficient space for privacy, whereas one reported not having space for privacy within the approved centre. Finally, out of the three responses, two residents stated that they had enough activities during the day whereas one resident felt that they did not have access to sufficient activities.

The inspection team also met with a representative of the IAN, who provided feedback that had previously been received from residents: that there was a need for more activities at the weekend. Some residents stated they would like to be involved in gardening activities and also that they would like a water dispenser in the Admission Unit so that they did not have to ask staff to refill water jugs.
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:

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

All clinical heads of discipline made themselves available to speak with the inspectors. Representatives from nursing, medical, social work, occupational therapy, and psychology each provided a clear overview of the governance within their respective departments. All heads of discipline had training in risk management. One head of discipline did not have training in health and safety. All had attended training in the National Incident Management System. The director of nursing and the clinical director were based on the St. Loman’s campus, allowing them to fulfil their management role on-site. The occupational therapy manager, principal psychology manager, and social work manager visited the approved centre approximately on a monthly basis for governance meetings. Defined lines of responsibility were evident in each department. Each head of discipline met with staff on a regular basis, and there were clear processes for escalating issues of concern to heads of discipline and to the area management team. Serious reportable events were escalated to the area management team and reported to the Mental Health Commission.

All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments. Staffing shortages were acknowledged as the biggest operational risk by all departments. Challenges relating to this risk included the increased use of medical and nursing agency staff, an increase in demand for one-to-one nursing observations, and the challenge of releasing staff for training. These were agenda items at senior management meetings. Key performance indicators assisted the organisation to measure how well it was doing in relation to achieving goals. None of the disciplines operated staff performance appraisals. Clear systems were in place to support quality improvement. Service user input was further facilitated by engagement with the service user engagement lead and advocacy within the approved centre.
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
- Director of Nursing
- Acting Hospital Administrator
- Acting Principal Psychology Manager
- Acting Social Work Manager
- Assistant Director of Nursing
- Registered Proprietor
- Clinical Nurse Manager 2 x 2
- Clinical Nurse Manager 3 x 2

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. A number of clarifications were provided regarding specific issues’ that had arisen during the course of this inspection, and these are incorporated into this report.
9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre used the following resident identifiers: name, date of birth, address, and ID number. The identifiers were person-specific and appropriate to the resident group profile and individual resident needs. Two identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. The approved centre used a yellow sticker system to alert staff to the presence of residents with the same or a similar name.

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

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

INSPECTION FINDINGS

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

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

Monitoring: A systematic review of menu plans had not been undertaken to ensure that residents received wholesome and nutritious food in accordance with their needs. Documented analysis had not been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Residents were not always provided with foods that involved an element of choice within the approved centre’s menus. Meals were prepared in the Midland Regional Hospital in Mullingar and delivered in cook-chill form. However, items listed on the menus did not always arrive in the approved centre. On the second day of inspection, two menu items were not delivered and kitchenette staff and multi-task assistants (MTAs) prepared alternative meals to make up the deficits. Staff reported that this occurred regularly, and the dietitian said that this could also be a problem for residents with special dietary requirements who did not always receive appropriate meals.

The dietitian was providing cover to four counties and spent approximately one half-day per month in the approved centre. Nutritional and dietary needs were not always addressed in the residents’ individual care plans (ICPs).

Food, including modified consistency diets, was presented in an appealing manner. Hot meals were served daily, and residents were offered hot and cold drinks regularly.

In St. Edna’s Unit, six residents were diagnosed with psychogenic polydipsia, with the result that their fluid intake was monitored and restricted in accordance with their ICPs. This involved a restriction of water sources throughout the unit, whereby all residents had to request fluids and access to bathroom and bedroom areas. Staff were observed providing residents with drinks regularly throughout the day.

The approved centre used the Malnutrition Universal Screening Tool to evaluate residents with special dietary requirements. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate.
The approved centre was non-compliant with section 2 of this regulation for the following reasons:

a) Residents were not always provided with foods that involved an element of choice.
b) Food did not always take account of special dietary requirements.
c) Nutritional and dietary needs were not always addressed in residents’ ICPs.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written food safety policy, which was last reviewed in September 2017. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: Food safety audits were not completed periodically. Food temperatures were recorded in line with food safety recommendations, and temperature log sheets were maintained and monitored. Documented analysis had not been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: The approved centre had appropriate hand-washing areas for catering staff as well as suitable and sufficient catering equipment. There were appropriate facilities in the approved centre for the refrigeration, storage, and preparation, cooking, and serving of food.

Hygiene in the approved centre was maintained to support food safety, and catering areas and associated equipment were appropriately cleaned. Residents were provided with a supply of suitable crockery and cutlery.

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

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ clothing, which was last reviewed in May 2017. It addressed all of the requirements of the Judgement Support Framework.

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

Monitoring: The availability of an emergency supply of resident clothing was monitored on an ongoing basis, and this was documented. At the time of inspection, no residents were wearing nightclothes during the day.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing. During the inspection, residents’ clothing was observed to be clean and appropriate to their needs. Residents had an adequate supply of individualised clothing. The approved centre had an emergency supply of clothing, which took account of residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents’ personal property and possessions, which was last reviewed in May 2017. It included all of the requirements of the Judgement Support Framework.

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

Monitoring: Personal property logs were monitored in the admission unit. Personal property logs were not monitored in St. Edna’s Unit. Documented analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents could bring personal possessions into the approved centre, the extent of which was agreed at admission. Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided in each unit and in the central administration area for each resident to store monies, valuables, personal property, and possessions.

The Admission Unit completed a property checklist at admission, and this was stored separately to residents’ individual care plans (ICPs). However, residents’ property and possessions were not recorded on St. Edna’s Unit. Where any money belonging to residents was handled by staff, signed records of staff issuing the money were retained and countersigned by the resident or their representative, where possible. Residents were supported to manage their own property, unless this posed a danger to themselves or to others, as indicated in their ICPs.

The approved centre was non-compliant with this regulation because a record was not maintained of residents’ personal property and possessions on St. Edna’s Unit, 8(3).
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities relating to the provision of recreational activities within the approved centre.
- The facilities available for recreational activities, including the identification of suitable locations within and outside of the approved centre.
- The process for supporting resident involvement in planning and reviewing recreational activities.

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

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

Evidence of Implementation: The approved centre provided a range of recreational activities appropriate to the resident group profile, including books, board games, walking groups, arts and crafts, DVDs, television, and table tennis competitions. Recreational activities were facilitated during the week and at weekends, and residents were provided with a weekly schedule of activities in an accessible format.

Recreational activity programmes were not developed, implemented, and maintained with resident input, although resident feedback was occasionally sought following activities. Where deemed appropriate, individual risk assessments were completed for residents in relation to the selection of activities. Records of resident attendance at activities were maintained. Residents’ decisions on whether or not to participate in activities were respected and documented. Adequate communal areas suitable for recreational activities were provided.

Opportunities were provided for residents to engage in indoor and outdoor exercise and physical activity but were dependent on the availability of nursing staff.

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

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

INSPECTION FINDINGS

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

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes 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 residents, and this was documented.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. Facilities were provided in the approved centre in support of residents’ religious practices, and a list of multi-faith chaplains was available. A priest visited once a week, and residents could attend mass locally if they wished, following a risk assessment.

The care and services provided within the approved centre were respectful of residents’ religious beliefs and values, and residents were facilitated in observing or abstaining from religious practice in line with their wishes. At the time of inspection, no resident had special religious requirements relating to the provision of services, care, and treatment.

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 policy in relation to visits, which was last reviewed in May 2017. It included requirements of the Judgement Support Framework, with the exception of the required visitor identification methods.

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

Monitoring: Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. Analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

There were designated rooms in the approved centre where residents could meet visitors in private, unless there was an identified risk to the resident or to others or a health and safety risk. Children visiting were accompanied at all times to ensure their safety. This was communicated to all relevant individuals publicly. The visiting rooms available were suitable for visiting children.

Justifications for restricting visitors were not clearly documented in residents’ individual care plans (ICPs). Where a visiting restriction was in place, this was recorded in the ICP, but there was no documentation in relation to the reason for the restriction.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident communication, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the exception of the communication services available to the resident.

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

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

Evidence of Implementation: Residents had access to external communications, including mail and telephone. On St. Edna’s Unit, residents could use mobile phones as long as they did not include cameras; on the Admission Unit, residents could use their phones for the duration of calls/texts, after which the phones had to be returned to staff. Residents did not have access to the Internet.

Individual risk assessments were completed for residents in relation to their external communication and documented in their clinical files, where appropriate. At the time of the inspection, no resident had been assessed as at risk in relation to external communication. The clinical director or a designated senior member of staff could examine incoming and outgoing communication, only if there was reasonable cause to believe that the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The policy did not reference the following:

- The processes for communicating the approved centre’s search policies and procedures to residents and staff.
- The considerations provided to residents in relation to their dignity, privacy, and gender during searches.

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

Monitoring: A log of searches was maintained, and each search record had been systematically reviewed to ensure the requirements of the regulation were complied with. Analysis had not been completed to identify opportunities for improving search processes.
Evidence of Implementation: The resident search policy and procedure had been communicated to residents. Searches were not carried out in St. Edna’s Unit. The clinical files of two residents in the Admission Unit were examined in relation to searches. A risk assessment was undertaken in advance of each search, and the residents’ consent was sought and received in both cases. The residents were informed by those implementing the search of what was happening and why.

A minimum of two clinical staff were in attendance at all times when the searches were being conducted, and the searches were completed with due regard to the residents’ dignity, privacy, and gender. The reason for each search was documented, and the names of staff in attendance were noted.

Routine environmental searches were not carried out in the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to care of the dying, which was last reviewed in May 2017. It addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- Advance directives in relation to end of life care, Do Not Attempt Resuscitation orders, and residents’ religious and cultural end of life preferences.
- The supports available to other residents and staff following a resident’s death.
- The process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred to another facility.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the exception of the resident access to their ICPs.

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

Monitoring: Resident ICPs were audited on a quarterly basis to assess compliance with the regulation. Documented analysis had been completed to identify opportunities for improving the individual care planning process.

Evidence of Implementation: The ICPs of 15 residents in the approved centre were inspected. Each ICP, was identifiable and uninterrupted, and was not amalgamated with progress notes. One ICP was not stored in the resident’s current clinical file. The ICPs were discussed, agreed where practicable, and developed with the involvement of residents, their representatives, family, or next of kin. Residents had access to their ICPs and were kept informed of any changes. When residents declined or refused copies of their ICPs, this was recorded, including the reason, if provided.

Residents were assessed at admission and an initial care plan was put in place by the admitting clinician to address residents’ immediate needs. The ICP was then developed within seven days of admission, following an assessment. In one case, the ICP reviewed was developed by nursing and medical staff only and was not developed by the MDT. In ten cases, there was no evidence of psychology input at ICP reviews. The admission assessment did not include details of the residents’ medication history and current medications.

In two ICPs, appropriate goals for the residents had not been identified. In one ICP, the care and treatment required to meet identified goals were not specified. In one ICP, the resident’s assessed needs were not detailed. In five ICPs, the resources required to provide the care and treatment identified were not specified.

The ICPs of residents in St. Edna’s were reviewed every three months by the MDT in consultation with the residents. The ICPs of residents in the Admission Unit were reviewed weekly by the MDT in consultation with the residents.
Although resident risk assessments were completed, a risk management plan was not always clearly documented as part of the ICP. Two ICPs did not contain documented preliminary discharge plans.

No child with educational requirements had been admitted to the approved centre since the last inspection.

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

a) One ICP did not comprise a composite set of documentation.
b) One ICP was not developed with MDT input.
c) In two ICPs, appropriate goals for the residents had not been identified.
d) In one ICP, the care and treatment required to meet identified goals were not specified.
e) In five ICPs, the resources required to provide the care and treatment identified were not specified.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

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

- The planning of therapeutic services and programmes within the approved centre.
- The resource requirements of the therapeutic services and programmes.
- The process for reviewing and evaluating therapeutic services and programmes.

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

Monitoring: Therapeutic services were monitored on an ongoing basis, but monitoring did not determine whether residents’ assessed needs were being met. Documented analysis had not been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: The range of therapeutic services and programmes available in the approved centre was not appropriate to the assessed needs of residents, as documented in their individual care plans (ICPs). In particular, not all residents had access to a social worker, as indicated in their ICPs. There were two social work groups in St. Edna’s, however the social worker described one of these groups as primarily recreational rather than therapeutic in nature.

Nursing groups were timetabled in the Admission Unit but often did not take place due to staff shortages. The rationale, design and evaluation of the group therapeutic programmes were not always evidence-based and directed towards restoring and maintaining optimal levels of psychosocial functioning of residents. The occupational therapist had identified further occupational therapy resources to meet the identified needs of the residents.

Not all therapeutic services and programmes in the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Adequate and appropriate resources were not available to provide therapeutic services and programmes because of staffing vacancies.

A list of services and programmes was available to residents. Where residents required therapeutic services or programmes that were not provided internally, arrangements were in place for these to be provided by an approved, qualified health professional in a suitable location. A record was maintained of resident participation and engagement in, and outcomes achieved in therapeutic services or programmes.
The approved centre was non-compliant with this regulation for the following reasons:

a) Not all residents had access to a social worker, in accordance with their ICPs, 16(1).
b) The therapeutic programmes and services provided in the approved centre were not all directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, 16(2).
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 admitted to the approved centre since the last inspection had educational requirements, this regulation was not applicable.
Regulation 18: Transfer of Residents

COMPLIANT
Quality Rating
Satisfactory

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The clinical files of two residents who had been transferred to the Midland Regional Hospital in Mullingar in emergency circumstances were reviewed. In each case, communication records with the receiving facility were documented and included the reason for the transfer, the residents’ care and treatment plan, and whether the residents required accompaniment on transfer. A pre-transfer assessment of the residents was completed, including an individual risk assessment relating to the transfer and the residents’ needs.

Neither clinical file contained documented consent of the residents to the transfer.

Relevant documentation was issued as part of each transfer, including a letter of referral with a list of current medications and details of the required medication for the residents during transfer. The emergency transfers were documented and followed up by a written referral to the hospital. Copies of all relevant documentation were retained in the residents’ clinical files. Checklists were completed by the approved centre to ensure that comprehensive resident records had been transferred to the hospital.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written general health policies: a maintenance of general health policy dated May 2017 and a responding to medical emergencies policy, dated September 2017. Together, the policies addressed requirements of the Judgement Support Framework, with the exception of the staff training requirements in relation to Basic Life Support.

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

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

Evidence of Implementation: The approved centre had an emergency trolley, and staff had access at all times to an Automated External Defibrillator. Weekly checks were completed on the emergency equipment. Records were available of any medical emergency that occurred in the approved centre and of the care implemented.

A registered medical practitioner assessed residents’ general health needs at admission and on an ongoing basis, as part of the approved centre’s provision of care. Residents received appropriate general health care interventions in line with their individual care plans. Residents’ general health needs were monitored and assessed as indicated by their specific needs but not less than every six months. Both units maintained a list of residents whose six-monthly physical examinations were due.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services. Records were maintained of general health checks and the associated results, and copies of these were retained and clearly identifiable in the clinical files.

Residents had access to applicable national screening programmes, but information regarding screening programmes available through the approved centre was not provided.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 20: Provision of Information to Residents

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident’s multi-disciplinary team;
(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;
(c) verbal and written information on the resident’s diagnosis and suitable written information relevant to the resident’s diagnosis unless in the resident’s psychiatrist’s view the provision of such information might be prejudicial to the resident’s physical or mental health, well-being or emotional condition;
(d) details of relevant advocacy and voluntary agencies;
(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

INSPECTION FINDINGS

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

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for providing information to residents, as set out in the policy.

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

Evidence of Implementation: Residents were provided with an information booklet at admission, which contained information on housekeeping arrangements, including arrangements for personal property, mealtimes, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents’ rights. Information on the multi-disciplinary team was displayed on posters and contained in the information folders on the units.

Residents had access to written and verbal information regarding their diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to their physical or mental health, well-being, or emotional condition. Verbal and written information was provided on the likely adverse effects of treatments, including risks and other potential side-effects. Information was available on indications for the use of all medications administered to the residents. Medication information sheets and verbal information were provided in a format that was appropriate to resident needs. Residents had access to interpretation and translation services, as required.

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities for the provision of resident privacy and dignity.
- The process applied when resident privacy and dignity were disrespected by staff.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. 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 had been undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a respectful manner. Staff were appropriately dressed and sought permission before entering residents’ rooms. Residents wore clothing that respected their privacy and dignity.

All bathrooms, showers, toilets, and single room had locks on the inside of their doors unless there was an identified risk to residents. Locks had an override facility. All observation panels on doors of treatment rooms and bedrooms were appropriately screened. Noticeboards in the nurses’ stations were shielded from public view to ensure that identifiable resident information was not displayed. Residents were facilitated to make private phone calls using a cordless phone.

The external garden was overlooked by residential properties, and the screening shrubs had not yet grown high enough to ensure resident privacy. However, residents had access to other outdoor areas that were appropriately screened.

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 22: Premises**

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

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

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

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

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


**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the premises, which was last reviewed in May 2017. The policy addressed requirements of the *Judgement Support Framework*, with the following exceptions:

- The approved centre's utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.
- The identification of hazards and ligature points in the approved centre.

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

**Monitoring:** The approved centre had not completed a hygiene audit. A ligature audit had been completed. Documented analysis had been undertaken to identify opportunities for improving the premises, and funding estimates had been delivered for a number of projects.

**Evidence of Implementation:** Residents had access to personal space and to appropriately sized communal areas. Resident accommodation was mainly in single, en suite bedrooms, which assured their comfort and privacy and met their assessed needs. Communal areas were adequately lit to facilitate reading and other activities. Rooms in the approved centre were ventilated.

The approved centre was not comfortably heated throughout at the time of inspection. The older part of the facility had oil heating and the newer area used a wood chip burner, which had broken down. A part for the boiler was on order, but rooms served by this heating system were cold.
Appropriate signage and sensory aids were not in place throughout the approved centre. One room in the Admission Unit that was marked as a toilet was being used as a store room.

Sufficient spaces, including outdoor spaces, were available for residents to move about. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, had been minimised.

Ligatures had not been minimised, and a number of ligature points were observed in both units, some of which had not been identified in the ligature audit.

The approved centre was not in a good state of repair, externally and internally. Some walls needed painting, graffiti were observed in a number of rooms and in corridors, windows throughout the approved centre were dirty, and some handles were missing from the doors leading to internal courtyard areas. In addition, conservatory areas, including the dining area of the Admission Unit, leaked during heavy rain. A system was in place for reporting maintenance issues, but there was no programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment.

A cleaning schedule was implemented in the approved centre, but the toilet in the seclusion room in St. Edna’s Unit was dirty. Current national infection control guidelines were not followed. Clinical waste bins were observed to be stored out in the open space on the admissions unit.

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

a) The premises were not clean and maintained in good decorative order throughout, 22(1)(a), as evidenced by the following:
   - Walls needed painting.
   - Graffiti were observed in some rooms and in corridors.
   - The toilet facility for the seclusion room in St. Edna’s Unit was dirty.
   - Windows were dirty.

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

c) A programme of routine maintenance and renewal of the fabric and decoration of the premises was not developed and implemented, 22(1)(c).

d) The condition of the physical structure and the overall approved centre environment was not maintained with due regard to the specific needs and the safety and well-being of residents, 22(3), as evidenced by the presence of ligature points, broken handles on doors, and leaks in conservatory areas.
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the exception of processes for the self-administration of medication and for medication management at admission, transfer, and discharge.

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

Monitoring: Audits of Medication Prescription and Administration Records (MPARs) were undertaken monthly to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: An MPAR was maintained for each resident, and 30 of these were inspected. At least two appropriate resident identifiers, including name, date of birth, address, or ID number, were used on each MPAR. Names of medications were written in full, all medications administered to residents were recorded, and the Medical Council Registration Number of every medical practitioner prescribing medication to residents was included.

Medication was reviewed at least six-monthly or more frequently, when required. Where there was an alteration in a medication order, the prescription was rewritten by the medical practitioner. All medicines were appropriately administered by two registered psychiatric nurses. The expiry dates of medications were checked prior to their administration, and good hand-hygiene and cross-infection control techniques were observed during the dispensing of medications. Where a resident’s medication was withheld, this was documented in the MPAR and clinical file. Where a resident refused medication, this was documented in the MPAR and clinical file and communicated to medical staff.

Controlled drugs were appropriately checked, administered, and recorded in the controlled drugs book. Residents could self-administer medications following a risk assessment, and directions to crush medication were only accepted from residents’ medical practitioners.

Medication arriving from the pharmacist was verified against the order to ensure that it was correct and accompanied by appropriate directions for use. Medication was stored in a locked trolley in a locked room,
and there was a separate secure cupboard for the storage of scheduled controlled drugs. Medication storage areas were clean and tidy.

At the time of the inspection, food items were being stored in the medication fridge and a log of fridge temperatures was not being maintained. A system of stock rotation was not implemented, and two expired medicines were identified in the medicine cabinet. Medications that were past their expiry date had not been returned to the pharmacy for disposal.

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

a) Medication was not appropriately stored.
b) A daily log of medication fridge temperatures was not maintained.
c) Medication past its expiry date was observed in the medication cabinet.
Regulation 24: Health and Safety

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety, which was last reviewed in September 2017. It also had a site-specific safety statement, dated June 2017. Together, the policy and safety statement addressed requirements of the Judgement Support Framework, with the following exceptions:

- The allocation of specific roles to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- Infection control measures relating to the following:
  - The raising of awareness among residents and visitors to infection control measures.
  - The support provided to staff following exposure to infectious diseases.
- Vehicle controls.
- The staff training requirements in relation to health and safety.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. Staff interviewed were able to articulate the processes 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: The approved centre had a written policy in relation to the use of CCTV, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The measures used to ensure the privacy and dignity of residents in relation to the use of CCTV or other monitoring equipment.
- The maintenance of CCTV cameras by the approved centre.
- The disclosure of the existence and usage of CCTV or other monitoring devices to the Inspector of Mental Health Services and/or the Mental Health Commission during the inspection of the approved centre or at any time on request.
- The process to cease monitoring a resident using CCTV in certain circumstances.

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

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

Evidence of Implementation: There was prominent signage to indicate the locations where CCTV cameras were operating throughout the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The Mental Health Commission and the Inspector of Mental Health Services had been informed about the approved centre’s use of CCTV.
The CCTV cameras and monitors were incapable of recording or storing a resident’s image in any format, and monitors could only be viewed by the health professionals responsible for the residents.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and monitoring pillars.
Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the recruitment, selection, and vetting of staff, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The staff performance and evaluation requirements.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan was reviewed quarterly at training meetings, and this was documented. The numbers and skill mix of staff were assessed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart in place, which identified the leadership and management structure and lines of authority and accountability of staff in the approved centre. Planned and actual staff rotas were in place. Staff were appropriately qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times.

The numbers and skill mix of staff were not sufficient to address the assessed needs of residents at the time of inspection. The Community Alcohol and Drugs Service and the Mullingar south and north teams did not have access to a social worker, with the result that residents’ social work needs were not being met.
The approved centre did not provide a written staffing plan that addressed the following:

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

Annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Training records indicated that, although efforts had been made to achieve compliance with this part of the regulation, not all health care professionals had up-to-date mandatory training in fire safety, Basic Life Support (BLS), the management of aggression and violence, and the Mental Health Act 2001.

At least one staff member was trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training completed in manual handling, infection control and prevention, care for residents with an intellectual disability, residents’ rights, risk management, incident reporting, and the protection of children and vulnerable adults. There was no documented evidence that staff had been trained in end of life care or recovery-centred approaches to mental health care and treatment.

Staff training was documented, and staff training logs were maintained. The Mental Health Act 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available throughout the approved centre.

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>Admission Unit</td>
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<td>shared</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
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<tr>
<td></td>
<td>RPN</td>
<td>5</td>
<td>3</td>
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<tr>
<td></td>
<td>MTA</td>
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<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Edna’s Unit</td>
<td>CNM3</td>
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<td>shared</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
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<td>0</td>
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<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>MTA</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

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

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

a) The numbers and skill mix of staff were not appropriate for the assessed needs of residents or the size and layout of the approved centre, 26(2).

b) Not all staff had up to-date mandatory training in fire safety, BLS, the management of aggression and violence, and the Mental Health Act 2001, 26(4) and 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

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

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

It did not reference the following:

- Record review requirements.
- General safety and security measures in relation to records.
- The retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. Clinical staff and other relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records, as set out in the policy. Not all clinical staff had received training in best-practice record keeping.

Monitoring: Resident records had not been audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had been completed to identify opportunities for improving processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were secure, up to date, and constructed, maintained, and used in accordance with the Data Protection Act 1988 and 2003, the Freedom of Information Act 1997 and 2003, and national guidelines and legislative requirements. Resident records were stored together and were appropriately secured from loss or destruction, tampering, and unauthorised access or use.
A record had been initiated for every resident in the approved centre, and these were reflective of residents’ current status and the care and treatment being provided. Resident records were maintained through the use of an addressograph label containing an ID number, name, date of birth, and address.

Resident records were developed and maintained in a logical sequence and in good order, and entries were written legibly and were factual and accurate. Documentation relating food safety and fire inspections was maintained in the approved centre. There had been no food safety inspection since the last Mental Health Commission inspection.

In two clinical files inspected, the time at which entries were made was not recorded. The approved centre did not maintain a record of all signatures used in the resident records, specifically the signatures of allied health professionals. Records were not retained/destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date register of residents, which was made available to the inspection team. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.
Regulation 29: Operating Policies and Procedures

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the following exceptions:

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

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

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the processes for developing and reviewing policies.

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

All of the operating policies and procedures required by the regulations had been reviewed within three years. Obsolete versions of operating policies and procedures were retained but removed from possible access by staff. Generic policies in use were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre had a written statement to this effect, adopting the policies in question.

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 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The approved centre had dedicated facilities for holding Mental Health Tribunals. Adequate resources were provided to support the tribunal process, and staff attended tribunals and provided assistance to patients, where required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 31: Complaints Procedures

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident’s individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in May 2017. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The confidentiality requirements in relation to complaints, including the applicable legislative requirements regarding data protection.
- The process for escalating complaints that cannot be addressed by the nominated person.

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

Monitoring: Audits of the complaints log and related records had been completed. Complaints data had been analysed. Details of the analysis had been considered by senior management, and required actions had been identified to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated individual with responsibility for dealing with all complaints, who was available in the approved centre. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy and the resident information booklet. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. Insofar as was practicable, the registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

A consistent and standardised approach was implemented for the management of all complaints, and all complaints, whether oral or written, were investigated promptly and handled appropriately and
sensitively. Minor complaints were addressed locally on each unit and documented in a minor complaints log. Where minor complaints could not be addressed locally, they were escalated to the nominated person and documented.

Details of complaints and of subsequent investigations and outcomes were fully recorded and kept distinct from residents’ individual care plans.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of written policies in relation to risk and incident management, which were dated June 2017. Together, the policies addressed all of the requirements of the Judgement Support Framework, including:

- The process of identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies.
- The process for the protection of children and vulnerable adults within the care of the approved centre.

Training and Education: Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff had received training in individual risk management processes. Managerial staff had been trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the risk management processes, as set out in the policies. All training was documented.

Monitoring: The risk register was audited at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.
Evidence of Implementation: Responsibilities were allocated at management level to ensure the effective implementation of risk management. The person with responsibility for risk was known by all staff in the approved centre. Risk management procedures actively sought to reduce identified risks to the lowest level, as was reasonably practicable.

Clinical, corporate, and health and safety risks had been identified, assessed, treated, reported, monitored, and recorded in the risk register. Structural risks such as ligature points had not been removed or effectively mitigated. A ligature audit had been completed, but ligature points observed by the inspection team during the inspection were not identified in the audit.

The approved centre completed risk assessments for all residents at admission to identify individual risk factors, before and during transfer and discharge, before and during the use of resident seclusion and physical restraint, and in conjunction with medication requirements or administration. The multidisciplinary teams were involved in the development, implementation, and review of individual risk management processes and reviewed all clinical incidents at their regular meeting. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents in the approved centre were recorded and risk-rated using the National Incident Management System. A six-monthly summary report of incidents occurring in the approved centre was sent to the Mental Health Commission in accordance with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. The approved centre had an emergency plan that incorporated fire evacuation procedures.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the training and education and evidence of implementation pillars.
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was prominently displayed in the reception area of the approved centre and the condition relating to registration was attached.

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: The approved centre had a written policy in relation to the use of Electro-Convulsive Therapy (ECT), which had been reviewed annually. It addressed all of the policy criteria of this rule, including provisions relating to the following:

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

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

Evidence of Implementation: Patients received ECT treatment off-site in the Midland Regional Hospital in Mullingar. The clinical file of one ECT patient was examined. It indicated that appropriate information about ECT was provided by the consultant psychiatrist, including details of likely adverse effects of the treatment. The information was in clear and simple language that the patient could understand.

The patient was assessed by the consultant psychiatrist as having capacity to give informed consent for ECT, and a written record of the capacity assessments was retained in the patient’s clinical file. A Form 16: Treatment without Consent Electroconvulsive Therapy – Involuntary Patient (Adult) was filled in and placed in the clinical file. A copy of the form was sent to the Mental Health Commission within five days.

The ECT prescription detailed the reason for using ECT, the consideration of alternative therapies before prescribing ECT, the communication with the patient and/or next of kin, and a mental state examination. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. The consultant psychiatrist in consultation with the patient reviewed the progress of the treatment. The ECT register was completed on the conclusion of the programme of ECT treatment, and a copy was placed in the patient’s clinical file.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of seclusion, which was last reviewed in May 2017. The policy identified those who were authorised to initiate seclusion and referenced the provision of information to the resident in seclusion. It identified staff training requirements in relation to the use of seclusion. The policy did not address ways of reducing the rates of seclusion. There was a separate policy on the use of closed circuit television (CCTV).

Training and Education: Not all staff involved in the use of seclusion had signed the signature log to indicate that they had read and understood the policy. Records were maintained of staff attendance at training in the use of seclusion.

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

Evidence of Implementation: The clinical files of two residents were examined in relation to seclusion. Residents in seclusion had access to toilet and bathroom facilities. The seclusion room in St. Edna’s Unit was furnished to ensure resident dignity and privacy insofar as was practicable, and furnishings were of a design and quality so as not to endanger resident safety.

In St. Edna’s Unit, the seclusion room’s toilet facility was not clean. In addition, the room was not maintained in a manner that ensured resident dignity because offensive graffiti on the back of the door had not been removed. There were two seclusion rooms in the Admission Unit, but one of these could not be inspected because it was in use. The second room included a blind spot, which prevented nursing staff from directly observing residents for the first hour of seclusion.

Inspection of the clinical files indicated that seclusion was used in rare and exceptional circumstances and in the best interests of residents’, when the residents posed an immediate and serious threat of harm to self or others. Seclusion was used after all other interventions to manage the patients’ unsafe behaviour had first been considered and following a risk assessment. The use of CCTV to monitor the seclusion room was appropriate. A medical review of the residents in seclusion occurred every four hours.

One episode of seclusion was not reviewed by the multi-disciplinary team (MDT) and recorded in the clinical file within two working days.

Risk Rating: MODERATE

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

a) One of the seclusion rooms in the Admission Unit included a blind spot that prevented nursing staff from directly observing residents for the first hour of seclusion, 5.1(a).

b) The seclusion room in St. Edna’s Unit was not maintained and cleaned to ensure that the dignity of residents in seclusion was maintained, 8.2.

c) The seclusion policy did not address ways of reducing the use of seclusion, 10.2(a).

d) Not all staff involved in the use of seclusion had signed the signature log to indicate that they had read and understood the policy, 10.2(b).

e) One episode of seclusion was not reviewed by the MDT and recorded in the clinical file within two working days, 10.3.
Section 69: The Use of Mechanical Restraint

Mental Health Act 2001
Bodily restraint and seclusion
Section 69

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

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

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

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

INSPECTION FINDINGS

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

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

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

57. (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.
   (2) This section shall not apply to the treatment specified in section 58, 59 or 60.

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

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

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

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

INSPECTION FINDINGS

The clinical files of three patients who had been in the approved centre for more than three months and in continuous receipt of medication were examined.

Two patients had been assessed as having capacity to consent. There was a written record of consent for each patient, which contained the following:

- The names of the medications prescribed.
- Confirmation of the patients’ capacity to understand the nature, purpose, and likely effects of the medication.
- Details of discussions with the patients in relation to the nature and purpose of the medication(s), the effects of medication(s), including any risks and benefits, and any views expressed by the patients.
- Any supports provided to the patients in relation to the discussion and their decision-making.
The third patient had been assessed as unable to consent to treatment and a Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed. A copy of the form was retained in the relevant clinical file. It documented the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medication and detailed the following:

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

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
12.0 Inspection Findings – Codes of Practice

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint, which was last reviewed in May 2017. The policy, which had been reviewed annually, addressed the following:

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

The policy did not contain a child protection process in the event that a child is restrained, nor did it reference staff training procedures in relation to the use of physical restraint that included the following:

- Areas to be addressed during training such as alternatives to the use of physical restraint and training in the prevention and management of violence.
- The identification of appropriately qualified individuals to deliver training.
- The mandatory nature of training for those involved in the use of physical restraint.

Training and Education: Not all staff involved in the use of physical restraint had signed the signature log to indicate that they had read and understood the policy. A record of attendance at training was maintained. Physical restraint was never used to ameliorate staff shortages.

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

Evidence of Implementation: The clinical files of three residents were examined in relation to the use of physical restraint. These indicated that physical restraint was initiated in rare and exceptional circumstances and in the best interests of the resident, where the residents posed an immediate and serious threat of harm to themselves or others. In each case, physical restraint was initiated following a risk assessment and after staff had first considered other interventions to manage residents’ unsafe behaviour. A designated staff member was the lead in all episodes of the use of restraint. Cultural awareness and gender sensitivity were demonstrated in each episode.

All episodes of physical restraint were recorded clearly in the clinical files, and copies of the completed clinical practice forms recording the use of physical restraint were placed in the respective clinical files. In one case, the clinical practice form was not signed by the clinical psychiatrist within 24 hours.

In two of the clinical files inspected, it was not documented that the consultant psychiatrist was notified of the use of physical restraint as soon as was practicable and it was not clear that a registered medical practitioner completed a medical examination of the residents within three hours of the start of physical restraint. None of the files examined contained evidence that residents were informed of the reasons for, likely duration of, and circumstances in which physical restraint would be discontinued. In one clinical file, there was no evidence that next of kin were informed of the use of physical restraint and no explanation for this was recorded.
The approved centre was non-compliant with this code of practice for the following reasons:

a) In two of the clinical files examined, it was not recorded that the consultant psychiatrist was notified of the use of physical restraint as soon as was practicable, 5.3.

b) There was no evidence in two clinical files that a registered medical practitioner completed a medical examination of the residents within three hours of the start of physical restraint, 5.4.

c) In one episode of physical restraint, the consultant psychiatrist did not sign the clinical practice form within 24 hours, 5.7(c).

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

e) In one episode, there was no evidence that next of kin were informed of the use of physical restraint and no explanation for this was recorded, 5.9(a).

f) Not all staff involved in the use of physical restraint had signed the signature log to indicate that they had read and understood the policy, 9.2(b).

g) The policy did not include the following staff training considerations:
   - Areas to be addressed during training such as alternatives to the use of physical restraint and training in the prevention and management of violence, 10.1(b).
   - The identification of appropriately qualified individuals to deliver training, 10.1(d).
   - The mandatory nature of training for those involved in the use of physical restraint, 10.1(e).

h) The physical restraint policy did not include a child protection process in the event of a child being restrained, 11.3.
Admission of Children

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of children, which was last reviewed in May 2017. The policy required each child admitted to the approved centre to be individually risk-assessed, and it included procedures in relation to family liaison, parental consent, and the identification of the person responsible for notifying the Mental Health Commission (MHC) of the admission of a child to an adult approved centre. The policy did not include procedures relating to confidentiality.

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

Evidence of Implementation: The clinical file of one child admitted to the approved centre since the last inspection was examined. It indicated that provisions were in place to ensure the safety of the child, to ensure their rights to have their views heard, and to respond to the particular needs of the child in an adult setting. Staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available in the approved centre.

Appropriate accommodation for the child was provided in the form of a single, en suite room, and gender sensitivity was displayed. The child received information on their rights and on the available facilities in an accessible form and language. Advice was available from local Child and Adolescent Mental Health Services when necessary. Consent for treatment was obtained from one or both parents. The MHC was notified of the child admission within the required 72-hour time frame.

Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre. The child did not have access to age-appropriate advocacy services because no national advocacy service for children was available.

Educational requirements did not apply because of the short duration of the admission.

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

a) Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre, 2.5(b).

b) There was no access to age-appropriate advocacy services, 2.5(g).

c) The policy on the admission of children did not specifically reference confidentiality, 2.5(d)(l).
Notification of Deaths and Incident Reporting

INSPECTION FINDINGS

Processes: The approved centre had a risk management policy that covered the notification of deaths and incident reporting to the Mental Health Commission. The policy identified the risk manager and specified the roles and responsibilities of staff in relation to the following:

- The reporting of deaths and incidents.
- The submission of forms to the MHC.
- The roles and responsibilities in relation to the completion of six-monthly incident summary reports.

The policy did not address the roles and responsibilities in relation to completing death notification forms.

Monitoring: There had been no deaths in the approved centre since the last inspection. Incidents were reviewed to identify and correct any problems as they arose and to improve quality.

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

The approved centre used the National Incident Management System to report incidents, and the standardised incident report form was available for inspection. A six-monthly summary of all incidents was sent to the Mental Health Commission.

The approved centre was non-compliant with this code of practice because the policy did not address the roles and responsibilities of staff in relation to completing death notification forms, 4.3.
Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

Please refer to the Mental Health Commission Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to working with people with an intellectual disability, which was last reviewed in September 2017. It reflected person-centred treatment planning, presumption of capacity, and least restrictive interventions, and it addressed the roles and responsibilities of staff. There was a separate policy in relation to the management of challenging behaviours. The policy did not contain procedures for training staff in working with people with intellectual disability that included the following:

- Induction training for new staff.
- Staff who should receive training.
- Areas to be addressed in training.
- Frequency of training.
- The identification of appropriately qualified individuals to deliver training.
- The evaluation of training programmes.

Training and Education: Staff had received training in support of the principles and guidance in this code of practice. Training included person-centred approaches, relevant human rights principles, and preventative and responsive approaches to problem behaviours.

Monitoring: The policy had been reviewed within the required three-year time frame. Restrictive practices were reviewed periodically.

Evidence of Implementation: As no resident in the approved centre had a primary diagnosis of intellectual disability at the time of inspection, the evidence of implementation pillar for this code of practice was not inspected against.

The approved centre was non-compliant with section 6.2 of this code of practice because its policy did not contain procedures for training staff in working with people with intellectual disability that addressed the following:

- Induction training for new staff.
- Staff who should receive training.
- Areas to be addressed in training.
- Frequency of training.
- The identification of appropriately qualified individuals to deliver training.
- The evaluation of training programmes.

Risk Rating: LOW
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.

As no voluntary patient was in receipt of a course of ECT at the time of inspection, this code of practice was not applicable.
INSPECTION FINDINGS

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

Admission: There were two admission policies, both of which were dated May 2017: an admission policy and an involuntary admission policy. They included a procedure for involuntary admission and protocols for urgent referrals, self-presenting individuals, and planned admission. They addressed timely communication with primary care and community mental health teams and the admission of homeless people. The approved centre also had a policy in relation to privacy and confidentiality.

Transfer: The transfer policy, which was dated May 2017, included procedures for involuntary transfer and outlined the roles and responsibilities of staff in relation to the transfer of residents. It detailed how a transfer was arranged, addressed the safety of the resident and staff during a transfer, and contained provisions for emergency transfer and transfer abroad.

Discharge: There were four policies in relation to discharge: a discharge policy dated September 2017 and policies on the discharge of older persons, homeless people, and residents with intellectual disability, all of which were dated May 2017. These included procedures for the discharge of involuntary patients and referenced prescriptions and supply of medication on discharge. The policies contained protocols for discharging homeless people, older people, and people with an intellectual disability, as well as post-discharge follow-up procedures.

Training and Education: There was documentary evidence that staff had read and understood the admission and discharge policies. Not all health care professionals had signed the signature log to indicate that they had read and understood the transfer policy.

Monitoring: An audit had been completed on the implementation of and adherence to the admission policy but not the discharge policy.

Evidence of Implementation:

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

Admission: One clinical file was inspected in relation to admission. The approved centre had a key worker system in place and the entire multi-disciplinary team record was contained in a clinical file. The decision to admit was taken by the registered medical practitioner (RMP), and a Form 6 – Admission Order (involuntary admission) was completed. The resident was admitted to the unit most appropriate to their needs. The resident was assessed at admission, and details of all assessments were documented in the clinical file.

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

Transfer: The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical files of two residents who had been transferred to hospital for medical treatment were inspected. The decision to transfer was made by the RMP and documented, and it was agreed with the receiving facility. A pre-transfer clinical assessment, including a risk assessment, was recorded. Each clinical file contained a copy of the referral letter. There was no evidence that that the residents’ wishes were respected or that consent for the transfers had been obtained.

Discharge: Two clinical files were inspected in relation to discharge. In each case, the decision to discharge was taken by the RMP and a discharge plan was in place as part of the residents’ individual care plans. The residents were comprehensively assessed prior to discharge. Primary care/community mental health teams were informed of the discharges within 24 hours. In one case, a preliminary discharge summary was not sent to the primary care/community health team within three days. Comprehensive discharge summaries were issued within 14 days.

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

a) There was no evidence that an audit had been completed on the implementation of and adherence to the discharge policy, 4.19.

b) Not all health care professionals had signed the signature log to indicate that they had read and understood the transfer policy, 9.1.

c) The approved centre did not comply with two regulations associated with this code of practice:
   • Regulation 8: Residents’ Personal Property and Possessions, 23.1.1.
   • Regulation 15: Individual Care Plan, 17.1.

d) There was no evidence in either file inspected in relation to transfer that that the residents’ wishes were respected or that consent for the transfers was obtained, 28.1.

e) In one file inspected in relation to discharge, a preliminary discharge summary was not sent to the primary care/community health team within three days, 38.3.
### Appendix 1 – Corrective and Preventative Action Plan

#### Regulation 5: Food and Nutrition

Report reference: Page 21-22

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring(^1) or New(^2) area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>1. Residents were not always provided with foods that involved an element of choice.</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Director of Nursing; Dietician Manager; Catering Manager</td>
<td>Choice of menu will be discussed with Director of Nursing, Catering Manager, Dietician Manager, Resident</td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM111 / Catering Manager</td>
<td>1) Patient food satisfaction survey. 2) Ongoing Checklist of food ordered versus foods received.</td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
<tr>
<td>2. Food did not always take account of special dietary requirements.</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Dietician Manager</td>
<td>Dietician Manager will alert MDT if such occurs</td>
<td>Achievable and realistic</td>
<td>28/02/2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Dietician Manager</td>
<td>Project proposal for Audit Dietician Manager</td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
</tr>
<tr>
<td>3. Nutritional and dietary needs were not always addressed in residents’ ICPs.</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CMT</td>
<td>Memo to Heads of Disciplines to remind all clinical staff to include food and nutrition requirements in all ICPs</td>
<td>Achievable and realistic</td>
<td>28/02/2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Audit 6 monthly</td>
<td></td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
</tbody>
</table>

\(^1\) Area of non-compliance reoccurring from 2016  
\(^2\) Area of non-compliance new in 2017
### Regulation 8: Residents’ Personal Property and Possessions

Report reference: Page 25

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>4. A record was not maintained of residents’ personal property and possessions on St. Edna’s Unit.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CNM11 St. Edna’s Ward</td>
<td>A record will be maintained as per Policy</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM11</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
### Regulation 15: Individual Care Plan

**Report reference: Page 33-34**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taken from the inspection report</strong></td>
<td><strong>Reoccurring or New area of non-compliance</strong></td>
<td>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. One ICP did not comprise a composite set of documentation.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Heads of Disciplines</td>
<td>All ICPs will comprise of a composite document.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: T/Hospital Administrator</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>6. One ICP was not developed with MDT input.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Psychology Manager; Registered Proprietor</td>
<td>1) Psychologist Manager has applied to fill 1.3 WTE vacant Psychology post. 2) Memo to all Heads of Disciplines to remind all that they must all be involved with ICP development.</td>
<td>Dependant on NRS filling vacant posts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Psychology Manager; Registered Proprietor</td>
<td>1) Recruitment of 1.3 WTE Psychologist. 2) Audit quarterly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>7. In two ICPs, appropriate goals for the residents had not been identified.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CMT</td>
<td>Memo to all Heads of Disciplines to remind them that appropriate goals to be identified for the resident in the ICP.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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</tr>
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</tr>
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<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>Preventative Action(s): Post-Holder(s) responsible: CNMIII</td>
<td>Audit quarterly</td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
<td></td>
</tr>
<tr>
<td>8. In one ICP, the care and treatment required to meet identified goals were not specified.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CMT</td>
<td>Memo to all Heads of Disciplines to remind them that appropriate goals to be identified for the resident in the ICP.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>Preventative Action(s): Post-Holder(s) responsible: CNMIII</td>
<td>Audit quarterly</td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
<td></td>
</tr>
<tr>
<td>9. In five ICPs, the resources required to provide the care and treatment identified were not specified.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CMT</td>
<td>Memo to all Heads of Disciplines to remind them that appropriate goals to be identified for the resident in the ICP.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>Preventative Action(s): Post-Holder(s) responsible: CNMIII</td>
<td>Audit quarterly</td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
<td></td>
</tr>
</tbody>
</table>
## Regulation 16: Therapeutic Services and Programmes

**Report reference: Page 35-36**

<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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</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
</tbody>
</table>

### 10. Not all residents had access to a social worker, in accordance with their ICPs.

**New**

- **Corrective Action(s):**
  - Social Worker Manager will apply for development funding for two new WTE’s.
  - Post-Holder(s) responsible: Social Worker Manager; Registered Proprietor

- **Preventative Action(s):**
  - Appointment of two new WTE’s
  - Post-Holder(s) responsible: Social Worker Manager; Registered Proprietor

- **Interim Plan** provided while awaiting approval for development funding

- **Dependant on development funding being made available**

- **Completed**

### 11. The therapeutic programmes and services provided in the approved centre were not all directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

**Reoccurring**

- **Corrective Action(s):**
  - Access to Community Social Worker and Inpatient O/T in addition to Nursing staff will provide evidenced based therapeutic interventions while awaiting approval for development funding.
  - Post-Holder(s) responsible: OT Manager; Social Worker Manager

- **Preventative Action(s):**
  - Audit 6 monthly
  - Post-Holder(s) responsible: OT Manager; Social Worker Manager

- **Access to Community Social Worker and Inpatient O/T in addition to Nursing staff will provide evidenced based therapeutic interventions while awaiting approval for development funding.**

- **Dependant on development funding being made available**

- **Completed**

| Date | 30/06/2018 | 31/03/2018 |
## Regulation 22: Premises

*Report reference: Page 43-44*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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</tr>
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<tr>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
</tbody>
</table>

### 12. The premises were not clean and maintained in good decorative order throughout, as evidenced by the following:
- Walls needed painting.
- Graffiti were observed in some rooms and in corridors.
- The toilet facility for the seclusion room in St. Edna’s Unit was dirty.
- Windows were dirty.

#### New Corrective Action(s):
- Post-Holder(s) responsible: Hospital Administrator
- Director of Nursing

#### Preventative Action(s):
- Post-Holder(s) responsible: CNMIII/Hospital Administrator / Registered Proprietor / ADON

**Achievable and realistic** 30/06/2018

### 13. The premises were not adequately heated.

#### New Corrective Action(s):
- Post-Holder(s) responsible: Estates; Maintenance Manager;

#### Preventative Action(s):
- Post-Holder(s) responsible: Estates; Maintenance Manager

**Achievable and realistic** 30/06/2018

### 14. A programme of routine maintenance and renewal of the fabric and decoration of the premises was not developed and implemented.

#### New Corrective Action(s):
- Post-Holder(s) responsible: Estates; Registered Proprietor

#### Preventative Action(s):
- Post-Holder(s) responsible: Estates; Hospital Administrator Registered Proprietor

**Audit 6 monthly** Achievable and realistic 30/06/2018
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<tr>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>15. The condition of the physical structure and the overall approved centre environment was not maintained with due regard to the specific needs and the safety and well-being of residents, as evidenced by the presence of ligature points, broken handles on doors, and leaks in conservatory areas.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Registered Proprietor / Estates</td>
<td>Remove elastic band from bins.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Hospital Administrator / Registered Proprietor / Estates/ CNMIII</td>
<td>Ligature Audit provided</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
## Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

**Report reference: Page 45-46**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>16. Medication was not appropriately stored.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CNM11</td>
<td>Medication will be appropriately stored</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM11</td>
<td>Audit quarterly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>17. A daily log of medication fridge temperatures was not maintained.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CNM11</td>
<td>Daily Log to be implemented</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM11</td>
<td>Audit quarterly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>18. Medication past its expiry date was observed in the medication cabinet.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: ADON</td>
<td>CNM11 to remove expired medication</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Appointment of Pharmacist Post-Holder(s) responsible: Registered Proprietor</td>
<td>Audit quarterly</td>
<td>Dependant on development funding</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

**Report reference: Page 50-51**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
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<tr>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>19. The numbers and skill mix of staff were not appropriate for the assessed needs of residents or the size and layout of the approved centre.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): Appointment of 1 WTE OT and 1 WTE Social Worker</td>
<td>CMT will develop a staff plan</td>
<td>Dependant on development funding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: OT Manager; Social Worker Manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): CMT identifies staff requirements that are required to meet Regulation 26 Staffing</td>
<td></td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: CMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Not all staff had up-to-date mandatory training in fire safety, BLS, the management of aggression and violence, and the Mental Health Act 2001.</td>
<td>Reoccurring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>21. One of the seclusion rooms in the Admission Unit included a blind spot that prevented nursing staff from directly observing residents for the first hour of seclusion.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Hospital Administrator</td>
<td>Convex mirror to be installed</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM111</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>22. The seclusion room in St. Edna’s Unit was not maintained and cleaned to ensure that the dignity of residents in seclusion was maintained.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Maintenance Manager/ Registered Proprietor / Hospital Administrator/Director of Nursing</td>
<td>Seclusion room cleaned. Cleaning Company contacted to remove writing</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNMIII</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>23. The seclusion policy did not address ways of reducing the use of seclusion.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: MDT Policy Review Group</td>
<td>Update Policy</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Working Policy Group</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>24. Not all staff involved in the use of seclusion had signed</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>Signature Log to be signed by staff</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<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>the signature log to indicate that they had read and understood the policy.</td>
<td>Post-Holder(s) responsible: Clinical Director; Director of Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventative Action(s): Post-Holder(s) responsible: Heads of Disciplines / CNM111</td>
<td></td>
<td></td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
<tr>
<td>25. One episode of seclusion was not reviewed by the MDT and recorded in the clinical file within two working days.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Clinical Director / Heads of Disciplines</td>
<td>Memo to all Heads of Disciplines re review of seclusions within two working days</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Social Worker Manager</td>
<td></td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
</tbody>
</table>
## Code of Practice: The Use of Physical Restraint

**Report reference: Page 72-73**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>26.</strong> In two of the clinical files examined, it was not recorded that the consultant psychiatrist was notified of the use of physical restraint as soon as was practicable.</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Clinical Director</td>
<td>1) Memo to RMP’s 2) Notice to be attached to the register 3) Training</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Clinical Director</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
<tr>
<td><strong>27.</strong> There was no evidence in two clinical files that a registered medical practitioner completed a medical examination of the residents within three hours of the start of physical restraint.</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Clinical Director</td>
<td>Training</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Clinical Director</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
<tr>
<td><strong>28.</strong> In one episode of physical restraint, the consultant psychiatrist did not sign the clinical practice form within 24 hours.</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Clinical Director</td>
<td>Training</td>
<td>Achievable and realistic</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Clinical Director</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td><strong>Provide corrective and preventative action(s) to address the area of non-compliance</strong></td>
<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td>29. There was no evidence that residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of restraint.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Post-Holder(s) responsible: Clinical Director / DON</td>
<td>Memo to TMVA Instructors re importance of informing residents of this</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM111</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>30. In one episode, there was no evidence that next of kin were informed of the use of physical restraint and no explanation for this was recorded.</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Post-Holder(s) responsible: Director of Nursing/ Clinical Director</td>
<td>Memo to TMVA Instructors of the importance of informing next-of-kin and recording of same</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM111</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>31. Not all staff involved in the use of physical restraint had signed the signature log to indicate that they had read and understood the policy</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Post-Holder(s) responsible: Director of Nursing/ Clinical Director</td>
<td>Memo to all Heads of Disciplines to remind them that all staff involved in the use of physical restraint are to sign signature log to indicate that they had read and understood the policy</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNM111</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>32. The policy did not include the following staff training considerations:</td>
<td><strong>New</strong></td>
<td>Corrective Action(s): Post-Holder(s) responsible:</td>
<td>Update Policy</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
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</table>

- Areas to be addressed during training such as alternatives to the use of physical restraint and training in the prevention and management of violence
- The identification of appropriately qualified individuals to deliver training
- The mandatory nature of training for those involved in the use of physical restraint.

33. The physical restraint policy did not include a child protection process in the event of a child being restrained.

MDT Policy Review Group

Preventative Action(s):
Post-Holder(s) responsible:
MDT Policy Review Group

Achievable and realistic

Completed
### Code of Practice: Admission of Children


<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taken from the inspection report</strong></td>
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<td>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>34. Age-appropriate facilities and a programme of activities appropriate to age and ability were not available in the approved centre.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Registered Proprietor / CAMHS Teams</td>
<td>1) In the unlikely event that a child is admitted St. Loman’s Hospital provides age appropriate treatment as per the Admission of Children Policy. 2) Clinical Director to memo CAMHs re adherence to Policy.</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td>35. There was no access to age-appropriate advocacy services.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible:</td>
<td>National Issue</td>
<td>National Issue</td>
</tr>
<tr>
<td>36. The policy on the admission of children did not specifically reference confidentiality.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible:</td>
<td>Update Policy</td>
<td>Achievable and realistic Completed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: MDT Policy Review Group</td>
<td>Achievable and realistic Completed</td>
<td></td>
</tr>
</tbody>
</table>

Preventative Action(s): CAMHS Teams to be encouraged to seek age appropriate facilities in the event of a child been considered for admission

Achievable and realistic

As and when a child is admitted
### Code of Practice: Notification of Deaths and Incident Reporting

*Report reference: Page 75*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</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>37. The policy did not address the roles and responsibilities of staff in relation to completing death notification forms.</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Working Policy Group</td>
<td>Update Policy</td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: MDT Policy Review Group</td>
<td></td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
</tr>
</tbody>
</table>
### Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

**Report reference: Page 76**

<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 details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td><strong>38. The policy did not contain procedures for training staff in working with people with intellectual disability that addressed the following:</strong></td>
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<tr>
<td>• Induction training for new staff.</td>
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<tr>
<td>• Staff who should receive training.</td>
<td></td>
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<tr>
<td>• Areas to be addressed in training.</td>
<td></td>
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<tr>
<td>• Frequency of training.</td>
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<tr>
<td>• The identification of appropriately qualified individuals to deliver training.</td>
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<tr>
<td>• The evaluation of training programmes.</td>
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</tr>
<tr>
<td><strong>New</strong></td>
<td><strong>Corrective Action(s):</strong></td>
<td><strong>Provide corrective and preventative action(s) to address the area of non-compliance</strong></td>
<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td><strong>Post-Holder(s) responsible:</strong></td>
<td><strong>Preventative Action(s):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working policy group</td>
<td>Post-Holder(s) responsible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Policy completed</strong></td>
<td><strong>Policy completed</strong></td>
<td></td>
<td><strong>Achievable and realistic</strong></td>
<td><strong>Completed</strong></td>
</tr>
<tr>
<td><strong>Copy of Policy attached</strong></td>
<td><strong>Copy of Policy attached</strong></td>
<td></td>
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</tr>
</tbody>
</table>


## Code of Practice: Admission, Transfer and Discharge

### Report reference: Page 78-79

<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 the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>39. There was no evidence that an audit had been completed on the implementation of and adherence to the discharge policy.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CNMIII</td>
<td>Audit completed</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CNMIII</td>
<td>Audit completed</td>
<td>Achievable and realistic</td>
<td>Completed Audit dated 16/08/2017 attached</td>
</tr>
<tr>
<td>40. Not all health care professionals had signed the signature log to indicate that they had read and understood the transfer policy.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: CMT</td>
<td>Signature Log to be completed</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: CMT or CNMIII</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
<tr>
<td>41. There was no evidence in either file inspected in relation to transfer that that the residents’ wishes were respected or that consent for the transfers was obtained.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Clinical Director / Heads of Disciplines</td>
<td>Resident’s wishes will be respected and consent obtained</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: Clinical Director; Hospital Administrator</td>
<td>Training / Audit 6 monthly Clinical Director; Hospital Administrator</td>
<td>Achievable and realistic</td>
<td>31/03/2018</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>42. In one file inspected in relation to discharge, a preliminary discharge summary was not sent to the primary care/community health team within three days.</td>
<td>New</td>
<td>Corrective Action(s): Post-Holder(s) responsible: Clinical Director</td>
<td>Discharge Summary will be sent to the Primary Care / Community Health Team within 3 days</td>
<td>Achievable and realistic</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Post-Holder(s) responsible: T/Hospital Administrator</td>
<td>Audit 6 monthly</td>
<td>Achievable and realistic</td>
<td>30/06/2018</td>
</tr>
</tbody>
</table>