Acute Psychiatric Unit, Cavan General Hospital

ID Number: AC0019

2018 Approved Centre Inspection Report (Mental Health Act 2001)

Acute Psychiatric Unit, Cavan General Hospital
Cavan
Co Cavan

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

Most Recent Registration Date:
1 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Teresa Dykes, General Manager, Mental Health – CHO1

Inspection Team:
Noeleen Byrne, Lead Inspector
Mary Connellan
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Inspection Date:
7 – 10 August 2018

Previous Inspection Date:
18 – 21 April 2017

Inspection Type:
Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
5 March 2019

2018 COMPLIANCE RATINGS

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH

CODES OF PRACTICE

Compliant
RATINGS SUMMARY 2016 – 2018

Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018

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 2016 – 2018
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1.0 Introduction to the Inspection Process

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

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

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

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

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

b) See every patient the proprietor 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, achievable, realistic, 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 – Review of Findings
Inspection 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.

In brief

The Acute Psychiatric Unit was located on the ground floor of Cavan General Hospital. Six consultant-led teams admitted to the approved centre and there were two consultant-led in-house teams. The approved centre was registered for 25 residents and had a catchment area of the counties Cavan and Monaghan.

It is disappointing to note that compliance with Regulations and Codes of Practice had decreased from 74% in 2017 to 63% in 2018. No area of compliance was rated excellent. There was non-compliance with three Regulations (Regulation 22: Premises, Regulation 26: Staffing and Regulation 31: Complaints) for the third consecutive year.

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

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.

Safety in the approved centre

Each resident had at least two personal identifiers for the individual provision of treatment. Food safety audits had been completed periodically; however, hygiene was not maintained to support food safety requirements. Catering areas and catering and food safety equipment were not appropriately cleaned, with dirt on the floor and on the castor wheels of a stainless steel storage unit.

Hazards had not been minimised appropriately, as a handrail was broken in the hallway, which had a sharp edge. Ligature points were not reduced to the lowest practicable level, based on risk assessment. There were non-compliances in the prescribing, administration and storage of medication. The medication policy did not reflect legislative changes to the Mental Health Act 2001, dated 2015, because it referenced the term “unwilling” to consent to treatment. To administer medication to a patient who is unwilling but capable to consent is unlawful.
Not all staff had received the required training in Basic Life Support, fire safety, the management or aggression and violence and the Mental Health Act 2001.

**Appropriate care and treatment of residents**

Each resident had a multi-disciplinary individual care plan (ICP) which was developed with the resident and was reviewed regularly. There were therapeutic services and programmes, which met the assessed needs of the residents and were outlined in the ICPs. Music therapy had been successfully piloted and funding was received for two 12-week sessions. There was access to a dietitian. While there were regular physical examinations, at least every six months, they did not adequately assess general health of the residents. The administration of Electro-Convulsive Therapy (ECT) was compliant with the relevant Rules and Codes of Practice.

Three children had been admitted since the last inspection. Provisions were in place to ensure the safety of the child, respond to the child’s special needs as a young person in an adult setting, and to ensure the right of the child to have his/her views heard. Age-appropriate facilities and a programme of activities were not provided and adequate arrangements for continuing children’s education were not made.

While admission procedures were in order, comprehensive discharge summaries were not issued within 14 days as required.

**Respect for residents’ privacy, dignity and autonomy**

Visitors could be met in private and residents could communicate externally without restriction. However, there was insufficient consideration of residents’ right to privacy: noticeboards displayed resident names; where a dormitory room overlooked a publicly accessible area, the windows were not fitted with opaque glass to ensure privacy; and clinical documents with identifiable information on the nurses’ desk from the hall window were visible to residents and visitors.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

Seclusion was not carried out in the approved centre. With regard to physical restraint, not all relevant staff involved in physical restraint had indicated that they had read and understood the use of physical restraint policy. Residents were not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, and residents were not afforded an opportunity to discuss episodes with members of the multi-disciplinary team involved in his/her care.

**Responsiveness to residents’ needs**

There was a wide range of recreational activities, including table tennis, a football table and an exercise bike. An artist had commenced weekly sessions and some work was displayed in the new garden. There was a good choice of meals and food was attractively presented.

The approved centre was not in a good state of repair externally and internally. Laundry bags and an empty ink cartridge were left in the corridor and there was a broken lock in a bedroom. There were significant issues with the programme of general maintenance, decorative maintenance, cleaning, decontamination, and
repair of assistive equipment, including a dirty bathroom, a dirty bedroom, a dirty kitchen, a dirty sluice room, a foul smell in the sluice room, and a smell of smoke. Towels were thrown around the dormitory. A cleaning schedule was implemented, but it was insufficient for the size of the ward.

Information about the approved centre, residents’ diagnoses and medication. There was a complaints process but it was not adequate: the complainant’s view of the investigation findings was not documented and the nominated person did not maintain a complaints log.

**Governance of the approved centre**

The approved centre was part of the HSE’s Community Healthcare Organisation (CHO) Area 1, which comprised of Donegal, Sligo/Leitrim/West Cavan, and Cavan/Monaghan. The approved centre had a system of governance and a number of meetings took place, evidence for which was provided. The Cavan/Monaghan area management team met monthly. The strategic plan was updated in June and outlined the priorities for development for Cavan/Monaghan Mental Health Services.

Business meetings were held monthly, and were attended by the executive clinical director, consultants, nursing management staff, a service user representative, and health and social care professionals working in the approved centre. The quality and safety committee for Cavan/Monaghan met monthly. Heads of discipline, approved centre management teams, as well as risk advisors and service user representatives attended these meetings. The risk register and incidents were reviewed at this meeting. Clinical auditing, quality improvement plans, and the report from the Policy, Procedure and Protocol Guideline Committee (PPPG) were also discussed at this meeting.

Clear lines of responsibility were evident in each department; heads of discipline attended regular meetings with staff. Clinical supervision was facilitated by all heads of discipline, except nursing; however, the area director of nursing outlined a plan to introduce this into the service.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The garden area was developed, by staff and residents, into a sensory garden. A garden party was held to launch the developed area.

2. Music therapy was successfully piloted and funding was received for two 12-week sessions.

3. An artist commenced weekly sessions and some work was displayed in the new garden.

4. Pet therapy had commenced once a week.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Acute Psychiatric Unit, which was well signposted, was located on the ground floor of Cavan General Hospital. Six consultant-led teams admitted to the approved centre and there were two consultant-led in-house teams. The approved centre was registered for 25 residents and had a catchment area of the counties Cavan and Monaghan.

The approved centre had three four-bed rooms, one six-bed room, and seven single en suite rooms. Residents had access to a central garden within the approved centre. There was also a family visiting room and a separate visiting room. Furnishings were comfortable throughout the unit. There was an information screen in the dining area, which provided ongoing information on services to residents. Residents had access to an internet station. The general hospital had a shop/newsagent and a large canteen, which residents and staff from the approved centre could use.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
</tr>
<tr>
<td>Total number of residents</td>
</tr>
<tr>
<td>Number of detained patients</td>
</tr>
<tr>
<td>Number of wards of court</td>
</tr>
<tr>
<td>Number of children</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

**Condition 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 HSE’s Community Healthcare Organisation (CHO) Area 1, which comprised of Donegal, Sligo/Leitrim/West Cavan, and Cavan/Monaghan. The approved centre had a system of governance and a number of meetings took place, evidence for which was provided. Due to the large geographical area, the Cavan/Monaghan area management team met monthly. The minutes provided indicated a large range of management issues were discussed including human resources and the filling of vacant posts, safeguarding, internet access, and future funding. The strategic plan was updated in June and outlined the priorities for development for Cavan/Monaghan Mental Health Services.

Business meetings were held monthly, and minutes of the previous meetings were provided to the inspection team. These meetings were attended by the executive clinical director, consultants, nursing management staff, a service user representative, and health and social care professionals working in the approved centre. These meetings discussed a broad range of issues, including risks, incidents, individual care plans, therapeutic services, audits, complaints, and smoking cessation. The delay in processing discharge summaries was discussed with an action plan created to ensure they were completed in a timely manner.

The quality and safety committee for Cavan/Monaghan met monthly. Heads of disciplines, approved centre management teams as well as risk advisors and service user representatives attended these meetings. The risk register and incidents were reviewed at this meeting. Clinical auditing, quality improvement plans, and the report from the Policy, Procedure and Protocol Guideline Committee (PPPG) were also discussed at this meeting.

The inspection team sought to meet with heads of discipline during the inspection. The inspection team met with the following individuals:

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

Heads of discipline from medical, social work, occupational therapy, and nursing each provided a clear overview of the governance within their respective departments. The acting executive clinical director was based in the approved centre, the acting area director of nursing attended three times a week, and other heads of discipline attended at least monthly.

Clear lines of responsibility were evident in each department; heads of discipline attended regular meetings with staff. Clinical supervision was facilitated by all heads of discipline, except nursing. However, the area director of nursing outlined a plan to introduce this into the service.

Additional therapeutic services had been arranged and residents were attending with enthusiasm. All management committees now had a service user representative. Some key operational risks cited by heads of discipline included difficulty in recruiting for permanent positions, retention of staff, and getting cover during extended absences.
The fact that the inspection team found that the approved centre was not clean was discussed. A meeting was held with management and the contract cleaners and a deep clean was arranged. Further meetings were planned to discuss the cleaning schedule and the required resources.

4.5 Use of restrictive practices

The door to the approved centre was locked and access was by swipe card.
5.0 Compliance

5.1 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 2017 and 2016 and the relevant risk rating when the service was non-compliant:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>Moderate</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>X</td>
<td>Low</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint</td>
<td>X</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Code of Practice on the Admission of Children</td>
<td>Not applicable</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Admission, Transfer and Discharge – Discharge</td>
<td>X</td>
<td>Low</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.

5.2 Areas of compliance rated “excellent” on this inspection

No areas of compliance were rated excellent on this inspection.
### 5.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Leaflets were distributed in the approved centre explaining the inspection process and inviting residents to talk to the inspection team.
- Set times and a private room were available to talk to residents.
- In order to facilitate residents who were reluctant to talk directly with the inspection team, residents were also invited to complete a service user experience questionnaire and give it in confidence to the inspection team. This was anonymous and used to inform the inspection process.
- The Area Lead from the HSE Mental Health Engagement Office was contacted.

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.

The inspection team met with three residents who were complimentary of their care and treatment. Residents said that the food was very nice and they had dinner in the middle of the day and early tea and a snack in the evening. The therapeutic services available were reported as being very good, and in particular, dog therapy, art sessions, and music therapy were commended. One resident returned a service-user experience questionnaire to the inspection team.
7.0 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:

- Acting Executive Clinical Director
- Registered Proprietor
- Business Manager
- Acting Area Director of Nursing
- Assistant Director of Nursing
- Area Lead Mental Engagement
- Policy Development and Clinical Auditor
- Principal Social Worker
- Principal Psychology Manager
- Senior Occupational Therapist
- Clinical Nurse Manager 2
- Quality Assurance Officer

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.
8.0 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 October 2016. The policy addressed requirements of the *Judgement Support Framework*, except that it did not address the required use of an appropriate resident identifier prior to the provision of therapeutic services and 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 for identifying residents, as set out in the policy.

**Monitoring:** An annual audit had not been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the resident identification process.

**Evidence of Implementation:** There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes. Identifiers were appropriate to the residents’ communication abilities and were person specific. Appropriate identifiers and alerts were used to alert staff to 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 processes, training and education, and monitoring pillars.
Regulation 5: Food and Nutrition

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in June 2018. The policy addressed requirements of the Judgement Support Framework, except for the monitoring of food and water intake.

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 been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: A dietitian approved the menus to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a variety of wholesome and nutritious food, which was presented in an attractive and appealing manner. Residents had at least two meal choices. Residents had access to safe, fresh drinking water and hot and cold drinks were provided regularly.

For residents with special dietary needs, nutritional and dietary needs were assessed and, where necessary, addressed in residents’ individual care plans. These needs were regularly reviewed by a dietitian. Residents and their representatives were educated about residents’ diets specifically in relation to any contraindications with medication. Weight, input, and output charts were maintained where appropriate. An evidence-based nutrition assessment tool was not used.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met/did not meet all criteria of the Judgement Support Framework under the processes, training and education, and evidence of implementation pillars.
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in April 2018. The policy 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. Not all relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had been completed periodically. Food temperatures were not recorded in line with food safety recommendations, and high fridge temperatures of up to nine degrees were recorded. A food temperature log was maintained, but there were gaps in the record. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Food was prepared in a manner that reduced risk of contamination, spoilage, and infection. Hygiene was not maintained to support food safety requirements. Catering areas and catering and food safety equipment were not appropriately cleaned, as there was dirt on the floor and the castor wheels of a stainless steel storage unit. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Appropriate protective and catering equipment was used during the catering process. Appropriate hand-washing areas were provided for catering services. Residents were provided with suitable crockery and cutlery that addressed their specific needs.

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

   a) Food temperatures had not always been checked before serving, 6 (1) (c).
   b) Fridge temperatures had not always been checked twice a day, 6 (1) (c).
   c) Fridge temperatures were high on two occasions, 6 (1) (c).
   d) There was dirt on the floor and on equipment in the kitchen, 6 (1) (c).
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 2018. The policy addressed requirements of the Judgement Support Framework, except that it did not detail the responsibility of the approved centre to provide new clothing to residents, where necessary, with consideration of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices.

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

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents had an adequate supply of individualised clothing, which were clean and appropriate to their needs. Residents changed out of nightclothes during daytime hours. However, the registered proprietor failed to ensure that when a resident did not have an adequate supply of their own clothing, the resident was provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times.

The approved centre was non-compliant with this regulation because the registered proprietor failed to ensure that, when a resident did not have an adequate supply of their own clothing, the resident was provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times, 27(1).
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 operational policy in relation to residents’ personal property and possessions, which was last reviewed in November 2016. The policy addressed requirements of the Judgement Support Framework, except for detailing a process to allow residents access to and control over their personal property and possessions, unless this posed a danger to the resident or others, as indicated by an individual risk assessment and the resident’s individual care plan.

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 residents’ personal property and possessions, as set out in the policy.

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

Evidence of Implementation: Residents were entitled to bring personal possessions into the approved centre. A resident property checklist was compiled on admission and updated as needed. The checklist was kept separately to the resident’s individual care plan (ICP) and was available to the resident. Where the approved centre assumed responsibility for a resident’s personal property and possessions, they were safeguarded appropriately. Secure facilities were provided for the safe-keeping of the residents’ personal property.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Access to and use of resident monies was overseen by two members of staff and the resident or their representative. Where money belonging to the resident was handled by staff, signed records of the staff issuing the money was retained and where possible counter-signed by the resident or their representative.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and monitoring pillars.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in January 2017. The policy addressed requirements of the Judgement Support Framework, except for processes for developing recreational activity programmes and 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 were able to articulate the processes for recreational activities, as set out in the policy.

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile. The recreational activities were appropriately resourced. Activities were provided throughout the week, with indoor and outdoor exercise opportunities provided. Activities included TV, DVDs, stereo system with CDs, video games, books, jigsaw puzzles, board games, colouring, knitting, and playing cards. There was also an activity room with table tennis, football table, exercise bike, and exercise mats. Residents also had access to a large external courtyard and an activity room with an exercise bike, exercise ab cruncher, and more exercise mats. There was also an occupational therapy room.

Information was provided to residents on the types and frequency of activities in an accessible format. Individual risk assessments were completed to help select activities. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. Residents were free to choose whether to participate and their decisions were respected and documented. Logs of participation were maintained for recreational activities.

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 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 September 2015. The policy 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 was not reviewed to ensure that it reflected the identified needs of residents.

**Evidence of Implementation:** Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. Facilities were provided within the approved centre for residents’ religious practices. Residents had access to local religious services and were supported to attend, if appropriate. Residents also had access to multi-faith chaplains. Care and services provided were respectful of the residents’ religious beliefs and values. Any specific religious requirements relating to the provision of services, care, and treatment were clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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 11: Visits

| (1) | The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident. |
| (2) | The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits. |
| (3) | The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors. |
| (4) | The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan. |
| (5) | The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident. |
| (6) | The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits. |

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to visits, which was last reviewed in October 2016. The policy and procedures addressed requirements of the *Judgement Support Framework*, except that it did not detail the process for:

- Restricting visitors based on a resident request, an identified risk to resident, an identified risk to others, or an identified health and safety risk.
- The required visitor identification methods.

**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 visits, as set out in the policy.

**Monitoring:** Documented analysis had not been completed to identify opportunities for improving visiting processes.

**Evidence of Implementation:** Visiting times were appropriate and reasonable, and were publicly displayed at the entrance to the approved centre. A separate visitor’s area was provided where residents met visitors in private, if appropriate. The visiting area was suitable for visiting children. Children visiting were accompanied at all times to ensure their safety, and this was communicated to all relevant individuals publicly. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and monitoring pillars.
Regulation 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 operational policy and procedures in relation to resident communication, which was last reviewed in August 2015. The policy and procedures addressed requirements of the Judgement Support Framework, with the following exceptions:

- The assessment of resident communication needs.
- The individual risk assessment requirements in relation to limiting resident communication 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 were able to articulate the processes for communication, as set out in the policy.

Monitoring: Resident communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to mail, fax, internet including e-mail, and telephone, unless otherwise risk-assessed. Access to the internet was via a PC, with a €1 charge. Individual risk assessments were completed and documented in relation to any risks associated with their external communication.

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 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 written operational policies and procedures in relation to the implementation of resident searches, which were last reviewed in August 2015 and April 2016. The policies and procedures 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 is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

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

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

As no searches had occurred 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 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and protocols in relation to care of the dying, which was last reviewed in June 2018. The policy and protocols addressed requirements of the Judgement Support Framework, except that it did not state the process for the identification and implementation of the resident’s physical, emotional, social, psychological, spiritual, and pain management needs in relation to end of life care.

Training and Education: Not all relevant staff had signed the signature log to indicate that they had read and understood the policy, as no doctors had signed the log. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

As no resident had died 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. The policy addressed requirements of the Judgement Support Framework, except that it did not detail the required content in the set of documentation making up 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 were able to articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Residents’ ICPs were not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had been completed to identify ways of improving the individual care planning process.

Evidence of Implementation: Ten ICPs were reviewed on inspection. Each resident was initially assessed at admission by the admitting nurse and an ICP was completed to address immediate needs of resident. An ICP was developed by the MDT following a comprehensive assessment, within seven days of admission. The comprehensive assessment included medical, psychiatric, and psychosocial history, current medications, current physical health assessment, a detailed risk assessment, social and physical-related issues, communication abilities, and educational, occupational, and vocational history. ICPs were discussed, agreed, and drawn up with the participation of the resident and their representative, as appropriate. Some residents attended their ICP meeting and reviews. Otherwise, residents completed a form relating to their ICP and care needs.

Each ICP was a composite set of documents, stored in the clinical file, identifiable and uninterrupted, and kept separately from progress notes. The ICPs identified residents’ goals, treatment, care, and the resources required to meet residents’ needs. The ICP included a preliminary discharge plan, where deemed appropriate, and a risk management plan. ICPs of child residents included their educational requirements. Evidence-based assessments were used where possible. A key worker was identified to ensure continuity in the implementation of each ICP. While a key worker was identified, this could be a different person depending who was on duty, and while the approved centre aimed to keep continuity, there was not a system of naming one person for the resident.

Each ICP was reviewed by the MDT in consultation with the resident on a weekly basis. The ICPs were updated following review and residents were kept informed of any changes. This was an active process, however, it was not always documented in the ICPs that the resident had been offered, given, or refused.
a copy of the ICP. There was a section for the date if this had occurred and it was often not filled in either. Residents were not always offered a copy of their ICP.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities in relation to the provision of therapeutic services and programmes.
- The planning and provision of therapeutic services and programmes within the approved centre.
- The recording requirements for therapeutic services and programmes.
- The facilities for the provision of 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 were able to articulate the processes relating to therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: Therapeutic programmes and services were appropriate and met the assessed needs of residents, as documented in their individual care plans (ICP). These included three groups, which had daily sessions lasting 30-45 minutes. Some sessions were co-facilitated with external providers, including an artist and music therapist. Programmes and services were aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Programmes and services were evidence-based.

Adequate and appropriate resources and facilities were available. Programmes were provided in a separate dedicated room containing facilities and space for individual and group therapies. Rooms included an occupational therapy kitchen, group room, recreational room, and two sitting rooms. Where no internal service existed, the approved centre found an appropriate external service with an approved, qualified health professional.

A list of services and programmes provided in the approved centre was available to residents. The list was updated weekly, and communicated with a slide show in the dining room. Timetables were given to residents at a coffee group where the therapeutic groups were planned with residents. A record was maintained of participation, engagement, and outcomes achieved through the therapeutic programme in residents’ ICPs or clinical files.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and monitoring pillars.
Regulation 18: Transfer of Residents

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents, which was last reviewed in January 2017. The policy addressed requirements of the Judgement Support Framework, except that it did not outline the roles and responsibilities for the resident transfer process, including the responsibility of the multi-disciplinary team and resident’s key worker.

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 the transfer of residents, as set out in the policy.

Monitoring: A log of transfers was maintained. Each transfer record had been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had not been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: The clinical file of one resident who was transferred in an emergency situation was inspected. An assessment of the resident was completed and documented prior to transfers, including an individual risk assessment. Verbal communication and liaison took place between the approved centre and the receiving facility prior to transfers, and included a discussion of the reasons for transfer, care and treatment plans, and the resident’s accompaniment requirements. Information was sent in advance and accompanied the resident upon transfer, to a named individual. A checklist was not completed by the approved centre to ensure comprehensive resident records were transferred.

Communications between the approved centre and receiving facility were documented and followed up with a written referral where there were emergency transfers. Documented consent of the resident to the transfer was available, or justification as to why consent was not received. Communication records with the receiving facility were documented and available on inspection.

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.

COMPLIANT
Quality Rating Satisfactory
Regulation 19: General Health

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in March 2018. The medical emergencies policy was last reviewed in September 2015. The policies and procedures included all of the requirements of the *Judgement Support Framework*.

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

**Monitoring:** Residents’ take-up of national screening programmes was not 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:** Residents received appropriate general health care interventions in line with their individual care plans. Registered medical practitioners assessed residents’ general health needs at admission and on an ongoing basis as indicated by the residents’ needs. Residents’ general health needs were monitored and assessed as indicated by the residents’ specific needs, but at least every six months.

Only one resident had been admitted over six months and their records were reviewed. The six-monthly general health assessment included a physical examination, family and personal history, blood pressure, weight, nutritional status, and a medication and dental review. The assessment did not document body mass index, waist circumference, or smoking status. A resident taking antipsychotic medication also received an assessment of blood lipids and an electrocardiogram (ECG). They did not receive an annual assessment of their glucose regulation and prolactin levels.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services. Referral arrangements were in place with medical and surgical teams, speech and language therapy, and physiotherapists in Cavan General Hospital. Residents had information on, and could access, appropriate national screening programmes, including breast checks, cervical screening, retina checks, and bowel screening. Medical emergencies, and the care provided, were recorded.
Residents’ completed general health checks and associated results were recorded. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator. Both were checked daily.

The approved centre was non-compliant with this regulation due to the failure to ensure that all six monthly reviews fulfilled the criteria stipulated by the Mental Health Commission, 19, 1 (b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the provision of information to residents, which was last reviewed in June 2017. The policy and procedures addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for identifying residents’ preferred ways of receiving and giving information.
- The methods for providing information to residents with specific communication needs.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes relating to the provision of 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 been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: An information booklet was provided to residents and their representatives at admission in the required format. The booklet was clearly and simply written, and outlined the required information on care, services, and housekeeping practices, including arrangements for personal property, mealtimes, visiting times, and visiting arrangements, the complaints procedure, relevant advocacy and voluntary agencies, residents’ rights, and details of the multi-disciplinary team.

A variety of diagnosis and medication-related information, including risks and potential side effects, was available and provided to residents as appropriate. Information included evidence-based information about diagnosis. Information was accessible and residents had access to interpretation and translation services as required. Documentation was not appropriately reviewed and approved prior to implementation.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education, and evidence of implementation pillars.
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 April 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.
- The approved centre layout and furnishing requirements to support resident privacy and dignity.
- The approved centre’s process for addressing a situation where resident privacy and dignity is not respected by staff.

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

Monitoring: A documented annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre were conducive to resident privacy. Analysis had not been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Staff had an appropriate demeanour and dressed appropriately. Staff communicated with residents appropriately, used discretion when discussing medical conditions or treatment, and used residents’ preferred names. Staff sought the resident’s permission before entering their room. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. Locks had an override function. All residents were wearing clothes that respected their privacy and dignity. Residents were facilitated to make private phone calls and could use a portable ward phone in their bedrooms.

Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. A noticeboard displayed resident names. Although a dormitory room overlooked a publicly accessible area, the windows were not fitted with opaque glass to ensure privacy. Clinical documents with identifiable information on the nurses’ desk from the hall window were visible to residents and visitors.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident’s privacy and dignity was appropriately respected at all times:

a) The use of clear glass in bedrooms facing a publicly accessible area.
b) A noticeboard displayed resident’s names.
c) Clinical notes with identifying information was visible to all through the window of the nurse’s station.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre did not have a current written policy in relation to its premises. A new policy is in draft.

Training and Education: There was no policy to read, sign, or articulate.

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

Evidence of Implementation: The residents had access to personal space with appropriate bedrooms and communal rooms. There was not sufficient space to move about in, as there was only one outdoor area. The rooms were well lit and were not excessively noisy, but were not well ventilated as one of the dormitories had a bad smell. A vacant bedroom was not cleaned. The rooms were well heated, but radiators were not guarded, and heating could not be controlled in a resident’s room. There was appropriate signage and sensory aids to support resident orientation needs. There were enough toilets and showers, which were appropriately placed and identified. There was a sluice room, cleaning room, and laundry room. There was not a dedicated therapy or examination room. A bedroom and interview room were used as storage areas.

The approved centre was not in a good state of repair externally and internally. Laundry bags and an empty ink cartridge were left in the corridor, and there was a broken lock in a bedroom. There were significant issues with the programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, including:

- A bathroom was dirty.
- A bedroom was unclean.
- A kitchen was dirty, despite an earlier report identifying this issue.

A dirty utility room was not cleaned including the bedpan washer or the sluice room. Staff reported that the household staff did not have these rooms on their cleaning schedule.

Where faults or problems with the premises were identified, this was communicated appropriately. There was a cleaning schedule implemented, but it was insufficient for the size of the ward. There was a foul smell in the sluice room and the smell of smoke in two areas. Towels were thrown around the dorm and bathroom. Hazards had not been minimised appropriately, as a handrail was broken in the hallway, which had a sharp edge. Ligature points were not reduced to the lowest practicable level, based on risk assessment.

Back-up power was available to the approved centre. Remote or isolated areas of the approved centre were monitored.

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

- The premises were not clean, in good structural and decorative condition 22 (1) (a)
- The premises were not adequately ventilated 22 (2) (b)
- The condition of the physical structure was not maintained with due regard to the safety of residents. 22 (3)
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in December 2016. The policy addressed requirements of the Judgement Support Framework, except that it did not outline the processes for medication management at admission, transfer, and discharge. The policy included the term “unwilling” to consent to treatment, which was removed from Sections 59 and 60 of the Mental Health Act 2001 in 2015.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) had not been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. 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: Ten MPARs were reviewed on inspection. All entries were legible, written in black, indelible ink, and used two appropriate identifiers. MPARs had dedicated space for routine, once-off, and “as-required” medications. A record of the dose/amount, administration route, date of initiation, allergy status, and generic and full name of medicines were kept. MPARs were signed by the medical practitioner after each entry. However, one MPAR did not state the frequency of administration for medicine, and two did not contain a record of all medications administered to a resident. One MPAR did not have a discontinuation date for each medication, and another did not have the Medical Council Registration Number of every medical practitioner prescribing medication.

All medicines were administered by a registered nurse or medical practitioner. Medicinal products were administered in accordance with the directions of the prescriber and pharmacist’s advice. The expiration date of medication was checked prior to administration; expired medications were not administered. Good hand-hygiene techniques were implemented during the dispensing of medications. Schedule 2 controlled drugs were: checked by two staff members, including one registered nurse, against the delivery form; details were entered on the controlled drug book; and signed by both staff members. The controlled drug balance corresponded with the balance recorded in the controlled drug book.

Where residents refused medication, this was documented in the MPAR and clinical file, and communicated to medical staff. Direction to crush medication was only accepted from the resident’s
medical practitioner. The medical practitioner documented the crush order and the reason why this was to be done. The pharmacist was consulted about the type of preparation to be used.

Medication was stored in an appropriate environment. Medication storage areas were free from damp, mould, clean, litter, dust, pests, spillage or breakage. Food and drink was not stored in areas used for medication storage. Medication storage areas were incorporated in the cleaning and housekeeping schedules. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit is taken daily. One fridge was recorded as having a temperature of 11 degrees.

Medication dispensed or supplied to residents was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere. The medication administration cupboards were unlocked at the time of inspection. Scheduled 2 and 3 controlled drugs were double locked in a separate cupboard from other medicinal products to ensure further security.

Medication was reviewed and rewritten at least six-monthly, or more frequently as appropriate; this was documented in clinical files. Medical practitioners rewrote prescriptions where alteration was required. The pharmacist implemented a system of stock rotation, but did not complete a monthly inventory of medications. The medication cupboard was observed to be disorganised and overcrowded. There was a process of returning old medication. However, on inspection medications that were no longer required were found in an unlocked cupboard. This was immediately addressed on discovery.

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

a) The frequency of administration was not complete on one MPAR.

b) There was not a record of all medications administered to the resident on two MPARs.

c) One MPAR did not document a discontinuation date.

d) A medication administration cupboard was unlocked.

e) The Medical Council Registration Number was not included on one MPAR.

f) The policy did not reflect legislative changes to the Mental Health Act 2001, dated 2015, because it referenced the term “unwilling” to consent to treatment.
**Regulation 24: Health and Safety**

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<th>COMPLIANT</th>
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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 safety statement in relation to the health and safety of residents, staff, and visitors, which was last reviewed in October 2016. The safety statement addressed requirements of the *Judgement Support Framework*, except that it did not outline the support provided to staff following exposure to infectious diseases.

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

**Monitoring:** The safety statement was monitored pursuant to Regulation 29: Operational Policies and Procedures.

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

**The approved centre was compliant with this regulation.**
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 and procedures in relation to its staffing requirement, which was last reviewed in June 2017. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment processes for all staff within the approved centre.
- The recruitment, selection, and appointment process of the approved centre, including the Garda vetting requirements.

The policy and procedures did not address the following:

- The organisational structure of the approved centre, including lines of responsibility.
- Staff performance and evaluation requirements.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- Orientation and induction training for all new staff.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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 relating to staffing, as set out in the policy.

Monitoring: The implementation and effectiveness of the staff-training plan was reviewed on an annual basis. This was documented. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: The numbers and skill mix of staffing were sufficient to meet resident needs. Access psychology services were arranged on a referral basis. Staff were recruited and vetted in accordance with the approved centre’s policy and procedure. Staff had the appropriate qualifications to
do their job. The required number of staff were on duty at night to ensure safety of residents in the event of a fire or other emergency. A planned and actual staff rota was maintained and an appropriately qualified staff member was on duty and in charge at all times; this was documented. There was an organisational chart to identify the leadership, management structure, and lines of authority and accountability. Where agency staff were used, there was a comprehensive contract between the approved centre and registered/licensed staffing agency, which set out the vetting requirements for potential staff.

There was no staffing plan. Annual staff training plans had been completed to identify required training and skills development. New staff completed orientation and induction training. Not all staff were not trained in fire safety, Basic Life Support, management of violence and aggression, resident rights, or the Mental Health Act 2001. Fire safety and Basic Life Support training was planned for September 2019. Staff did receive training in Children First, manual handling, dementia care, end of life care, and a range of other areas.

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

Staff training was documented and staff training logs were maintained. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff 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>Unit A</td>
<td>CNM2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychologist</td>
<td></td>
<td>By referral</td>
</tr>
</tbody>
</table>

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

The approved centre was non-compliant with this regulation because not all staff had received the required training in Basic Life Support, fire safety, the management or aggression and violence and the Mental Health Act 2001, 26 (4)
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in January 2017. The policy and procedures 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.

The policy and procedures did not address the following:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- 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. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policy. Not all clinical staff had been trained in best-practice record keeping.

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

Evidence of Implementation: The approved centre maintained a record for every resident who was assessed or provided with care. Records had a unique identifier, were up to date and maintained in line with national guidelines and legislative requirements. Only authorised staff could access data and make new entries, and residents could access records in line with data protection legislation. Staff had access to the information needed to carry out their job responsibilities. However, records were not appropriately secured from loss, destruction, tampering, or unauthorised access or use, as temporary folders were used.
Documents, in these temporary folders, were attached to a clipboard.

Records were maintained appropriately, including being factual, consistent, written legibly in indelible black ink, using date and time (using the 24-hour clock), and signed appropriately. All entries made by student nurses or clinical training were countersigned by a registered nurse or clinical supervisor. The approved centre maintained a log of signatures used in resident records. Records were reflective of residents’ status. Where an error was made, it was not scored out with a single line and the correction written alongside with the time, date and initials.

Documentation of food safety, health and safety, and fire inspections was maintained. Records were retained or destroyed in accordance with legislative requirements.

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

a) Not all records were in good order 27 (1).
b) Errors were not corrected in line with best practice 27 (1).
c) Not all records were secured; a clipboard was used to hold notes of a resident who was newly admitted 27(1).
**Regulation 28: Register of Residents**

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

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

**INSPECTION FINDINGS**

The approved centre had a documented register of residents, which was not up to date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record diagnosis on admission or diagnosis on discharge. There were ten entries since January 2018 that did not have a diagnosis on admission code, and there were many gaps with regard to diagnosis on discharge.

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

a) The register was not up-to-date, 28(1).

b) The register did not always document admission codes, 28 (2).

c) The register did not always document discharge codes, 28 (2).
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to the development and review of operating policies and procedures required by the regulations, which were last reviewed in February 2018 and November 2016. It addressed requirements of the Judgement Support Framework, except for the following:

- The roles and responsibilities in relation to the development, management, and review of operating policies and procedures.
- The process for making obsolete and retaining previous versions of operating policies and procedures.

Training and Education: All relevant staff had signed the signature log to indicate that they had read and understood the policies. Relevant staff had been trained on approved operational policies and procedures. Relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures were developed by the Policy, Procedure and Protocol Guideline Committee (PPPG). The PPPG had a small membership and had input from allied health professionals and others as required. The PPPG met monthly and reported to the quality and safety committee, which was made up of wider multi-disciplinary team members and included a service user representative.

The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately formatted, approved, and communicated to all relevant staff. Policies were available to staff as a hard copy and online. The approved centre was improving how its policies are communicated to staff and how to ensure signage on part of staff. Relevant policies had been reviewed within the past three years. Obsolete versions of operating policies and procedures were retained but removed from access by staff.

Generic policies were appropriate to the approved centre and the resident group profile. Where generic policies were used, the approved centre has a written statement to this effect (adopting the generic policy).

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 pillar.
Regulation 30: Mental Health Tribunals

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.
(2) In circumstances where a patient’s condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

Processes: The approved centre had a written policies and procedures in relation to the facilitation of Mental Health Tribunals, which were both last reviewed in March 2017. The policies and procedures 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 policies. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policies.

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

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in March 2017. The policy and procedures addressed requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

The policy and procedures did not address the methods available to all persons to make complaints regarding the service, care, or treatment by the approved centre, specifically via e-mail or through complaint, feedback, or suggestions forms.

Training and Education: Relevant staff had not been trained on the complaints management process. 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 not been completed. Complaints data was not analysed. Required actions had not been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: Residents and their representatives were provided with information on the complaints process, with information being well publicised and accessible. The information was provided in a leaflet on admission, at a weekly meeting, and on an as needed basis. Residents and their representatives were assisted to make complaints using appropriate methods and facilitated to access an advocate. However, complaints could not be made via email. There was a nominated person who was responsible for dealing with complaints, who was clearly identified. There was also a method for addressing minor complaints. The nominated person dealt with minor complaints that could not be addressed locally.
All complaints were investigated promptly and handled appropriately and sensitively. The complaints process was consistent and standardised. Complainants were provided with appropriate timeframes and informed promptly of the outcome and details of the appeals process. Details of the complaint, investigation, and outcomes were kept, distinct from the resident’s individual care plan. The complainant’s view of the investigation findings was not documented. The nominated person did not maintain a complaints log.

The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected because of the complaint being made. All information obtained in the complaints process was treated confidentially, consistent with relevant legislation.

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

a) The registered proprietor did not ensure that the nominated person maintains a record of all complaints relating to the approved centre 31(6).

b) The registered proprietor did not ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded 31 (7).
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 four written policies in relation to risk management and incident management procedures:

- Risk management, last reviewed in February 2017.
- Risk Screen and management policy, last reviewed in January 2017.
- Suicide and self-harm policy, last reviewed in February 2017.
- Safety statement, last reviewed in October 2016.

The policy addressed all of the requirements of the Judgement Support Framework, including the following:

- The process for 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 emergencies.
- The process for protecting children and vulnerable adults in 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 were trained in individual risk management processes. Management were trained in organisational risk management. 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 policy. Not all staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

**Monitoring:** The risk register was not reviewed 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:** The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical, corporate, and health and safety risks were identified, assessed, treated, reported, monitored, and documented in risk registers. Structural risks, including ligature points, were removed or effectively mitigated. A plan was implemented to reduce risks to residents while works to the premises were ongoing. The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management processes.

Individual risk assessments were completed prior to and during resident transfer, discharge, physical restraint, and specialised treatment, in conjunction with medication requirements or administration. Multi-disciplinary teams, residents, and their representatives were involved in the development, implementation, and review of individual risk management processes.

Incidents were recorded and risk-rated in a standardised format. The designated risk manager reviewed incidents for any trends or patterns occurring in the services, and clinical incidents reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of that review and recommended actions. The Mental Health Commission was provided with a six-monthly summary report of all incidents, with information anonymised at a resident level.

The requirements for the protection of children and vulnerable adults were appropriate and implemented. There was an emergency plan that specified responses by staff to possible emergencies, including 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 monitoring 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 covered by 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 with one condition to registration attached. The certificate was prominently displayed.

The approved centre was compliant with this regulation.
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 and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated November 2017. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated suite for the delivery of ECT, including a private waiting room and adequately equipped treatment and recovery rooms. The suite was located in a theatre in Cavan General Hospital. A named consultant psychiatrist and anaesthetist had overall responsibility for ECT management and anaesthesia respectively. There were at least two registered nurses in the ECT suite at all times, one of whom was a designated ECT nurse. Materials and equipment in the ECT suite were in line with best international practice. ECT machines were regularly maintained and serviced; this was recorded.

One record of a patient receiving ECT was reviewed on inspection. A wide range of appropriate and accessible information on ECT was provided by the consultant psychiatrist to enable the patient to make a decision on whether to consent to receiving ECT treatment. Questions asked by the patient were answered and discussions about ECT were documented in clinical file. An assessment of capacity was undertaken and recorded by a consultant psychiatrist prior to obtaining consent; and this was recorded. In the record reviewed, the patient was unable to consent.

The anaesthesia and ECT were prescribed, administered, and recorded appropriately. The patient’s clinical and cognitive status was assessed before, during, and after each ECT session and programme. The continued use of ECT was reviewed by the consultant psychiatrist in consultation with the patient.

ECT was administered according to section 59(1)(b) of MHA 2001, as amended. Two consultant psychiatrists assessed and recorded how ECT would benefit the patient, the views of the patient, and the
The patient’s ability to consent. The responsible consultant psychiatrist prescribed ECT and recorded the prescription. A **Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent** was completed by both consultant psychiatrists for each ECT programme. The form was placed in a clinical file and a copy was sent to the Mental Health Commission within five days.

The approved centre was compliant with this rule.
10.0 Inspection Findings – Mental Health Act 2001

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

56. In this Part “consent”, in relation to a patient, means consent obtained freely without threat or inducements, where –

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

a) the patient gives his or her consent in writing to the continued administration of that medicine, or

b) where the patient is unable to give such consent –

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. In both cases, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment, or equivalent, following administration of medication for a continuous period of three months. In both cases the patients were unable to consent, and a form 17 was completed which contained:

- The name of the medication(s) prescribed.
- Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s).
- Details of discussion with patient, including the nature, purpose, effects of the medication(s).
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Any views expressed by the patient.
- The approval and authorisation of two consultant psychiatrists.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.
11.0 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. The policy had been reviewed annually and was dated December 2017. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

Training and Education: Medics had not signed a record to indicate they read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: Three episodes of physical restraint were reviewed on inspection. In all cases, physical restraint was used in rare, exceptional circumstances and in the best interests of the resident. Physical restraint was only exercised where a resident posed immediate threat of serious harm to self or others, after all alternative interventions had been considered, and based on a risk assessment. Orders for physical restraint did not last for longer than 30 minutes. Residents were not informed of reasons for, likely duration of, or circumstances leading to discontinuation; the reason for this was not recorded.

Physical restraint was initiated by an appropriate health professional in line with the physical restraint policy. A designated staff member was responsible for leading the physical restraint and monitoring the head and airway of the resident. The consultant psychiatrist or duty consultant psychiatrist was notified as soon as practicable; this was documented. Cultural awareness and gender sensitivity was demonstrated. A same sex staff member was present at all times during physical restraint where practicable.

Registered medical professionals completed a medical examination within three hours of the end of the episode. As soon as practicable, and with resident’s consent, the resident’s representative was informed of the use of physical restraint; this was recorded.

Each episode of physical restraint was documented in a clinical file. A clinical practice form was completed by the initiator of physical restraint within three hours. That form was signed by a clinical psychiatrist within 24 hours and placed into the resident’s clinical file. There was no evidence that each episode was reviewed by members of the MDT and documented within two working days. However, residents were not given the opportunity to discuss the episode with the MDT.

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

a) Not all relevant staff involved in physical restraint had signed a log to indicate that they had read and understood the use of physical restraint policy, 9.2.
b) Residents were not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, 5.8.

c) Residents were not afforded an opportunity to discuss episode with members of the multidisciplinary team involved in his/her care as soon as was practicable, 7.2.
Admission of Children

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in April 2016. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Not all staff had signed a log to indicate they had received training in relation to the care of children.

Evidence of Implementation: Three children had been admitted since the last inspection. Age-appropriate facilities and a programme of activities were not provided. Provisions were in place to ensure the safety of the child, respond to child’s special needs as a young person in an adult setting, and to ensure the right of the child to have his/her views heard. Adequate arrangements for continuing children’s education were not made.

Children had their rights explained and information about the ward and facilities provided in an understandable way; this was recorded. Children did not have access to child advocacy services. Consent for treatment was obtained from one or both parents.

Appropriate visiting arrangements and accommodation was provided, with children assigned single en suite rooms. Observation arrangements, including assignment of a designated staff member, was provided as considered clinically appropriate and acknowledged gender sensitivity.

Advice from the Child and Adolescent Mental Health Service was available. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. The Commission was notified of children admitted to approved centres for adults within 72 hours of admission using the associated notification form. Staff having contact with the child had undergone Garda vetting.

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

a) Not all staff had signed a log to indicate they had received training in relation to the care of children, 2.5 (e).
b) Age-appropriate facilities and a programme of activities were not provided by the approved centre, 2.5 (b).
c) Adequate arrangements for continuing children’s education were not made, 2.5 (f).
d) Children did not have access to child advocacy services, 2.5 (g).
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated November 2017. It contained protocols that were developed in line with best international practice, including

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated suite for the delivery of ECT, including a private waiting room and adequately equipped treatment and recovery rooms. The suite was located in a theatre in Cavan General Hospital. A named consultant psychiatrist and anaesthetist had overall responsibility for ECT management and anaesthesia respectively. There were at least two registered nurses in the ECT suite at all times, one of whom was a designated ECT nurse. Materials and equipment in the ECT suite were in line with best international practice. ECT machines were regularly maintained and serviced; this was recorded.

One record of a resident receiving ECT was reviewed on inspection. An assessment of capacity was undertaken and recorded by a consultant psychiatrist prior to obtaining consent; and this was recorded. A wide range of appropriate and accessible information on ECT was provided by the consultant psychiatrist to enable the resident to make a decision whether to consent to treatment. Questions asked by the resident were answered, and ECT discussions were documented in clinical file. The resident was given 24 hours to reflect on the information they received.

The anaesthesia and ECT were prescribed, administered, and recorded appropriately. The resident’s clinical and cognitive status was assessed before, during, and after each ECT session and programme. The continued use of ECT was reviewed by the consultant psychiatrist in consultation with the resident.

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

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in February 2017, addressed the policy-related criteria for this code of practice, but did not address the protocol for planned admission with reference to referral letters.

Transfer: The transfer policy, which was last reviewed in January 2017, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in June 2018, included all of the policy-related criteria for this code of practice.

Training and Education: There was no documentary evidence that relevant staff had read and understood the admission, transfer, or discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission and discharge policies, but not for the transfer policy.

Evidence of Implementation:

Admission: All admissions were on the basis of mental illness or mental disorder. Admission assessments were completed and included an appropriate range of assessments. Resident’s representatives were involved in the admission process, with the resident’s consent. A key worker system was in place.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The approved centre maintained discharge plans, which included documented communication with relevant health professionals, an estimated date of discharge, and a follow-up plan. However, it did not include references to early warning signs of relapse and risks.

Discharge meetings were attended by residents and their representatives, key worker, and relevant members of multi-disciplinary team. Discharge assessments addressed medical, social, housing, and informational needs. Discharges were not coordinated by a key worker.

Preliminary discharge summaries were sent to the appropriate health practitioner within three days; however, comprehensive discharge summaries were not issued within 14 days. Resident representatives were involved in discharge process. A timely follow-up appointment was made.

The approved centre was non-compliant with this code of practice for the following reasons:
a) The admission policy did not address the protocol for planned admission with reference to referral letters, 4.3.
b) There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies, 9.1.
c) Audits had been completed on the implementation of and adherence to the admission and discharge policies, but not for the transfer policy, 4.19.
d) Discharge plans did not include a reference to early warning signs of relapse and risks, 34.2.
e) Discharges were not coordinated by a key worker, 34.4.
f) Comprehensive discharge summaries were not issued within 14 days, 38.3(b).
### Area(s) of non-compliance

<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>
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</table>
| 1. Food temperatures had not always been checked before serving, 6 (1) (c). | Corrective Action(s): Multi Task Attendant in Acute Psychiatry Unit kitchen will ensure that the food temperature is checked before serving at all meals  
Post-Holder(s) responsible: Multi-task attendant in Acute Psychiatry Unit kitchen and CNM2 in Acute Psychiatry Unit | CNM2 in Acute Psychiatry Unit will monitor completion of food temperature checks weekly | No barriers | Completed |
| | Preventative Action(s): All Multi Task Attendants who work in the Acute Psychiatry Unit kitchen must have HACCP training  
Post-Holder(s) responsible: ADON Acute Psychiatry Unit | Annual monitoring of training records of all Multi Task Attendants who work in the Acute Psychiatry Unit kitchen | No barriers | Completed |
| 2. Fridge temperatures had not always been checked twice a day, 6 (1) (c). | Corrective Action(s): Multi Task Attendant in Acute Psychiatry Unit kitchen will ensure that the fridge temperatures are checked twice per day  
Post-Holder(s) responsible: Multi Task Attendant in Acute Psychiatry Unit kitchen and CNM2 in Acute Psychiatry Unit. | CNM2 in Acute Psychiatry Unit will monitor completion of fridge temperature checks weekly | No barriers | Completed |
| | Preventative Action(s): All Multi Task Attendants who work in the Acute Psychiatry Unit kitchen must have HACCP training  
Post-Holder(s) responsible: ADON Acute Psychiatry Unit | Annual monitoring of training records of all Multi task attendants who work in the Acute Psychiatry Unit kitchen | No barriers | Completed |
| 3. Fridge temperatures were high on two occasions, 6 (1) (c). | Corrective Action(s): Since the inspection visit there is a schedule for monitoring fridge temperatures with direction for appropriate action if temperature is outside the normal range  
Post-Holder(s) responsible: ADON Acute Psychiatry Unit | CNM2 in Acute Psychiatry Unit will monitor completion of fridge temperature checks weekly | No barriers | Completed |
4. There was dirt on the floor and on equipment in the kitchen, 6 (1) (c).

<table>
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<tr>
<th>Preventative Action(s):</th>
<th>Post-Holder(s) responsible:</th>
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</thead>
</table>

Corrective Action(s): Since the inspection visit there has been a daily and weekly schedule for cleaning of Equipment in the Acute Psychiatry Unit kitchen.

Increase in cleaning hours and cleaning personnel in the Acute Psychiatry Unit

Post-Holder(s) responsible: ADON Acute Psychiatry Unit

Post-Holder(s) responsible: CNM2 Acute Psychiatry Unit

| Preventative Action(s): All relevant staff in the Acute Psychiatry to sign that they have read and understood the policy; Food Safety Approved centres |
| Post-Holder(s) responsible: CNM2 Acute Psychiatry Unit |

| CNM2 in Acute Psychiatry Unit monitors compliance with the schedule of cleaning weekly |

| No barriers | Completed |

1. Quarterly hygiene audit in The Acute Psychiatry Unit
2. Cleaning log folder in Acute Psychiatry Unit monitored daily

| No barriers | End Q1 |

| CNM2 in Acute Psychiatry Unit will monitor this annually |

| No barriers | Completed |
### Regulation 7: Clothing

**Report reference: Page 21**

<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>
</table>
| 5. The registered proprietor failed to ensure that, when a resident did not have an adequate supply of their own clothing, the resident was provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times, 27(1). | **New** Corrective Action(s):There is now an adequate supply of appropriate individualised clothing in the Acute Psychiatry Unit  
Post-Holder(s) responsible: ADON Acute Psychiatry Unit  
Preventative Action(s):The log book will be reviewed quarterly to ensure there is always an adequate supply of emergency clothing  
Post-Holder(s) responsible:CNM2 Acute Psychiatry Unit | There is a log book to monitor the clothing stock in the Acute Psychiatry Unit  
Quarterly review analysis of the clothing log book to ensure there is an adequate supply of clothing and to identify areas of improvement | No barriers  
No barriers | Completed  
immediate |
### Regulation 19: General Health

*Report reference: Pages 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>
</tr>
</thead>
<tbody>
<tr>
<td>6. Failure to ensure that all six monthly reviews fulfilled the criteria stipulated by the Mental Health Commission, 19, 1 (b).</td>
<td><em>New</em> Corrective Action(s): A Physical health project has been introduced as a pilot from mid-January 2019 which fulfils all the criteria stipulated by Mental Health Commission. Post-Holder(s) responsible: Executive Clinical Director (ECD), Acute Psychiatry Unit. An audit will be done, after the pilot project. There will be an annual audit thereafter.</td>
<td>No barriers</td>
<td>completed</td>
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<td></td>
<td>Preventative Action(s): All relevant staff in the Acute Psychiatry to sign that they have read and understood the policy; <em>General health</em> Post-Holder(s) responsible: CNM2 and ECD, Acute psychiatry unit</td>
<td>CNM2 and ECD in Acute Psychiatry Unit will monitor this annually</td>
<td>No Barriers</td>
<td>Completed</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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| 7. The use of clear glass in bedrooms facing a publicly accessible area | Corrective Action(s): Opaque covering on glass in bedrooms facing a publicly accessible area  
Post-Holder(s) responsible: ADON Acute Psychiatry Unit  
Preventative Action(s):  
Post-Holder(s) responsible: | Not applicable | No barriers | Completed |
| 8. A noticeboard displayed resident’s names                  | Corrective Action(s): To use a blind to cover the notice board displaying resident’s names.  
Post-Holder(s) responsible: ADON, Acute Psychiatry Unit  
Preventative Action(s):  
Post-Holder(s) responsible: | Not applicable | No barriers | End of Q1 |
| 9. Clinical notes with identifying information was visible to all through the window of the nurse’s station | Corrective Action(s): Opaque covering on glass of the window of the nurse’s station  
Post-Holder(s) responsible: ADON, Acute psychiatry unit  
Preventative Action(s):  
Post-Holder(s) responsible: | Not applicable | No barriers | Completed |
## Regulation 22: Premises

### Report reference: Page 40 & 41

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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<tbody>
<tr>
<td>10. The premises were not clean, in good structural and decorative condition 22 (1) (a)</td>
<td>Increase in cleaning hours and cleaning personnel in the Acute Psychiatry Unit</td>
<td>1. Quarterly hygiene audit in the Acute Psychiatry Unit 2. Cleaning log folder in the Acute Psychiatry Unit monitored daily</td>
<td>No barriers</td>
<td>End of Q1</td>
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<td></td>
<td>Premises policy will be developed by the service and will include the protocol for maintenance of the premises</td>
<td>Review the policy every three years</td>
<td>No barriers</td>
<td>End of Q1</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: ADON, Acute Psychiatry Unit CNM3, Quality and Compliance</td>
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<tr>
<td></td>
<td>Preventative Action(s): All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policy, Premises</td>
<td>CNM 2 will monitor this on an annual basis</td>
<td>No barriers</td>
<td>End of Q1</td>
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<td></td>
<td>Post-Holder(s) responsible: CNM2 Acute Psychiatry Unit</td>
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<tr>
<td>11. The premises were not adequately ventilated 22 (2) (b)</td>
<td>Corrective Action(s): The maintenance department have been asked to assess the</td>
<td>Hygiene audit is being done quarterly</td>
<td>No barriers</td>
<td>End of Q1</td>
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<td>Reoccurring</td>
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<td>Reoccurring</td>
<td>ventilation needs in The Acute Psychiatry Unit and their recommendations will be implemented</td>
<td>Post-Holder(s) responsible: ADON, Acute Psychiatry Unit</td>
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<td>Preventative Action(s):</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
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<td>12. The condition of the physical structure was not maintained with due regard to the safety of residents. 22 (3)</td>
<td>Corrective Action(s): Broken hand rail is fixed</td>
<td>Ligature audit is done when required and at a minimum annually.</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
<td></td>
<td>No barriers</td>
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<tr>
<td>Preventative Action(s): All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policy, Premises</td>
<td>CNM 2 will monitor this on annual basis</td>
<td>No barriers</td>
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<tr>
<td>Post-Holder(s) responsible:</td>
<td></td>
<td>End of Q1</td>
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<td>CNM 2, Acute Psychiatry Unit</td>
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Completed
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<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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</table>
| 13. The frequency of administration was not complete on one MPAR | Corrective Action(s)  
  Post-Holder(s) responsible:                                             |             |                        |            |
| 14. There was not a record of all medications administered to the resident on two MPARs | Preventative Action(s): Increase the frequency of MPAR audit to monthly until end of Q2 and then quarterly thereafter.  
  All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policy, Ordering, prescribing, storing and administration of medicines  
  Post-Holder(s) responsible  
  CNM3, Quality and Compliance  
  Office of Practice Development  
  CNM 2, Acute Psychiatry Unit | Monthly audits until end of Q2  
  CNM2 will monitor this on annual basis | No barriers | Immediate |
<p>| 15. One MPAR did not document a discontinuation date          |                                                                         |             |                        |            |
| 16. The Medical Council Registration Number was not included on one MPAR |                                                                         |             |                        |            |
| 17. A medication administration cupboards was unlocked        | Corrective Action(s): Medication cupboard is now locked when not in use  | Monthly audits until end of Q2 and then quarterly thereafter | No barriers | completed |</p>
<table>
<thead>
<tr>
<th>18. The policy did not reflect legislative changes to the Mental Health Act 2001, dated 2015, because it referenced the term “unwilling” to consent to treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New</strong></td>
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<tr>
<td><strong>Corrective Action(s):</strong> Amend the policy to reflect the legislative changes to Mental Health Act 2001</td>
</tr>
<tr>
<td><strong>Post-Holder(s) responsible:</strong> CNM 3, Quality and Compliance</td>
</tr>
<tr>
<td><strong>Preventative Action(s):</strong> Review the policy every three years</td>
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<td><strong>No barriers</strong></td>
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<tr>
<td><strong>Immediate</strong></td>
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</tbody>
</table>
## Regulation 26: Staffing

*Report reference: Pages 45 & 46*

<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>
</table>
| 19. Not all staff had received the required training in Basic Life Support, fire safety, the management or aggression and violence and the Mental Health Act 2001, 26 (4) | Corrective Action(s):  
Post-Holder(s) responsible:  
Monitor as per condition¹ | | | |
| | Preventative Action(s):  
Post-Holder(s) responsible: | | | |

¹ **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.
<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>20. Not all records were in good order 27 (1)</td>
<td>Corrective Action(s): All records are in good order</td>
<td>Audit maintenance of records on quarterly basis</td>
<td>No barriers</td>
<td>completed</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Clerical Officer Acute Psychiatry Unit</td>
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<tr>
<td></td>
<td>Preventative Action(s): A newly designed folder is now available</td>
<td>Audit maintenance of records on quarterly basis</td>
<td>No barriers</td>
<td>immediate</td>
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<td>for newly admitted residents.</td>
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<td></td>
<td>Post-Holder(s) responsible: CNM 2, Acute psychiatry unit</td>
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<tr>
<td>21. Errors were not corrected in line with best practice 27 (1)</td>
<td>Corrective Action(s) All errors have been corrected in line with best practice</td>
<td>Audit maintenance of records on quarterly basis</td>
<td>No barriers</td>
<td>completed</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Individual responsible clinician</td>
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<td></td>
<td>Preventative Action(s): All relevant staff in the Acute Psychiatry Unit</td>
<td>CNM2 will monitor this annually</td>
<td>No Barriers</td>
<td>Immediate</td>
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<tr>
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<td>to sign that they have read and understood the policy, <em>Maintenance of Records</em></td>
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<td></td>
<td>Post-Holder(s) responsible: CNM2, Acute Psychiatry Unit</td>
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<td>Office of Practice Development</td>
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</tr>
</tbody>
</table>
### Regulation 28: Register of Residents

**Report reference: Page 49**

<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>
</table>
| 22. The register was not up-to-date, 28(1).                                               | **New**  
Corrective Action(s): The register has been brought up to date.  
Post-Holder(s) responsible: ECD, Acute Psychiatry Unit | Annual review of the register                                                | No barriers             | completed       |
| 23. The register did not always document admission codes, 28 (2).                         |                                                                                       |                           |                        |                |
| 24. The register did not always document discharge codes, 28 (2).                         | Preventative Action(s): A Memorandum will be sent to all doctors and administrative staff in the service to remind them that it is mandatory to enter all required information listed in schedule 1 in MHA 2001 in the register  
Post-Holder(s) responsible: ECD, Acute Psychiatry Unit | Annual review of the register                                                | No Barriers             | immediate       |
## Area(s) of non-compliance

### 25. The registered proprietor did not ensure that the nominated person maintains a record of all complaints relating to the approved centre 31(6)

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action(s): The nominated person is maintaining a record of all complaints relating to the approved centre Post-Holder(s) responsible: ADON Acute Psychiatry Unit</td>
<td>6 monthly audit of record of complaints maintained in the Approved Centre</td>
<td>No barrier</td>
<td>completed</td>
</tr>
<tr>
<td>Preventative Action(s): Post-Holder(s) responsible:</td>
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</tbody>
</table>

### 26. The registered proprietor did not ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded 31 (7)

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action(s): All complaints and the results of any investigations and any actions taken on foot of a complaint are being fully and properly recorded Post-Holder(s) responsible: ADON Acute Psychiatry Unit</td>
<td>6 monthly audit of record of complaints maintained in the Approved Centre</td>
<td>No Barrier</td>
<td>completed</td>
</tr>
<tr>
<td>Preventative Action(s): Post-Holder(s) responsible:</td>
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</tr>
</tbody>
</table>
## Code of Practice on the Use of Physical Restraint

**Report reference:** Page 64 & 65

<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>27. Not all relevant staff involved in physical restraint had signed a log to indicate that they had read and understood the use of physical restraint policy, 9.2.</td>
<td>Reoccurring</td>
<td>Corrective Action(s): All relevant staff in the Acute Psychiatry Unit to sign that they have read and understood the policy; Physical Restraint Post-Holder(s) responsible: CNM2, Acute Psychiatry Unit</td>
<td>CNM 2 will monitor this on annual basis</td>
<td>No barriers</td>
</tr>
</tbody>
</table>

**Corrective Action(s):**
All relevant staff in the Acute Psychiatry Unit to sign that they have read and understood the policy; Physical Restraint

**Post-Holder(s) responsible:**
CNM2, Acute Psychiatry Unit

<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>28. Residents were not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, 5.8.</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preventative Action(s):**
We will update the algorithm to be followed in the use of physical restraint to include these actions. When algorithm is completed, it will be part of PMAV training.

All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policy, on use of physical restraint

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

**Quarterly audit**
| Preventative Action(s): | Quarterly audit | No barriers | End of Q3 |

| Immediate | | | | |
29. **Residents were not afforded an opportunity to discuss episode with members of the multi-disciplinary team involved in his/her care as soon as was practicable, 7.2.**

<table>
<thead>
<tr>
<th>New</th>
<th>Corrective Action(s):</th>
<th>Preventative Action(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADON and ECD, Acute Psychiatry Unit</td>
<td>We will update the algorithm for the use of physical restraint to include this action. When algorithm is completed, it will be part of PMAV training.</td>
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<tr>
<td></td>
<td></td>
<td>All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policy on use of physical restraint</td>
</tr>
</tbody>
</table>

Post-Holder(s) responsible:
ADON and ECD, Acute Psychiatry Unit

Quarterly audit
CNM2 will monitor on annual basis

No barriers
No Barriers

End of Q3
Immediate
<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>30. Not all staff had signed a log to indicate they had received training in relation to the care of children, 2.5 (e).</td>
<td>Corrective Action(s): All staff of the Acute Psychiatry Unit will provide evidence that they have completed ‘children first’ training and a log of this is kept within the Acute Psychiatry Unit.</td>
<td>Quarterly training analysis</td>
<td>No barriers</td>
<td>End Q1</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Monitoring of training analysis log book to ensure all staff in the Acute Psychiatry Unit have done the ‘children first’ training.</td>
<td>Quarterly training analysis</td>
<td>No barriers</td>
<td>immediate</td>
</tr>
<tr>
<td>31. Age-appropriate facilities and a programme of activities were not provided by the approved centre, 2.5 (b).</td>
<td>Corrective Action(s): CAMHS OT is involved in providing age appropriate programme of activities for a child under 18 admitted to the Acute Psychiatry Unit. Family room and OT room are made available in the exceptional circumstances of a child under 18 who has been admitted.</td>
<td>OT manager will review and analyse the programme of activities in place for a child under 18 who has been admitted. After each child admission a review and analysis will be completed by CAMHS OT.</td>
<td>No barriers</td>
<td>Completed</td>
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</tbody>
</table>
| 32. Adequate arrangements for continuing children’s education were not made, 2.5 (f). | child being admitted to the Acute Psychiatry Unit  
Post-Holder(s) responsible:  
Preventative Action(s):  
Post-Holder(s) responsible:  
Corrective Action(s):  
Post-Holder(s) responsible: | It is not possible to meet this requirement in an Acute Adult in-patient setting |
|   |   |   |
| 33. Children did not have access to child advocacy services, 2.5 (g). | child being admitted to the Acute Psychiatry Unit  
Post-Holder(s) responsible:  
Preventative Action(s):  
Post-Holder(s) responsible:  
Corrective Action(s):  
Post-Holder(s) responsible: | It is not possible to meet this requirement in an Acute Adult in-patient setting |
## Admission, Transfer and Discharge – Discharge

**Report reference:** Page 68 & 69

<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>
</table>
| 34. The admission policy did not address the protocol for planned admission with reference to referral letters, 4.3 | **New**  | Corrective Action(s): The Admission Policy will be updated and will address the protocol for planned admission with reference to referral letters  
Post-Holder(s) responsible: CNM3 Quality and Compliance | Annual review of the admission policy | No barriers            | End Q1     |
|                                                                                           |          | Preventative Action(s):              |                        |            |
|                                                                                           |          |                                      |                        |            |
| 35. There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies, 9.1. | **Reoccurring** | Corrective Action(s): All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policies; Admission, Transfer and Discharge.  
Post-Holder(s) responsible: CNM2 Acute Psychiatry Unit | CNM2 will monitor this annually | No Barriers            | Immediate  |
|                                                                                           |          | Preventative Action(s):              |                        |            |
|                                                                                           |          |                                      |                        |            |
| 36. Audits had been completed on the implementation of and adherence to the admission and discharge policies, but not for the transfer policy, 4.19. | **Reoccurring** | Corrective Action(s): An audit on implementation and adherence to the transfer policy will be done annually  
Post-Holder(s) responsible: | Yearly audit | No barriers            | annually    |
<table>
<thead>
<tr>
<th>Preventative Action(s):</th>
<th>Post-Holder(s) responsible:</th>
<th>Corrective Action(s):</th>
<th>Yearly review of Discharge policy</th>
<th>No barriers</th>
<th>End Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td></td>
<td>CNM3 Quality and Compliance</td>
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<tr>
<td>37. Discharge plans did not include a reference to early warning signs of relapse and risks, 34.2.</td>
<td>Preventative Action(s): All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policy on Discharge</td>
<td>Corrective Action(s): Discharge policy will be updated to include a reference to early warning signs of relapse and risks</td>
<td>Yearly review of Discharge policy</td>
<td>No barriers</td>
<td>End Q1</td>
</tr>
<tr>
<td>New</td>
<td></td>
<td>Post-Holder(s) responsible: CNM3 Quality and Compliance</td>
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<tr>
<td>38. Discharges were not coordinated by a key worker, 34.4.</td>
<td>Preventative Action(s): All relevant staff in the Acute Psychiatry unit to sign that they</td>
<td>Corrective Action(s): The Keyworker does coordinate discharges and the discharge policy will be updated to include that discharges are coordinated by a key worker</td>
<td>Yearly review of Discharge policy</td>
<td>No barriers</td>
<td>End Q1</td>
</tr>
<tr>
<td></td>
<td>Corrective Action(s): All discharged patients will have a comprehensive summary issued within 14 days</td>
<td>Preventative Action(s): All relevant staff in the Acute Psychiatry unit to sign that they have read and understood the policy on Discharge</td>
<td>Post-Holder(s) responsible: ECD Acute Psychiatry Unit</td>
<td>Post-Holder(s) responsible: ECD Acute Psychiatry Unit</td>
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<tr>
<td>39. Comprehensive discharge summaries were not issued within 14 days, 38.3(b).</td>
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