St. Ita's Ward, St. Brigid's Hospital

ID Number: AC0016

2018 Approved Centre Inspection Report (Mental Health Act 2001)

St. Ita's Ward,
St. Brigid's Hospital
Kells Road,
Ardee
Co. Louth

Approved Centre Type:
Continuing Mental Health Care/Long Stay
Mental Health Rehabilitation
Psychiatry of Later Life

Most Recent Registration Date:
01 March 2017

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Ger. McCormack, General Manager, Mental Health Services, MLM CHO

Inspection Team:
Dr. Enda Dooley MCRN 004155, Lead Inspector
Susan O'Neill
Carol Brennan-Forsyth

Inspection Date:
28 - 31 August 2018

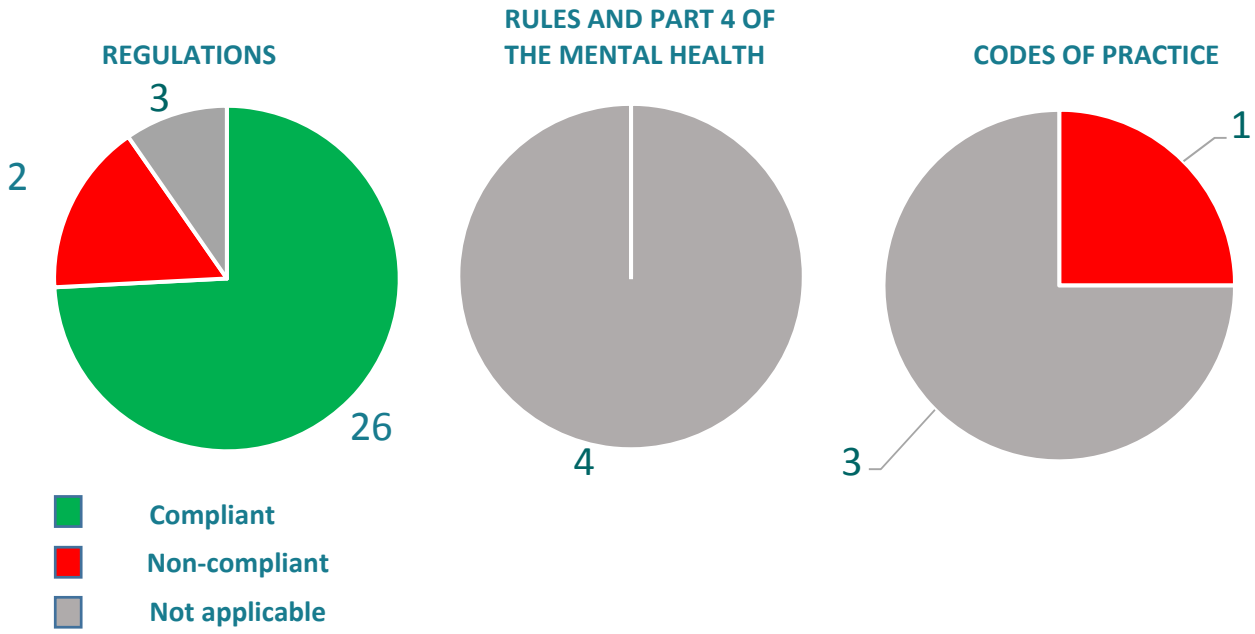
Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
28 - 31 March 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
7 February 2019

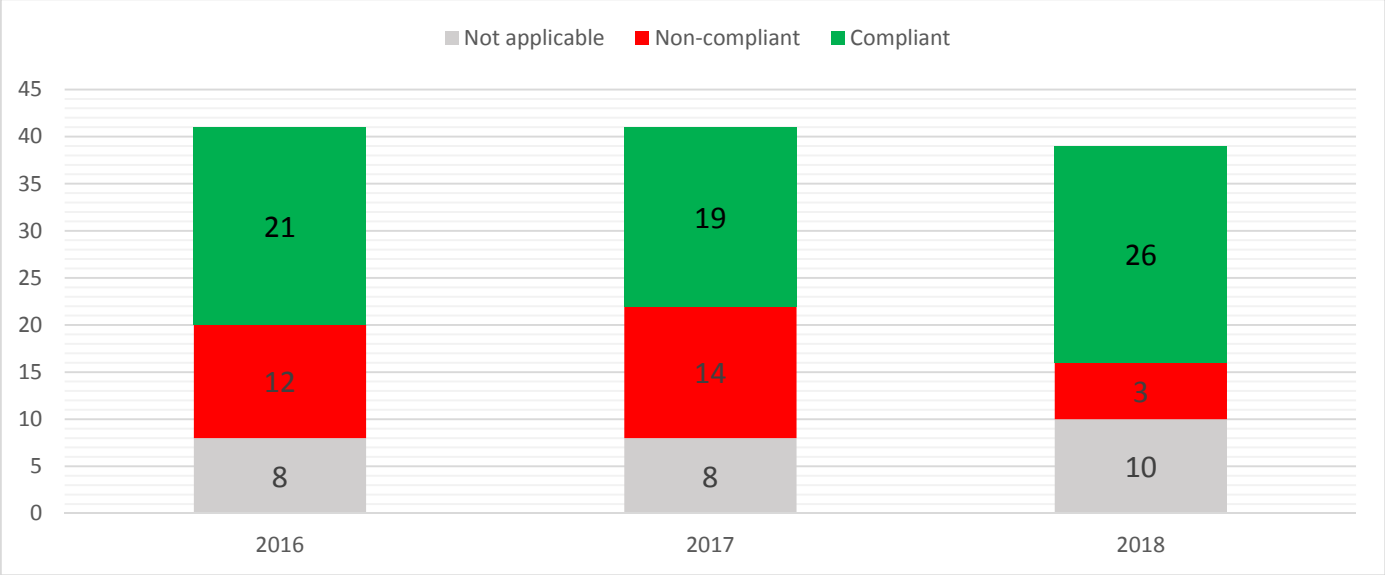
2018 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2018

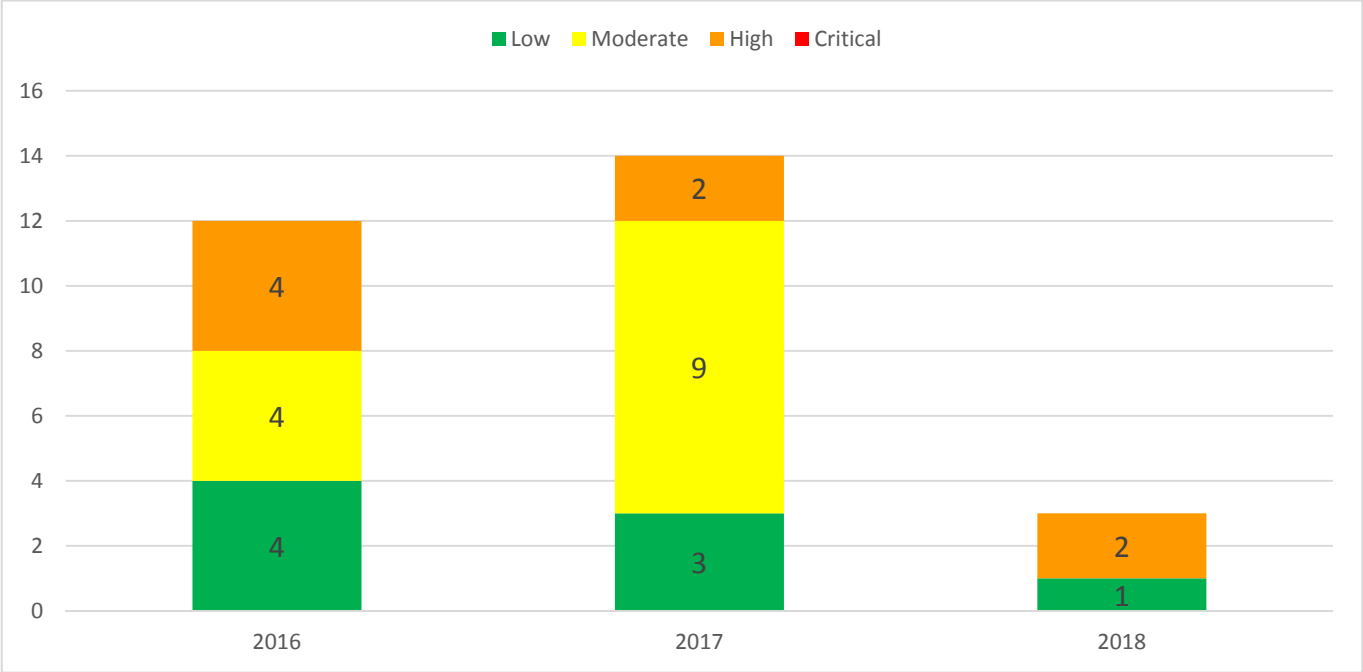
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



Contents

1.0 Introduction to the Inspection Process

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

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

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

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

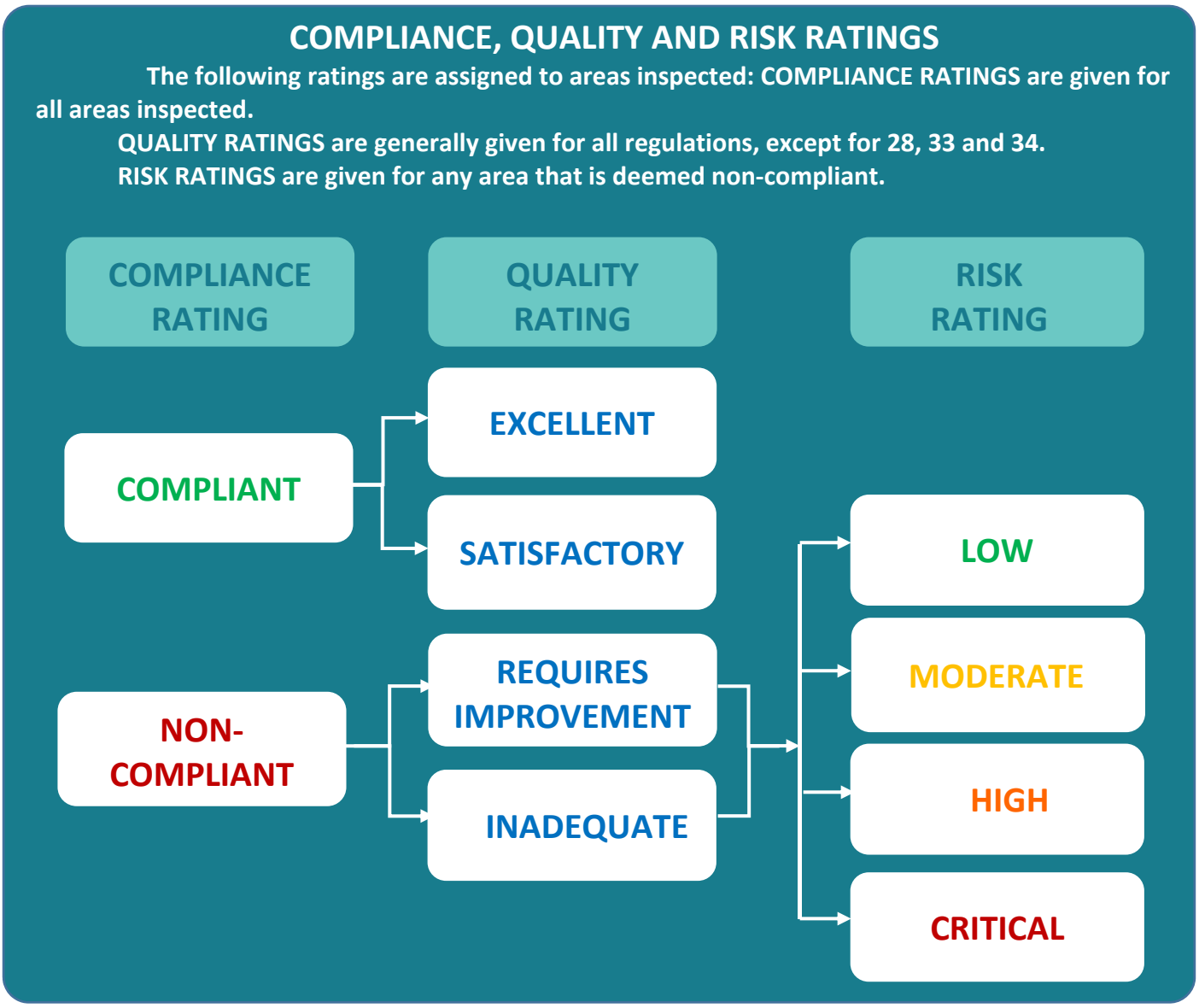
a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the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

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

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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are

deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, 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

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

St. Ita's Ward was located within St. Brigid's Hospital in Ardee. It was the last in-patient unit still functioning within the hospital. While the approved centre was registered for 20 beds, the number of beds in operation had decreased to nine at the time of this inspection and each resident had their own bedroom. It was under the clinical care of the Rehabilitation and Recovery Team. There had been no admissions since the last inspection and an active process promoting the movement of residents to the community was in place.

There has been a very significant improvement in compliance with Regulations, Rules and Codes of Practice: from 58% in 2017 to 90% in this inspection. There were six compliances quality rated as excellent. There was one condition attached to the registration of this approved centre at the time of inspection.

Condition 1: To ensure adherence to *Regulation 22: Premises*, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

During this inspection, the approved centre was found to be compliant with Regulation 22 Premises.

Safety in the approved centre

Food safety audits were carried out regularly and the kitchen areas were clean. Medication was stored safely but there were a number of deficits in the recording of administration of medication and residents' allergies to medication were not recorded in all cases. Ligature points were minimised in line with individual risk assessments. Not all staff had up to date training in fire safety, Basic Life Support, prevention and management of aggression and violence, Children First, and the Mental Health Act 2001.

Appropriate care and treatment of residents

Each resident had a multi-disciplinary individual care plan that was developed with the resident and was regularly reviewed. Therapeutic activities were evidence-based and had input from an occupational therapist, social worker, psychologist, and dietitian. Physical health was assessed and monitored at least every six months and the assessment included screening for metabolic syndrome.

Respect for residents' privacy, dignity and autonomy

Each resident wore their own clothes and retained control over their own property. There was unrestricted access to external communications and residents could meet their visitors in private. The approved centre had single bedrooms for all residents and privacy and dignity was not compromised. The approved centre operated a closed door policy with the result that residents had to request to enter and leave the ward.

Responsiveness to residents' needs

Food was nutritious and attractively presented with a choice of menu. There was a range of recreational activities throughout the week and weekend. Religious practice was facilitated. Information about the approved centre and residents' medication and diagnosis was available in written form. There was a complaints process in place in line with HSE policy.

The premises was clean, was well maintained, and was in a good state of repair, with a regular programme of general maintenance.

Governance of the approved centre

The approved centre was under the management and governance of the Health Service Executive (HSE). Minutes of the Multi-disciplinary Executive Management Team (MEMT) and Area Clinical Governance Committee outlined consideration of a variety of governance issues pertinent to or incorporating the approved centre. In addition, there was a local Clinical Governance Committee and other rehabilitation service committees, which specifically dealt with management of services within the approved centre. These various minutes indicated an active governance process involving all disciplines working in the approved centre. Risk management was satisfactory and the risk register was regularly reviewed.

3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Updated resident information booklet.
2. Provision of dedicated visiting room.
3. Introduction of new Medication Prescription and Administration Record (MPAR).
4. Development of a gardening group.

4.0 Overview of the Approved Centre

4.1 Description of approved centre

St. Ita's Ward was located within St. Brigid's Hospital in Ardee. It was the last in-patient unit still functioning within the hospital campus. While the approved centre was registered for 20 beds, the number of beds in operation had decreased from 16 at the time of previous inspection to nine at the time of this inspection.

The approved centre was managed by the Rehabilitation Team which was based close by. There had been no admissions since the last inspection and an active process promoting the movement of residents to the community was in place. All residents had a history of medium to long term care with an elderly age profile. All had been resident over six months. The approved centre operated a closed door policy with the result that residents had to request to enter and leave the ward.

The decrease in resident numbers had facilitated the provision of individual bedrooms to all residents. A variety of refurbishment and redecoration work had been undertaken since the last inspection throughout the approved centre. A garden area had been developed and was maintained by the residents. A new visiting room was available which was suitable for children visiting.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**9**
Number of detained patients	0
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	9
Number of patients on Section 26 leave for more than 2 weeks	0

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 22: Premises*, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.

4.3 Reporting on the National Clinical Guidelines

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

4.4 Governance

The approved centre was under the management and governance of the Health Service Executive (HSE). The General Manager for Mental Health Services in CHO 8 was the registered proprietor of the approved centre. Minutes were provided of a number of groups overseeing various aspects of governance, both throughout the service and in the approved centre specifically. Minutes of the Multi-disciplinary Executive Management Team (MEMT) and Area Clinical Governance Committee outlined consideration of a variety of governance issues pertinent to or incorporating the approved centre.

In addition, there was a local Clinical Governance Committee and other rehabilitation service committees, which specifically dealt with management of services within the approved centre. These various minutes indicated an active governance process involving all disciplines working in the approved centre.

4.5 Use of restrictive practices

The approved centre operated a closed door policy which obliged residents, all of whom were voluntary, to request permission to enter or leave the ward.

5.0 Compliance

5.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas in 2017 and 2016 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating 2016		Compliance/Risk Rating 2017		Compliance/Risk Rating 2018	
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✗	Moderate	✗	High
Regulation 26: Staffing	✗	High	✗	Moderate	✗	High
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	Low	✗	Low

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

The following areas were rated excellent on this inspection:

Regulation
Regulation 4: Identification of Residents
Regulation 5: Food and Nutrition
Regulation 7: Clothing
Regulation 9: Recreational Activities
Regulation 10: Religion
Regulation 18: Transfer of Residents

5.3 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.

Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

6.0 Service-user Experience

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

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

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

During the course of the inspection, three residents met with the inspection team. All were satisfied with their treatment and care within the approved centre. They did not raise any issues of concern which required the attention of management. In addition, two family members of a resident met with the inspection team. They expressed satisfaction regarding their relative's care within the approved centre and with their engagement with the staff of the approved centre. No resident returned a questionnaire based on the information leaflets distributed.

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:

- Head of Service and Registered Proprietor nominee
- Executive Clinical Director
- Director of Nursing
- Consultant Psychiatrist in Rehabilitation
- Assistant Director of Nursing
- Clinical Nurse Manager2
- Occupational Therapy Manager
- Senior Social Worker
- Mental Health Act Administrator
- Basic Grade Occupational Therapist

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. There were no specific clarifications or factual corrections received.

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

COMPLIANT

Quality Rating **Excellent**

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 June 2016. The policy included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs were used when administering medications, undertaking medical investigations, and providing other health care services. This included name, date of birth, and photograph. An appropriate identifier was used prior to provision of therapeutic services.

The identifiers were person-specific and detailed within the residents' clinical files. Identifiers were appropriate to the residents' communication abilities. The service had an alert process to identify residents' with the same or similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 5: Food and Nutrition

COMPLIANT

Quality Rating **Excellent**

(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 May 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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. Relevant staff attended quarterly Food and Nutrition Committee meetings to discuss relevant issues. Documented analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Approved centre menus were approved by a dietician to ensure nutritional adequacy in line with residents' needs. Residents were provided with a variety of wholesome and nutritious food. Residents had at least two choices of meals and hot meals were provided on a daily basis. Food was presented in an attractive and appealing manner. Hot and cold drinks were offered to residents regularly and a safe and fresh source of drinking water was available to residents at all times.

For residents with special dietary requirements, an evidence-based nutrition assessment tool (Malnutrition Universal Screening tool) was used. Residents and their representatives were educated about resident's diets. The dietician assessed nutritional and dietary needs. These were addressed in the residents' individual care plan and were reviewed by the dietician as required. Weight charts were implemented, monitored, and acted upon for residents and intake and output charts were maintained.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 6: Food Safety

COMPLIANT

Quality Rating **Satisfactory**

(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 October 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the process for food preparation, handling, storage, distribution, and disposal controls.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role.

Monitoring: Food safety audits had been completed periodically. Food temperatures were recorded in line with food safety recommendations. A daily food temperature log sheet was maintained and monitored. Documented analysis had been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services. Appropriate protective equipment was used during the catering process. There was suitable and sufficient catering equipment, crockery, and cutlery within the approved centre. Food was prepared elsewhere in the complex, but there were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food.

Hygiene was maintained to support food safety requirements. Catering areas and food safety equipment were appropriately cleaned.

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

Regulation 7: Clothing

COMPLIANT

Quality Rating **Excellent**

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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

Monitoring: The availability of an emergency supply of clothing for residents was monitored and documented on an ongoing basis. None of the residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing, which were clean and appropriate to their needs. Residents had an adequate supply of individualised clothing. The supply of emergency clothing was appropriate and took account of resident preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

Quality Rating **Satisfactory**

(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 April 2016. The policy included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for residents' personal property and possessions, as set out in the policy.

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

Evidence of Implementation: Residents were supported to manage their own property where suitable, as indicated in their individual care plans (ICPs). If the approved centre assumed responsibility for personal property and possessions, they were safeguarded within a secure safe in a locked clinical room. Property lists were maintained and kept separately to residents ICPs and were available to residents. The lists were updated when necessary.

Two members of staff oversaw the process for residents, or their representatives, to access their monies. Signed records of the staff issuing the money were retained and, where possible, countersigned by the resident or their representative.

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

Regulation 9: Recreational Activities

COMPLIANT

Quality Rating **Excellent**

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 June 2016. It included all of the requirements of the *Judgement Support Framework*.

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

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile, including TV, music, gardening, games, and reminiscence. Indoor and outdoor exercise and physical activity opportunities were provided. Recreational activities were scheduled for weekdays and the weekend. Communal areas were flat, free of obstruction, and large enough to facilitate activities.

Information containing the types and frequency of activities was provided in an appropriate and accessible format. Where applicable, individual risk assessments were completed to help select appropriate activities. Residents were free to choose whether to participate and their decisions were respected and documented. Logs of participation were maintained for recreational activities.

The recreational activities were appropriately resourced. Nursing staff and an occupational therapist had input into activities. Recreational activity programmes were developed, implemented, and maintained for residents, with resident involvement.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 10: Religion

COMPLIANT

Quality Rating **Excellent**

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 March 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation of the policy to support residents' religious practices was reviewed and documented 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 practicable. The care and services were respectful of residents' religious beliefs and values. Resident were facilitated to observe or abstain from religious practice in line with their wishes.

Facilities for residents' religious practices were made available; with Mass held on premises, and priests visiting the unit on a weekly basis if required. Residents had access to local religious services and were supported to attend, if appropriate.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 11: Visits

COMPLIANT

Quality Rating **Satisfactory**

(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 written policies and procedures in relation to visits, which were last reviewed in May 2018. 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 were able to articulate the processes for visits, as set out in the policies.

Monitoring: At the time of the inspection, there were no visitor restrictions in place. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times were appropriate, reasonable, and publicly displayed. A separate visitor's room was provided so residents could meet visitors in private. The visiting room was suitable for visiting children. The corridor where visitors waited had recently been refurbished.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting were accompanied at all times to ensure their safety, and this was communicated in the resident information booklet.

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

Regulation 12: Communication

COMPLIANT

Quality Rating **Satisfactory**

(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 in relation to resident communication. The policy was last reviewed in March 2017. The policies and procedures included all of the requirements of the *Judgement Support Framework.*

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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: The approved centre supported residents to communicate freely. Residents had access to mail and phone, but not internet or email. An internet kiosk was provided, but had never been functional. No residents were considered to require risk assessment or limitation on their communication.

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

Regulation 13: Searches

COMPLIANT

(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 September 2016. The policies and procedures addressed all of the requirements of the *Judgement Support Framework.* This included requirements relating to the following:

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

Training and Education: 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 searching processes, as set out in the policies.

The monitoring and evidence of implementation pillars for this regulation were not inspected, as no search had been conducted in the approved centre since the last inspection.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

Quality Rating **Satisfactory**

(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 written operational policies and protocols in relation to care of the dying, which were last reviewed in May 2017. The policies and procedures addressed all of the requirements of the *Judgement Support Framework.*

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

Monitoring: Since the last inspection, no resident had received end of life care in the approved centre. Deaths which had occurred offsite were not palliative prior to transfer to hospital. As a result, the monitoring pillar for this regulation was not inspected against.

Evidence of Implementation: Support was provided to residents and staff following the deaths of residents. Support was provided through individual and group conversations with residents as needed. Staff received individual support from line managers and had access to an external support service.

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

Regulation 15: Individual Care Plan

COMPLIANT

Quality Rating **Satisfactory**

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 February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: 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. All multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: Residents' ICPs were audited, but not 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: Nine ICPs were reviewed on inspection. 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. Not all ICPs included a risk management plan.

A key worker was identified to ensure continuity in the implementation of each ICP. The ICPs were developed with the participation of residents and, where appropriate, their representatives. Evidence-based assessments were used as applicable.

Each ICP was reviewed by the MDT in consultation with the resident at least every six months. The ICPs were updated following review and residents were kept informed of any changes. Each resident was offered a copy of their ICP, including any reviews.

The approved centre was compliant with this regulation. The quality assessment was rated was satisfactory and not rated excellent because the approved centre met all criteria of the *Judgement Support Framework* under the monitoring and evidence of implementation pillars.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

Quality Rating **Satisfactory**

(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 June 2016. The policy addressed requirements of the *Judgement Support Framework*, with the exception of not referencing resident risk assessment when considering the appropriateness of services.

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 services and programmes, as set out in the policy.

Monitoring: Therapeutic services were monitored on an ongoing basis to ensure that the assessed needs of residents were met. This was achieved through service user feedback forms, monitoring outcomes.

Documented analysis had been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

Evidence of Implementation: Therapeutic services were appropriate and met the assessed needs of residents, as documented in their individual care plans (ICP). Services were aimed towards restoring and maintaining optimal levels of physical and psychosocial functioning. Therapeutic services and programmes were delivered mainly through individual sessions, though a gardening group had recently concluded.

The services were evidence-based, and included input from an occupational therapist, social worker, psychologist, and dietician. The occupational therapist and/or psychologist engaged with the majority of residents on a weekly basis. Where no internal service existed, the approved centre explored an appropriate external service with an approved, qualified health professional.

Adequate and appropriate resources and facilities were available, including petty cash to support additional therapeutic resources. There was an appropriately resourced and dedicated activities room, with a second room available for individual sessions. 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 rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, and training and education pillars.

Regulation 18: Transfer of Residents

COMPLIANT

Quality Rating **Excellent**

(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 written policy and procedures in relation to the transfer of residents. The policy was last reviewed in February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for 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 been completed to identify opportunities for improving the provision of information during transfers.

Evidence of Implementation: An assessment 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. Full and complete written information accompanied the resident upon transfer, to a named individual. Information included a letter of referral, medication requirements, and a transfer form. A checklist was completed by the approved centre to ensure comprehensive resident records were transferred.

Copies of all records relevant to the resident transfer were retained in the resident's clinical file. Documented consent from the resident was available, or justification as to why consent was not received. Communication records with receiving facility were documented and available on inspection.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*.

Regulation 19: General Health

COMPLIANT

Quality Rating **Satisfactory**

(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, which were last reviewed on September 2015, March, and July 2018. The policies and procedures addressed requirements of the *Judgement Support Framework*, but did not address:

- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.

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 recorded and monitored. A systematic review of processes had not been undertaken. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: Residents received appropriate general health care interventions as indicated by their individual care plan. Residents had access to general health services, national screening programmes, and referrals to other health services.

Residents' general health needs were monitored and assessed at least every six months, and as indicated by their specific needs. The general health assessments included a physical examination, and assessed family and personal history, body mass index, weight, and waist circumference, blood pressure, smoking and nutritional status, and a medication and dental review. Residents on antipsychotic medication received an annual assessment considered glucose regulation, blood lipids, heart health via an electro-cardiogram exam, and prolactin levels. Records were available demonstrating residents' completed general health checks and associated results.

The approved centre had an emergency trolley and staff have access at all times to an automated external defibrillator (AED). Weekly checks were completed on the resuscitation trolley and the AED.

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

Framework **under the processes, training and education, monitoring, and evidence of implementation pillars.**

Regulation 20: Provision of Information to Residents

COMPLIANT

Quality Rating **Satisfactory**

(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 written policies and procedures in relation to the provision of information to residents, which were last reviewed in May 2017. The policies and procedures addressed requirements of the *Judgement Support Framework*, except for outlining the process for managing the provision of information to residents' representatives, family, and next of kin, as appropriate.

Training and Education: 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 policies.

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

Evidence of Implementation: An information booklet was provided to all residents. 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.

A variety of diagnosis and medication-related information, including risks and potential side effects, was available and provided to residents. This included evidence-based information about diagnosis, unless the provision of such information would be detrimental to a resident's health and well-being. Residents were provided with the details of their multi-disciplinary team and had access to interpretation and translation services as required. Documentation was appropriately reviewed and approved.

The approved centre was compliant with this regulation. The quality assessment was rated 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 21: Privacy

COMPLIANT

Quality Rating **Satisfactory**

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 February 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: A documented annual review had 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 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 by knocking on the door. Most bedrooms had thumb turn locks. However, one bedroom's thumb turn mechanism was missing. Another room had a lock and key, but the key was not provided in case of loss. Where residents wanted to lock their room upon leaving, nursing staff locked the doors. All 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. Noticeboards did not display resident names or other identifiable information.

Where rooms were overlooked by public areas, net curtains and rolling blinds were installed. All observation panels were fitted with roller style blinds.

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

Regulation 22: Premises

COMPLIANT

Quality Rating **Satisfactory**

(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.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its premises, which was last reviewed in August 2017. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The approved centre had completed hygiene audits. 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, with weekly maintenance checklists undertaken and a maintenance schedule for the premises.

Evidence of Implementation: The residents had access to personal space and room to move about, with individual bedrooms, communal rooms, a patio and garden area, and the grounds of St Brigid's Hospital available. There were suitable furnishings and supports to assist resident independence and comfort. There were enough toilets and showers, which were appropriately located and identified. There was a sluice room, cleaning room, and on-site laundry facility for residents.

Rooms were well heated and ventilated. Heating could not be changed in individual resident rooms, as heating was controlled centrally. The approved centre had adequate lighting, appropriate signage and sensory aids, and no excessive noise was noted. Hazards were appropriately identified and minimised. There was a daily cleaning schedule and the approved centre was clean and hygienic. Current national infection control guidelines were followed. Ligature points were minimised in line with individual risk assessments.

The approved centre was in a good state of repair, with a regular programme of general maintenance. Maintenance and faults were recorded and communicated appropriately. The approved centre had access to back-up power.

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

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

NON-COMPLIANT

Quality Rating Requires Improvement
Risk Rating HIGH

(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.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in May 2018. The policy addressed requirements of the *Judgement Support Framework*, with the exception of outlining a process for medication reconciliation.

Training and Education: All nursing and medical staff had signed the signature log to indicate that they had read and understood the policy. All nursing 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 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 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: Nine MPARS were reviewed on inspection. MPARs included two appropriate resident identifiers, name and photo, which were used when medication was administered. Names of medications were written in full, and the MPARs contained space for recording routine, once-off, and as-required medication. However, micrograms had not always been written in full but abbreviated as 'mcg'. The frequency of administration, the dosage, and the administration route for medications were recorded, as were the dates of initiation for each medication.

MPARs included the appropriate registration numbers of the medical practitioners prescribing medication, who signed each MPAR entry. All entries were written in black, indelible ink. A record of allergies or sensitivities was not recorded in all cases. In addition, in four of the nine MPARs reviewed there were unexplained gaps in the administration records of medications administered to the residents.

Medicines were administered by a registered nurse (except those for self-administration) in accordance with directions of the prescriber and pharmacist. The expiration date of the medication was checked prior to administration; expired medications were not administered. Good hand-hygiene techniques were used when dispensing medication. Schedule two controlled drugs were checked by two staff members, including one registered nurse, against the delivery form. Details were entered in a controlled drug book and signed by both staff members.

Medication was reviewed, rewritten, and documented at least six-monthly or more frequently where required. Where a prescription was altered, a medical practitioner rewrote the prescription. A stock

rotation system was in place, and an inventory of medications was conducted monthly. Medications that were no longer required or past their expiry date were stored appropriately and returned to the pharmacy for disposal.

Medication was stored in an appropriate environment and food and drink was not stored in areas used for storing medication. Medication storage areas were incorporated in cleaning and housekeeping schedules. However, a medication fridge temperature log was not maintained on a daily basis, with omissions for a number days noted.

The medication trolley and medication was stored securely in a locked storage unit. The medication trolley and medication administration cupboard was locked and secured, and scheduled controlled drugs were secured separately.

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

a) **Gaps in the administration record were not accounted for, 23 (1)**
b) **Allergy status was not recorded in all MPARs, 23 (1).**

Regulation 24: Health and Safety

COMPLIANT

(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 written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in March 2018, and the Safety Statement was last reviewed in December 2016. The policies (including a separate policy on the use of HSE vehicles for patient transport) and safety statement addressed requirements of the *Judgement Support Framework*.

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

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Quality Rating Requires Improvement

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to its staffing requirements, which was last reviewed in June 2018. The policy included all of the requirements of the *Judgement Support Framework*.

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

Monitoring: The implementation and effectiveness of the staff-training plan was reviewed as part of the St. Ita's Ward Clinical Governance process. The numbers and skill mix of staff had not been reviewed against the levels recorded in the approved centre's registration. Analysis had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents.

Evidence of Implementation: There was an organisational chart to identify the approved centre's leadership and management structure and lines of authority and accountability. Planned and actual staff rosters were in place, and the numbers and skill mix of staffing met resident needs. Staff were recruited, selected, and vetted in line with approved centre guidelines. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. Where agency staff were used, there was a comprehensive contract between the approved centre and the agency. No written staffing plan was available in the approved centre.

An annual staff-training plan was completed to identify required training, consistent with the needs of the resident group profile. Staff training records indicated that significant deficits in mandatory training remain, including training on fire safety, basic life support, management of violence and aggression, the Mental Health Act 2001, and Children First. However, staff received orientation and induction training, and training on a range of other topics, including dementia care, end of life care, and resident rights. The approved centre maintained records of staff training undertaken. However, an individualised log was not available at inspection.

Opportunities and resources were available to staff for further training and education, and all in-service training was delivered by appropriately qualified staff. The Mental Health Act 2001, the associated regulations, Mental Health Commission rules and codes of practice, and all other relevant Mental Health Commission documentation and guidance were made available to staff throughout the approved centre.

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

Ward or Unit	*Staff Grade*	*Day*	*Night*
Unit A	CNM2	1	-
	CNM1	1	1
	RPN	3	2
	HCA	-	-
	Occupational Therapist	Variable	-
	Social Worker	Variable	-
	Psychologist	Variable	-

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

The approved centre was non-compliant with this regulation because:

a) **Not all staff had up to date training in fire safety, basic life support, Professional Management of Aggression and Violence, Children First, and the Mental Health Act 2001, 26 (4) and 26.5.**

Regulation 27: Maintenance of Records

COMPLIANT

Quality Rating **Satisfactory**

(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.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in June 2018. The policy addressed the 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 did not address the record review requirements or the retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: Not all clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. 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 audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: The approved centre maintained a discrete record for every resident. Records had a unique identifier, were secure, up to date, in good order, and maintained in line with national guidelines and legislative requirements. Only authorised staff could access data and make new entries. Residents' could access records in line with data protection legislation. Staff had access to the information needed to carry out their job. Records were generally maintained appropriately, including being factual, consistent, and using appropriate identifiers. However, the approved centre did not maintain a record of all signatures used in the resident record.

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

Regulation 28: Register of Residents

COMPLIANT

(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 up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in May 2017. The policy included all of the requirements of the *Judgement Support Framework*.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff 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 timeframes. Analysis had not been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The operating policies and procedures were developed with input from clinical and managerial staff and in consultation with relevant stakeholders, including service users. The policies incorporated relevant legislation, evidence-based best practice, and clinical guidelines. The policies were appropriately formatted, approved, and communicated to all relevant 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 rated satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the monitoring pillar.

Regulation 31: Complaints Procedures

COMPLIANT

Quality Rating **Satisfactory**

(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 in relation to the management of complaints, which was last reviewed in January 2016. The policy addressed all of the requirements of the *Judgement Support Framework*, including the following processes:

- Managing complaints, including the raising, handling, and investigation of complaints from any person regarding any aspect of the services or care.
- Treatment provided in or on behalf of the approved centre.

Training and Education: Relevant staff had been trained on the complaints management process. 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: There had not been a sufficient number of complaints to enable an audit. However, complaints data was analysed at a clinical governance meeting. Details of the analysis had been considered by senior management. 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. Residents and their representatives were assisted to make complaints using appropriate methods. They were also provided contact details for an advocate. There was a nominated complaints officer who was responsible for dealing with complaints, who was clearly identified. There was also a method for addressing minor complaints, which were documented in a log. The complaints officer 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. The complaints officer maintained a log for complaints they dealt with, including complete details of the complaint, investigation, outcomes, and the complainant's view of the outcome. This was kept distinct from the resident's individual care plan.

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

Regulation 32: Risk Management Procedures

COMPLIANT

Quality Rating **Satisfactory**

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

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in May 2018. The policy addressed requirements of the *Judgement Support Framework*, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of most 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.

The policy did not address the process of identification, assessment, treatment, reporting, and monitoring of capacity risks relating to the number of residents in the approved centre.

Training and Education: Relevant staff had 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. All staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.

Monitoring: The risk register was reviewed at least quarterly. The audit measured actions taken to address risks identified against the timeframes identified in the register. 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. 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, and 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. Ligature points in the approved centre were assessed as not being a risk for the current cohort of residents.

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

Regulation 33: Insurance

COMPLIANT

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

COMPLIANT

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 relating to Regulation 22: Premises. The certificate was displayed prominently.

The approved centre was compliant with this regulation.

9.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable to this approved centre. Please see *Section 5.3 Areas of compliance that were not applicable on this inspection* for details.

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.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **LOW**

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 transfer and discharge. There was no policy on admissions, as the approved centre was no longer admitting residents.

Admission: This section was not applicable, as the approved centre was no longer admitting residents.

Transfer: The transfer policy, which was last reviewed in February 2018, included all of the policy-related criteria for this code of practice.

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

Training and Education: There was documentary evidence that relevant staff had read and understood the transfer policy. However, not all staff had signed the equivalent log for the discharge policy.

Monitoring: An audit had been completed on the implementation of and adherence to the transfer policy and for the discharge policy.

Evidence of Implementation:

Admission: This section was not applicable, as the approved centre was no longer admitting residents.

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

Discharge: One clinical file was reviewed on inspection. The approved centre maintained a discharge plans, which included documented communication with relevant health professionals, and a follow-up plan. However, the plan did not include an estimated date of discharge or a reference to early warning signs of relapse and risks.

Discharge meetings were attended by resident and their representatives, key worker, and relevant members of multi-disciplinary team. Discharge assessments addressed medical, social, housing, and informational needs. Discharges were coordinated by a key worker.

A preliminary discharge summary was sent to the appropriate health practitioner within three days. However, a comprehensive discharge summary was not issued within 14 days. The discharge summary included details such as medical information, follow-up arrangements, and names and contact details of key people. 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 discharge plan did not estimate the date of discharge, 34.2.**

b) There was no reference to early warning signs of relapse and risk in the discharge plan, 34.2.

Appendix 1: Corrective and Preventative Action Plan – St Brigid's Ardee – 2018 Inspection Report

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

Report reference: Pages 36 & 37

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
1. Gaps in the administration record were not accounted for, 23 (1).	*Reoccurring*	Corrective Action(s): ALL MPAR's reviewed to ensure omissions are recorded Post-Holder(s) responsible: CNM2	Ongoing monthly audit schedule.	Achievable	Ongoing
		Preventative Action(s): A monthly audit will be completed as part of nurse metric programme with specific criteria measuring compliance with recording reasons where medication omitted Post-Holder(s) responsible: CNM1/CNM2	Monthly audit programme, results and action plans communicated to all staff at respective staff forums, handover reports, staff meetings, and governance meetings.	Achievable	Monthly
2. Allergy Status was not recorded in all MPARs, 23 (1).	*New*	Corrective Action(s): All MPARs reviewed and allergy status recorded where applicable Post-Holder(s) responsible: CNM2	Ongoing monthly audit schedule.	Achievable	Ongoing
		Preventative Action(s): A monthly audit will be completed as part of nurse metric programme with specific criteria measuring compliance with recording of allergy status Post-Holder(s) responsible: CNM1/CNM2	Monthly audit programme, results and action plans communicated to all staff at respective staff forums, handover reports, staff meetings, and governance meetings.	Achievable	Monthly

Regulation 26: Staffing

Report reference: Pages 39 & 40

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
3. Not all staff had up to date training in fire safety, basic life support, professional Management of Aggression and Violence, Children First and the Mental Health Act 2001, 26 (4) and 26.5.	*Reoccurring*	Corrective Action(s): Training plan developed for 2018 outlining training dates for specific mandatory training for the whole of 2018. 13 BLs training sessions scheduled for 2018, 11 PMAV training sessions (11 hour programme) scheduled for 2018 Post-Holder(s) responsible: Nurse Practice development Co-ordinator	Ongoing review of attendance levels.	Achievable-	Schedule complete
		Preventative Action(s): Quarterly reports will be provided on status of compliance of training levels and reviewed at local governance group and service governance group and followed up by respective line managers Post-Holder(s) responsible: Heads of Disciplines	Quarterly reports provided on current status of compliance levels for mandatory training.	Achievable	Quarterly

Code of Practice on Admission, Transfer and Discharge

Report reference: Page 54

Area(s) of non-compliance		Specific	Measureable	Achievable / Realistic	Time-bound
4. An audit had not been completed regarding the implementation or adherence to the transfer policy, 4.19.	*Reoccurring*	Corrective Action(s): Yearly audit to be carried out in relation to transfer process, Post-Holder(s) responsible: CNM1/CNM2	Results reviewed at St. Ita's Governance group with monitoring of action plan where areas not met	Achievable	30/04/2018
		Preventative Action(s): Review of completion of audits and audit schedule at St. Ita's governance group Post-Holder(s) responsible: Rehabilitation team	Standing item schedule on St. Ita's Governance Group meeting for review of audits and yearly audit plan	Achievable	31/03/2019
5. The discharge plan did not estimate the date of discharge, 34.2. 6. There was no reference to early warning signs of relapse and risk in the discharge plan, 34.2.	*New*	Corrective Action(s): Review of current discharge plan documentation to incorporate estimate date of discharge and early warning signs Post-Holder(s) responsible: Rehabilitation team	Progress of action monitored at St. Ita's Governance Group monthly meeting	Achievable	31/03/2019
		Preventative Action(s): Audit on discharge processes to capture key criteria as estimate date of discharge, reference to early warning signs of relapse and risk Post-Holder(s) responsible: Rehabilitation team	Discharge audit to be incorporated into yearly schedule of audit programme	Achievable	30/06/2019