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

ID Number: AC0016

2017 Approved Centre Inspection Report (Mental Health Act 2001)
St. Ita's Ward, St. Brigid's Hospital
Kells Road
Ardee
Co. Louth

Conditions Attached: Yes

Approved Centre Type: Continuing Mental Health Care/Long Stay Mental Health Rehabilitation

Most Recent Registration Date: 1 March 2017

Inspection Team:
Dr David McGuinness, Lead Inspector
Mary Connellan
Carol Brennan-Forsyth

Inspection Date: 28 – 31 March 2017
Inspection Type: Unannounced Annual Inspection

Previous Inspection Date: 27 – 29 September 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: 14 September 2017

2017 COMPLIANCE RATINGS

REGULATIONS

Rules and Part 4 of the Mental Health Act 2001

Codes of Practice
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

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

1.0 Introduction to the Inspection Process ................................................................. 5
2.0 Inspector of Mental Health Services – Summary of Findings .................................. 7
3.0 Quality Initiatives .................................................................................................. 10
4.0 Overview of the Approved Centre ........................................................................... 11
   4.1 Description of approved centre ............................................................................. 11
   4.2 Conditions to registration ...................................................................................... 12
   4.3 Reporting on the National Clinical Guidelines ....................................................... 12
   4.4 Governance ........................................................................................................... 12
5.0 Compliance ............................................................................................................. 13
   5.1 Non-compliant areas from 2016 inspection ........................................................... 13
   5.2 Non-compliant areas on this inspection ................................................................. 14
   5.3 Areas of compliance rated Excellent on this inspection ........................................ 14
6.0 Service-user Experience ......................................................................................... 15
7.0 Interviews with Heads of Discipline ....................................................................... 16
8.0 Feedback Meeting .................................................................................................. 17
9.0 Inspection Findings – Regulations ......................................................................... 18
10.0 Inspection Findings – Rules ................................................................................ 63
11.0 Inspection Findings – Mental Health Act 2001 .................................................... 67
12.0 Inspection Findings – Codes of Practice .............................................................. 69
Appendix 1 – Corrective and Preventative Action Plan ............................................. 80
1.0 Introduction to the Inspection Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspector of Mental Health Services                      Dr Susan Finnerty

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

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

Safety in the approved centre

The approved centre had a written policy in relation to health and safety and an associated safety statement. It also had an occupational safety, health and welfare statement. A risk management policy was in place. At least two person-specific resident identifiers were used. It was noted that the kitchen in the approved centre was not clean which compromised food safety. The ordering prescribing and storage of medication was good but not all medications administered to the resident were recorded and there was no information on whether medications were withheld by nursing staff or refused by residents. Not all staff had received training in fire safety, Basic Life Support (BLS), Professional Management of Aggression and Violence (PMAV), and the Mental Health Act (MHA) 2001, as required. The senior occupational therapist was trained in Children First. Ligature points had not been minimised and while the approved centre’s resident profile was deemed low risk, there was no ligature audit completed since 2015.

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

Appropriate care and treatment of residents

Residents had an individual care plan (ICP) and the ICPs identified residents’ goals, treatment, and care and the resources required to meet residents’ needs. There was evidence of multidisciplinary team (MDT) involvement and the ICPs were developed with the participation of residents, and the involvement of resident representatives, family, and next of kin was recorded in nine of the ICPs inspected. There was evidence that the ICPs were reviewed quarterly by the new MDT in consultation with residents. There was a lack of therapeutic services and programmes. The recently appointed occupational therapist was in the process of assessing residents in terms of the appropriateness of the limited therapeutic programmes and services available. Residents received appropriate general health care in line with their individual care plans, and their general health needs were monitored and assessed at least every six months. Residents could access general health services or be referred to other health services, as required. Although there were two residents in the approved centre with an intellectual disability, staff members had not completed relevant
training. Not all clinical files were in good order or had been developed and maintained in a logical sequence to ensure easy retrieval. There was no written record indicating that staff had read and understood the policy on the use of physical restraint and the policy did not include information on the areas to be addressed during training, including alternatives to physical restraint. In the episodes examined, it was not recorded whether physical examinations were completed no later than three hours after the start of the physical restraint. The use of mechanical restraint in the approved centre was compliant with Part 5 of the Code of Practice: Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others. There were deficits in the admission and discharge policies.

AREAS REFERRED TO

Respect for residents’ privacy and dignity
The sleeping accommodation comprised a mix of double and single rooms along with one dormitory-style bedroom, which accommodated two residents. The dormitory also served as a thoroughfare, through which up to eight residents passed through to get to their respective bedrooms. Some residents expressed a preference for single rooms. Some toilet cubicles were mixed – male and female. Residents were supported to keep and wear their personal clothing, and residents’ clothing was observed to be clean and appropriate to their needs. Residents were encouraged to manage and keep their own property. Valuables were kept in the dedicated ward safe, and each resident had their own log book, which was updated when necessary. Not all male staff were professionally attired while on duty. The toilets in a shared male-female bathroom were not adequately cleaned and smelled malodorous, which was not respectful of residents’ dignity. In one shared bedroom, one privacy screen was missing and the other screen was falling down in places and in need of cleaning. Two residents were accommodated in an area off a main thoroughfare corridor, which could be accessed by eight other residents. Screening was in place in this area, but this was not an appropriate living/sleeping space for residents.

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

Responsiveness to residents’ needs
Menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a range of wholesome and nutritious food choices. Food was presented in an attractive and appealing manner, and residents on modified consistency meals (puréed) had two menu choices. Four residents complained about insufficient activities during the day. Recreational activities were developed with limited resident involvement and only when nursing staff had the time to facilitate resident input. Recreational activities were sporadic, limited in choice, and insufficient for residents’ needs. Residents were facilitated in the practice of their religion. Visiting times, which were appropriate and reasonable, were displayed in the approved centre. Rooms suitable for visits were available, including a separate area where
Residents could meet visitors in private. Residents had access to external communications, including a cordless phone on the ward and a landline phone for making private calls. There was pay-as-you-go Internet access and two PCs for residents use if they so wished. Relevant information for residents was available in a booklet and information about diagnosis and medication was given to residents.

The approved centre was undergoing a programme of refurbishment at the time of the inspection and was not in a good state of structural and decorative repair. As part of the premises upgrade, the approved centre had been freshly painted. A maintenance programme was in place but had not been fully implemented, and there were considerable delays in completing general maintenance tasks. Although a new cleaning schedule and system had been introduced, bathroom and toilet areas were not adequately cleaned or free of offensive odours, and other areas were not clean. There was a well-maintained garden, but it contained an overflowing cigarette receptacle and overflowing bin. The approved centre had an excellent complaints process, which was well publicised and accessible to both residents and their representatives. Complaints were investigated promptly and handled appropriately and sensitively.

**AREAS REFERRED TO**

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

**Governance of the approved centre**

St. Ita’s clinical governance group had been established. The head of service was the registered proprietor of the approved centre. Many members of the area management team were based on the St. Brigid’s Hospital campus. An area lead in mental health engagement had recently taken up post and was a member of the area management team. In addition, there was a service user representative from the consumer panel on the area management team. There was an organisational chart to identify the approved centre’s leadership and management structure and lines of authority and accountability. 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. Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders and were appropriately approved by the mental health lead for the CHO 8 area before becoming effective. There was a process in place for communicating operating policies and procedures to all relevant staff. All operating policies and procedures required by the regulations were reviewed within the required three-year time frame.

**AREAS REFERRED TO**

Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The establishment of a St. Ita’s clinical governance group.
2. The development of a risk register for St. Ita’s Ward.
3. The assignment of an assistant director of nursing as training coordinator.
4. The development of plans to change a dormitory-style bedroom into a therapeutic/activities room.
4.1 Description of approved centre

St. Ita’s Ward was located on the St. Brigid’s Hospital campus in Ardee, Co. Louth, and was the last in-patient ward still functioning within the hospital campus.

The approved centre had 20 beds, with 16 residents and at the time of inspection. It provided medium- to long-term care for residents. There was a mixed profile of residents: all but one resident was over age 65 and all residents were over six months in the approved centre. The approved centre operated a closed door policy, with the result that two residents had to request to exit and enter the ward.

Since the last inspection, one multi-disciplinary team – the Rehabilitation Service – had now been put in place. The multi-disciplinary team was based in close proximity to the approved centre. The approved centre was not accepting new admissions.

St. Ita’s Ward had recently been painted, and some residents had chosen the colours for their own bedrooms. Furnishings were to be acquired - some soft furnishings were on order while others were to be re-upholstered. At the time of inspection, some renovations were ongoing. For example, a dormitory-style bedroom was being renovated to make some space in the approved centre for a therapeutic/activities room. The accommodation comprised a mix of double and single rooms along with one dormitory-style bedroom, which accommodated two residents. The dormitory also served as a thoroughfare, through which up to eight residents passed through to get to their respective bedrooms. Some toilet cubicles were mixed – male and female. The premises were identified as a risk and placed on the risk register. One sitting/dining area contained two personal computers with Internet available on a pay-as-you-go basis. At resident interviews, it was commented that there was a lack of garden area, and this was corroborated by the inspection team. However, at the feedback meeting, assistant inspectors were informed that there were plans in place to extend the garden area for residents.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>20</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>16</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>2</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>16</td>
</tr>
</tbody>
</table>
4.2 Conditions to registration

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

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

**Condition 2:** To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programmed 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 head of service was the registered proprietor of the approved centre. There was an organisational chart and clear governance structures and processes were in place. Many members of the area management team were based on the St. Brigid’s Hospital campus. An area lead in mental health engagement had recently taken up post and was a member of the area management team. In addition, there was a service user representative from the consumer panel on the area management team.

Since the last inspection, a new clinical governance group for St. Ita’s had been established. It was chaired by the quality and risk manager and its membership consisted of the recently appointed consultant psychiatrist, senior social worker, and senior occupational therapist as well as the director of nursing, assistant director of nursing, and clinical nurse manager. Minutes of the governance committee and team meetings were provided to the inspection team. Processes relating to Corrective and Preventative Action requirements, incident reporting, audits, complaints, and quality initiatives were included in the minutes.

The quality and risk manager reviewed adverse events in the approved centre.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 27 – 29 September 2016 identified the following areas that were non-compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
5.2 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 6: Food Safety</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 18: Transfer of Residents</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>N/A</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Notification of Deaths and Incident Reporting</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 5: Food and Nutrition</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
<tr>
<td>Regulation 12: Communication</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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

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

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

Five residents and one family member agreed to be interviewed. In addition, six residents completed the questionnaire. All residents praised the care they were receiving and said that the nursing staff were “kind”. Some residents had a preference for single rooms. One resident expressed dissatisfaction that there was no space for gardening at St. Ita’s.
7.0 Interviews with Heads of Discipline

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

- Consultant Psychiatrist for the Rehabilitation Service
- Occupational Therapy Manager
- Principal Social Worker
- Area Director of Nursing
- Executive Clinical Director

All heads of discipline made themselves available to speak with the lead assistant inspector. Representatives from nursing, medical, occupational therapy and social work each provided a clear overview of the governance within their respective disciplines.

Most heads of discipline were based on the St. Brigid’s Hospital campus, which was in close proximity to the approved centre and enabled them to fulfil their management role on-site. A principal social worker had recently taken up the post. Heads of discipline commented on recent appointments within their respective disciplines, namely a consultant psychiatrist, senior social worker, and senior occupational therapist. Senior clinical psychologist and senior registrar posts had been approved but were not in place at the time of the inspection.

Defined lines of responsibility were evident in each discipline, with the heads of discipline reporting to the executive clinical director. Supervision across some disciplines varied from weekly to monthly. Where scheduled supervision was not used in a discipline, meetings were scheduled with staff to ensure that they were adequately supported. All heads of discipline identified strategic aims for their staff and discussed potential operational risks with their departments, including difficulties in covering leave and getting approval for additional posts.

The structure and culture of St. Ita’s was under review at the time of the inspection, and the aim was to foster a more rehabilitative ethos among residents and staff. There was an interim care group in place to oversee the quality of care processes from admission to discharge. There was an ethos to support quality improvement.

Three heads of discipline had training in risk management, one had training on health and safety and four had training in the National Incident Management System. There were only two trainers for Professional Management of Aggression and Violence at the time of the inspection, which limited this training requirement among all health care professionals.
8.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Registered Proprietor
- Executive Clinical Director
- Consultant Psychiatrist
- Principal Clinical Psychologist
- Director of Nursing
- Senior Occupational Therapist
- Occupational Therapy Manager
- Principal Social Worker
- Senior Social Worker
- Clinical Nurse Manager 2
- Assistant Director of Nursing X2
- Area Lead Mental Health Engagement
- Quality and Risk Manager
- Business Manager

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. The inspection team outlined the initial findings of the inspection process and provided an opportunity for the service to offer any corrections or clarifications as appropriate.

The assistant director of nursing supplied the inspection team with an improvement plan for hygiene standards. On foot of the positive initial findings regarding individual care plans, the service enquired whether their condition might be removed. The executive clinical director added that some residents had chosen the paint colour for their bedrooms. The consultant psychiatrist noted that the pharmacist had met with the clinical team and that a process for reviewing Medication Prescription and Administration Records would ensue.
9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

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

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

Monitoring: An annual audit was completed in November 2016 to ensure that clinical files contained appropriate resident identifiers. There was documentary evidence that analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: At least two person-specific resident identifiers were used – photograph, name, and date of birth – and these were appropriate to the residents’ communication abilities. Two resident identifiers were checked before the administration of medication, the undertaking of medical investigations, and the provision of other health care services. An appropriate identifier was also used prior to the provision of therapeutic services and programmes. A system was in place to alert staff to the presence of residents with the same or a similar name.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 5: Food and Nutrition

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

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

INSPECTION FINDINGS

**Processes:** The approved centre had a written policy in relation to the provision of appropriate food and nutrition to residents, which was last reviewed in August 2016. It included all of the requirements of the Judgement Support Framework.

**Training and Education:** Relevant staff had signed a log indicating 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 received wholesome and nutritious food in accordance with their needs. Minutes of the Food and Nutrition Committee indicated that there was ongoing review and analysis of processes relating to food and nutrition.

**Evidence of Implementation:** Menus were approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs. Residents were provided with a range of wholesome and nutritious food choices. Food was presented in an attractive and appealing manner, and residents on modified consistency meals (puréed) had two menu choices. Hot meals were provided daily, and residents had regular access to hot and cold drinks, including a supply of fresh drinking water.

Where residents had special dietary requirements, an evidence-based nutrition assessment tool was used. All residents were assessed by the dietitian and followed up as necessary. Nutritional and dietary needs were evaluated with input from a speech and language therapist, where necessary. This was documented in the individual care plans.

Weight charts were implemented, monitored, and acted upon, where appropriate. Residents identified as having special nutritional requirements were regularly reviewed by a dietitian, and residents, their representatives, family, and next of kin were educated about the residents’ diets, where 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 6: Food Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food safety, which was last reviewed in October 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP).

Monitoring: There was documentary evidence that food safety audits had been undertaken. A food hygiene and management system audit had been completed in October 2016. Food temperatures were recorded in line with safety recommendations, and a temperature log was maintained and monitored. Analysis had been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: All food was prepared in the main hospital kitchen and served in the approved centre. The catering equipment was suitable and adequate, with appropriate facilities for the refrigeration, storage, and serving of food. Adequate hand-washing areas were provided for catering services, and hygiene was maintained to support food safety. Residents had access to a supply of suitable crockery and cutlery.

On the first day of the inspection, it was noted that the kitchen in the approved centre was not clean. In addition, three tables in the dining room had not been properly cleaned after the breakfast serving. These issues were rectified immediately by management and household personnel.

The approved centre was non-compliant with this regulation because the kitchen in the approved centre was not clean. In addition, three tables in the dining room had not been properly cleaned. Regulation 1(c)
Regulation 7: Clothing

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to clothing, both of which were last reviewed in May 2016: a clothing policy and a document entitled Policy on the Management of the Prescribed Use of Night Attire as Part of a Treatment Plan. These included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policies. Relevant staff interviewed could articulate the processes in relation to residents’ clothing, as set out in the policies.

Monitoring: There was no ongoing monitoring of the availability of an emergency supply of clothing for residents.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, and residents’ clothing was observed to be clean and appropriate to their needs. An emergency supply of new clothing was available for residents of both gender. Residents were encouraged to change out of nightclothes during the day and only wore night attire if they were in bed, as per the approved centre’s policy. Residents had an adequate supply of individualised clothing. They were brought shopping for clothes regularly, and family/next of kin could bring clothes also.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to residents' personal property and possessions. Entitled Management of Property and Possessions in Mental Health Care Facilities, it was last reviewed in January 2016. The HSE document Patient’s Private Property Guidelines was also available. The property management policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the property management policy. Relevant staff interviewed could articulate the processes relating to residents’ property and possessions, as set out in the policy.

Monitoring: Residents’ personal property was logged on an ongoing basis. A personal accounts audit had been conducted in November 2016, and recommendations were made. Analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions. As part of analysis conducted, residents expressed wish to having lockable cupboards and management were sourcing these.

Evidence of Implementation: Residents could bring personal possessions into the approved centre and were encouraged to manage and keep their own property unless doing so posed a danger to themselves or others, as indicated in their individual care plans (ICPs). Signed property checklists were maintained, and these were held separately from the ICPs. Personal property was recorded in the property log.

When the approved centre assumed responsibility for residents’ property, personal effects were secured. Valuables were kept in the dedicated ward safe, and each resident had their own log book, which was updated when necessary.
Two members of staff oversaw the process of providing residents with access to their monies. Signed records of the staff issuing the money were retained and, where possible, countersigned by the resident or their representative. Two nurses undertook weekly checks of all residents’ money.

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 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of recreational activities, which was last reviewed in May 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to recreational activities, as set out in the policy.

Monitoring: There were gaps in the documentation of the occurrence of planned recreational activities, including a record of resident uptake/attendance. There was an attendance book, but it was not filled in for the first two months of 2017. Entries had recommenced in March 2017. There was no documentary evidence that analysis had been completed to identify opportunities for improving the processes in relation to recreational activities.

Evidence of Implementation: Between four and six residents participated in the day services programme on different days, depending on the activity provided. A whiteboard in the day room listed activities for the morning and afternoon. However, the activities listed did not match the activities being facilitated on the named days. Residents had access to TV, DVDs, books, and skittles. A number of residents went on day leave during the day.

Four residents had complained about insufficient activities during the day, and one resident commented on this to a member of the inspection team. Recreational activities were developed with limited resident involvement and only when nursing staff had the time to facilitate resident input. Recreational activities were provided by the approved centre on weekdays and at the weekend, but they were sporadic, limited in choice, and insufficient for residents’ needs. There was, however, a strong commitment by staff to address this.

Where applicable, individual risk assessments were completed for residents in relation to the selection of appropriate activities. At the time of the inspection, the occupational therapist was in the process of assessing each resident, and this included an assessment of recreational pursuits. Residents’ decisions on whether or not to participate in activities were respected. Opportunities were available for indoor and outdoor exercise and physical activity, where appropriate. Communal areas were suitable for recreational activities.
Recreational activities were not appropriately resourced and were dependent on nursing staff numbers. Records of resident attendance at events were not consistently maintained.

The approved centre was not compliant with this regulation because residents did not have access to appropriate recreational activities.
Regulation 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in March 2017. The policy included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating 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 had been reviewed to ensure that residents’ identified religious needs were met, and the policy was updated accordingly.

Evidence of Implementation: Residents were facilitated in the practice of their religion, insofar as was practicable. There was an allocated room where mass was celebrated on Sundays, and communion was offered to residents who were unable or chose not to attend. Residents could access local religious services and were supported to attend, if it was deemed appropriate following a risk assessment.

The care and services provided within the approved centre were respectful of residents’ religious beliefs and values. Residents were facilitated in observing or abstaining from religious practice in line with their wishes.

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

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident’s individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which was last reviewed in March 2014. The policy included all of the requirements of the Judgement Support Framework.

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

Monitoring: Analysis had not been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were displayed in the approved centre. Rooms suitable for visits were available, including a separate area where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Staff were proactive in terms of ensuring visitor safety and the safety of residents during visits. Children were welcomed when accompanied by an adult and supervised. Children visiting were accommodated in the approved centre’s open seating area to ensure safety. There were no restrictions on residents’ visiting rights at the time of the inspection.

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

Compliant

Quality Rating
Excellent

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

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

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

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

INSPECTION FINDINGS

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

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff could articulate the processes for facilitating residents’ communication.

Monitoring: There was no documentary evidence that residents’ communications needs and restrictions on communication were monitored on an ongoing basis. Analysis had been completed to identify opportunities for improving communication processes. As part of action monitoring group, new internet kiosks were provided.

Evidence of Implementation: There was documentary evidence that the resident communication policy and procedures were implemented throughout the approved centre. Residents had access to external communications, including a cordless phone on the ward and a landline phone for making private calls. There was pay-as-you-go Internet access and two PCs for residents use if they so wished.

Where appropriate, individual risk assessments were completed for residents in relation to external communication and documented in their individual care plans. A senior member of staff could examine resident communication only where there was reasonable cause to believe that the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
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 a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to searches, which was last reviewed in April 2016. It 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 a log indicating that they had read and understood the policy. Relevant staff could detail the procedures for undertaking a search.

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

The approved centre was compliant with this regulation.
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to care of the dying, which was last reviewed in September 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff members interviewed could articulate the processes relating to end of life care, as set out in the policy.

Since the last inspection, no resident had received end of life care and there had been no sudden or unexplained deaths in the approved centre. As a result, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in May 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Training records indicated that all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: A multi-disciplinary care planning audit was undertaken in December 2016 to assess compliance with the regulation. Following the audit, analysis was completed to identify opportunities to improve the individual care planning process. A new ICP template was subsequently developed and was in use.

Evidence of Implementation: Eight ICPs were inspected. Each 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, and care and the resources required to meet residents’ needs.

Residents were assessed at admission and an initial care plan was put in place. An ICP was developed within seven days by the MDT, following an assessment. Evidence-based assessments were used where possible. The assessment did not include an evaluation of residents’ communication abilities.

The ICPs were developed with the participation of residents, the involvement of resident representatives, family, and next of kin was recorded in nine of the ICPs inspected.

The residents’ assessed needs were clearly identified and legible because each ICP was typed. A key worker was identified to ensure continuity in the implementation of the ICP. There was evidence that the ICPs were reviewed quarterly by the new MDT in consultation with residents. They were updated following review as indicated by residents’ changing needs, condition, circumstances, and goals. Residents signed each review, where applicable, and they were offered a copy of the updated ICP.

COMPLIANT

Quality Rating: Satisfactory
The ICPs referenced inadvertent self-harm but did not include comprehensive risk management plans.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was last reviewed in June 2016. It included requirements of the Judgement Support Framework, with the exception of a process for risk-assessing residents in terms of the appropriateness of services and programmes.

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed could clearly articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: There was no documentary evidence that the range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents’ assessed needs were met. Minutes from rehabilitation services meetings indicated that analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes. This identified the need for horticultural activities and increased access to garden space.

Evidence of Implementation: At the time of the inspection, the approved centre provided few therapeutic services and programmes. In conjunction with the newly appointed social worker, the recently appointed occupational therapist was in the process of assessing residents in terms of the appropriateness of the limited therapeutic programmes and services available. As the assessments had not been completed, it could not be determined whether the programmes provided were appropriate to the assessed needs of residents, as outlined in their individual care plans.

Residents’ participation and engagement in the available therapeutic services and programmes as well as the outcomes achieved were recorded in their clinical files. Where residents required a service or programme that was not available internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The therapeutic services and programmes provided by the approved centre were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents because there was a limited number of programmes available and the assessment of residents in terms of the appropriateness of the available therapeutic services and programmes had not been completed at the time of the inspection.
Resources and facilities were available in the approved centre to provide therapeutic services and programmes, but there was no designated therapeutic/activities room.

The approved centre was not compliant with this regulation because it did not provide specific therapeutic programmes in support of maintaining the optimal levels of physical and psychosocial function of residents, 16(2).
<table>
<thead>
<tr>
<th>Regulation 17: Children’s Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>The registered proprietor shall ensure that each resident who is a child is provided with appropriate educational services in accordance with his or her needs and age as indicated by his or her individual care plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
</tbody>
</table>
(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

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

**INSPECTION FINDINGS**

**Processes**: The approved centre had a written policy in relation to the transfer of residents, which was last reviewed in April 2016. It included requirements of the *Judgement Support Framework*, with the exception of a process for emergency transfers.

**Training and Education**: Relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy.

**Monitoring**: The approved centre maintained a transfer log in the nursing office, but it was not up to date because it did not reflect all transfers that were known to have taken place. Analysis had not been completed to identify opportunities for improving the provision of information during transfers.

**Evidence of Implementation**: Two clinical files were inspected in relation to transfers. Communication records with the receiving facility were not uniformly documented, and neither file contained medical notes. There was documentary evidence of consent to transfer.

In one file, there was no documentation in relation to a pre-transfer assessment. Neither file contained evidence that full and complete written information regarding the residents was transferred. In one clinical file, there was no evidence that a referral letter or list of required medications were sent to the receiving facility.

In the case of emergency transfers, there was no evidence that the receiving facility was sent follow-up referral letters. A transfer checklist has been completed for one transfer but not for the others. Copies of all relevant records were not retained in the clinical files.

The approved centre was not compliant with this regulation because there was no evidence that all relevant information about the resident was forwarded to the receiving facility, 18(1).
Regulation 19: General Health

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

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

INSPECTION FINDINGS

Processes: The approved centre had a number of policies relating to the provision of general health care: a general health
policy dated May 2016, a medical emergencies policy dated September 2015, and guidelines for cardiopulmonary
resuscitation and use of the Automated External Defibrillator (AED) dated March 2014. The policies included requirements of the
Judgement Support Framework, with the following exceptions:

- The ongoing assessment of residents’ general health needs.
- The resource requirements for general health services.
- The protection of resident privacy and dignity during general health assessments.
- The referral process for general health needs of residents.

Training and Education: All clinical staff had signed a log indicating that they had read and understood the policies. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policies.

Monitoring: Residents’ take-up of national screening programmes were recorded and monitored. A systematic review had been undertaken to ensure that six-monthly general health checks took place. Analysis had not been completed to identify opportunities for improving general health processes.

Evidence of Implementation: The approved centre had an AED, which were checked weekly. Records were not available of medical emergencies or of the care provided.

The non-consultant hospital doctor assessed residents’ physical health on admission and on an ongoing basis. Residents received appropriate general health care in line with their individual care plans, and their general health needs were monitored and assessed at least every six months. Residents could access general health services or be referred to other health services, as required. Records were maintained of completed general health checks and associated results. Residents could access age- and gender-appropriate national screening programmes, and information was provided the screening programmes available through the approved centre.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, monitoring, and evidence of implementation pillars.
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to the provision of information to residents, which was last reviewed in March 2015. It included requirements of the Judgement Support Framework, with the exception of the process for managing the provision of information to resident representatives, family, and next of kin.

Training and Education: All staff had signed a log indicating that they had read and understood the policy. Staff interviewed could articulate the processes for providing information to residents, as set out in the policy.

Monitoring: There was no documented evidence that the provision of information to residents was audited on an ongoing basis to ensure it was appropriate and accurate. Analysis had been completed to identify opportunities for improving the processes around the provision of information and work had begun on development of new information booklet.

Evidence of Implementation: Required information was provided to residents and/or their representatives at admission in a comprehensive resident information booklet. This included details of the available care and services as well as the housekeeping arrangements, complaints procedures, visiting times and arrangements, advocacy and voluntary agencies, and residents’ rights.

Residents received copies of their individual care plans, containing details of their multi-disciplinary team. Each resident was provided with a folder containing information specific to their needs, which they retained. The folders included evidence-based information about diagnosis, unless the provision of such information might be detrimental to a resident’s health and well-being. The approved centre sourced information from the NHS’ Choice and Medication website.
A variety of diagnosis and medication-related information, including risks and potential side-effects, was available. Documentation provided by or in the approved centre was appropriately reviewed and approved prior to implementation.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy. Entitled Privacy, Confidentiality and Consent, it was last reviewed in February 2015. It included all of the requirements of the Judgement Support Framework.

Training and Education: All staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: An annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had been completed to identify opportunities for improving the processes relating to residents' privacy and dignity and actions had been identified.

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to interact with residents in a professional and courteous manner. Whereas female staff were observed to be professionally attired, not all male staff were. Staff sought permission before entering residents’ rooms, and conducted all conversations relating to residents’ clinical and therapeutic needs with discretion and respect. Residents were observed to be dressed in a manner that respected their privacy and dignity. They had an adequate supply of personal clothing that had been laundered and labelled as required.

Bathrooms and toilet facilities had locks on the inside of the doors, and these had an override facility. The toilets in a shared male-female bathroom were not adequately cleaned and smelled malodorous, which was not respectful of residents’ dignity. In one shared bedroom, one privacy screen was missing and the other screen was falling down in places and in need of cleaning. These issues were noted by management and rectified immediately.

Rooms were not overlooked by public areas, and windows and observation panels had screening. The observation panels in two bedrooms had no blinds but were obscured by opaque film. Noticeboards did not display identifiable resident information. Residents were facilitated in making and taking private phone calls.
The approved centre was not compliant with this regulation for the following reasons:

a) Not all male staff were professionally attired.
b) The inadequate cleaning of a unisex bathroom was not respectful of residents’ dignity.
c) One shared bedroom had inadequate privacy screening.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had no written policy in relation to its premises.

Training and Education: There was no written premises policy for staff to have read and understood. Relevant staff interviewed were able to articulate the processes relating to the maintenance of the premises.

Monitoring: A hygiene audit had been undertaken by an independent service provider, AV Direct. Analysis had been completed to identify opportunities to improve the premises, and a list of actions were compiled. A ligature audit had not been conducted since 2015.

Evidence of Implementation: The approved centre provided residents with access to personal space, with adequately sized dining and day sitting rooms. Rooms were comfortably heated and ventilated, but the lighting was described as too bright by staff and was being replaced as part of an ongoing refurbishment programme.

Appropriate signage and sensory aids were provided to support residents’ orientation. Hazards such as large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces were minimised. Ligature points had not been minimised, but the approved centre’s resident profile was deemed low risk.
The approved centre did not provide accommodation that assured the comfort and privacy of residents and met their assessed needs. Two residents were accommodated in an area off a main thoroughfare corridor, which could be accessed by eight other residents. Screening was in place in this area, but this was not an appropriate living/sleeping space for residents. One shared double room lacked adequate privacy screening, and this was rectified during the inspection.

The approved centre was undergoing a programme of refurbishment at the time of the inspection and was not in a good state of structural and decorative repair. As part of the premises upgrade, the approved centre had been freshly painted. A maintenance programme was in place but had not been fully implemented, and there were considerable delays in completing general maintenance tasks.

There was a maintenance request system, with issues documented in a book. Copies of requests were retained in the approved centre. Records indicated that requests for new toilet seats had been sent to the maintenance department on two occasions but had not been supplied by the time of the inspection.

Although a new cleaning schedule and system had been introduced, bathroom and toilet areas were not adequately cleaned or free of offensive odours, and other areas were not clean. For example, one bathroom was malodorous and the local kitchen was not adequately cleaned on the first day of the inspection. The issues were immediately remedied. There was a well-maintained garden, but it contained an overflowing cigarette receptacle and overflowing bin.

The approved centre had adequate toilet and bathroom facilities, including assisted needs facilities, with at least one assisted toilet per floor. The wheelchair accessible toilet was not for visitor use, however. There were designated cleaning and sluice rooms. There was no designated laundry room. Soiled laundry was kept in a large bathroom and collected on a daily basis for laundering.

Residents’ bedrooms were appropriately sized, but shared bedrooms varied in size, with some more spacious than others. Furnishings throughout the approved centre supported residents’ independence, and comfort, and new seating had been acquired since the last inspection.

The approved centre did not have dedicated therapy/examination rooms.

The approved centre was not compliant with this regulation for the following reasons:

a) Toilet and bathroom facilities and a kitchenette were inadequately cleaned on the first day of the inspection, 22(1)(a).

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

c) A programme of routine maintenance had not been implemented in full, 22(1)(c).

d) The condition of the physical structure and the overall approved centre environment had not been developed and maintained with due regard to the specific needs of residents and patients and the well-being of residents, staff, and visitors, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in May 2016 and had an addendum dated October 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: All nursing, medical, and pharmacy staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ordering, prescribing, storing, and administering medicines, as set out in the policy. Staff had access to up-to-date information on all aspects of medication management, and all clinical staff had received training on the importance of reporting medication incidents, errors, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were completed, and analysis was undertaken to identify opportunities for improving medication management. Incident reports were recorded for medication incidents/errors.

Evidence of Implementation: An MPAR was maintained for each resident, and all of these were inspected. Two appropriate resident identifiers were used when medication was being administered. Names of medications were written in full, and generic names were recorded where applicable. The frequency of administration, the dosage, and the administration route for medications were recorded, as were the dates of initiation and discontinuation for each medication, where applicable.

Seven of the MPARs inspected contained gaps in the administration record. All medications administered to the resident were not recorded and there was no information on whether medications were withheld by nursing staff or refused by residents.

The Medical Council Registration Numbers of medical practitioners prescribing medication were recorded on the MPARs, and each entry was accompanied by the prescriber’s signature. The allergy section was completed in all cases.

Residents’ medication was reviewed at least six-monthly. The MPARs only allowed for administration records for up to 42 days, after which they had to be rewritten. Where there were alterations in the medication order, the medical practitioner rewrote the prescription. Medication was administered by two registered nurses, but the administration record did not indicate whether the directions of the prescriber were adhered to. The expiration date of the medication was checked prior to administration, and good
hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. In relation to medication that required refrigeration, a new fridge had been installed since the 2016 inspection, but a daily log of fridge temperatures was not maintained. Medication storage areas were clean and were not used to store food and drink.

Medication dispensed to residents was stored securely in a locked trolley and secured in a locked room. A system of stock rotation was in place. The medication trolley was checked and cleaned weekly, at which time supply needs were identified. However, a formal inventory of medications was not undertaken.

The approved centre was not compliant with this regulation because there were gaps in the administration records in 7 of the 16 MPARs inspected, 23(1).
Regulation 24: Health and Safety

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to health and safety and an associated safety statement, which were last reviewed in June 2016. It also had an occupational safety, health and welfare statement dated 2016. The policy and safety statement included requirements of the *Judgement Support Framework*, with the exception of details of the following:

- Vehicle controls.
- Staff training requirement in relation to health and safety.

**Training and Education:** All staff had signed a log indicating that they had read and understood the policy and safety statement. Staff interviewed were able to articulate the processes relating to health and safety, as set out in the policy.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 26: Staffing

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to staffing, which was last reviewed in May 2016. It referenced the HSE’s guidelines for confined recruitment, and it covered requirements of the Judgement Support Framework, including the following:

- The roles and responsibilities for the recruitment, selection, vetting, and appointment of staff.
- The recruitment, selection, and appointment process, including Garda vetting requirements.

It did not outline the following:

- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- The roles and responsibilities in relation to staff training.

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

Monitoring: There was no evidence that the approved centre had reviewed the implementation and effectiveness of the staff training plan. Analysis had not been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents. The number and skill mix of staff had been assessed against the levels recorded in the approved centre’s registration.

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 an electronic copy of the roster was presented for inspection. Staff were recruited, selected, and vetted in line with the approved centre’s policy. 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.

There was no documentary evidence that the approved centre had a written staffing plan. Annual training plans were in place for all staff. Orientation and induction training had been completed. Not all staff had received training in fire safety, Basic Life Support (BLS), Professional Management of Aggression and Violence (PMAV), and the Mental Health Act (MHA) 2001. The senior occupational therapist was trained in Children First.

Not all staff were trained in accordance with the assessed needs of residents. Although there were two residents in the approved centre with an intellectual disability, all staff members had not completed relevant training.

Staff training was documented, and training logs were maintained. Resources were available to staff for further training and education, and in-house trainers were appropriately qualified. The MHA 2001, the associated regulation, Mental Health Commission rules and codes, and all other documentation and guidance were available to staff throughout the approved centre.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Ita’s Ward</td>
<td>CNM1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN).

The approved centre was not compliant with this regulation because not all staff had up-to-date training in fire safety, BLS, PMAV, and the MHA 2001, 26(4) and (5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in June 2014. It was the HSE Dublin Northeast policy, covering Louth, Meath, Cavan, Monaghan Mental Health Services. The policy covered all of the requirements of the Judgement Support Framework, including policies and procedures relating to the following:

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

It did not make explicit reference to record review requirements.

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

Monitoring: Resident records were audited using the nursing metric programme to ensure their completeness, accuracy, and ease of retrieval. Analysis had been conducted to identify opportunities for improving the processes relating to the maintenance of records.

Evidence of Implementation: Residents’ records were stored together in a secure location: in a filing cabinet in a locked office. Records were reflective of the residents’ current status and the care and treatment being provided. Each resident had an individual file, and appropriate identifiers – photograph, hospital number, name, and date of birth – were in use. Only authorised staff could make entries in residents’ records.
Not all records were in good order or had been developed and maintained in a logical sequence to ensure easy retrieval. Loose pages were observed in one clinical file. Details of residents’ six-monthly physical examinations were not correctly filed and an indexing template for clinical files was not consistently implemented.

Resident files contained factual, consistent, and accurate entries. Entries were dated and time-stamped, but the 24-hour clock was not always used and entries were not always written in black ink. Each entry was accompanied by a signature, and a log of all signatures used in resident records was maintained.

Documentation relating to food safety, health and safety, and fire inspections was maintained. Records were retained or destroyed in accordance with legislative requirements and the approved centre’s policy and procedures.

The approved centre was not compliant with this regulation for the following reasons:

a) Records were not maintained in a good order, as evidence by loose pages, 27(1).

b) Records contained misfiled elements and were not arranged to ensure easy retrieval, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date and contained all of the required information listed in Schedule 1 of the Mental Health Act 2001.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the development and review of operating policies and procedures, which was last reviewed in March 2017. It included requirements of the Judgement Support Framework, with the exception of a process for making obsolete and retaining previous versions of policies and procedures.

Training and Education: Relevant staff had signed a log indicating that they had read and understood the policy. Staff had received training on approved operational policies and procedures. Relevant staff interviewed were able to articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: There was documentary evidence that an annual audit had been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes relating to developing and reviewing policies.

Evidence of Implementation: Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. They incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were appropriately approved by the mental health lead for the CH0 8 area before becoming effective. There was a process in place for communicating operating policies and procedures to all relevant staff.

All operating policies and procedures required by the regulations were reviewed within the required three-year time frame. Obsolete versions were destroyed at ward level, and the original signed document was archived. Policies and procedures were presented in a standardised format that included the title, reference and version number, details of the document owner, date of implementation, and details of approvers and reviewers. The total number of pages in the document was not recorded.

Where generic policies were used, there was a written statement adopting the policy in question. Generic policies used were appropriate to the approved centre and the resident cohort.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and evidence of implementation pillars.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

As no resident in the approved centre had been admitted involuntarily, this regulation was not applicable.
(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to making, handling, and investigating complaints, which was last reviewed in January 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had received formal training on complaints. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy. All staff had signed a log indicating that they had read and understood the policy.

Monitoring: Complaints data were assessed at the monthly meeting of the Clinical Governance Committee, where trends were documented and action plans aimed at improving the complaints management process were implemented.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. Residents were able to speak directly to staff about minor complaints, which were documented using a newly introduced template. There was a log for more serious complaints, which could be escalated to the complaints officer, if necessary. The complaints officer was responsible for acknowledging written complaints and forwarding them to relevant individuals to be addressed.

Ways in which residents and their representatives could lodge a complaint were detailed in the approved centre’s policy, in a service user information booklet, and on a displayed notice. Copies of the HSE Your Service, Your Say leaflet were available and a complaint box was in place.
The approved centre’s complaints management processes were well publicised and accessible to both residents and their representatives. Complaints were investigated promptly and handled appropriately and sensitively. There was no evidence that the quality of service, care, and treatment of a resident were adversely affected by reason of a complaint being made. Details of complaints, investigations, and outcomes were recorded and kept separately from the resident’s individual care plan. Time frames for responding to, investigating, and resolving complaints were provided, and complainants were informed promptly of the outcome of the investigation and of the appeal process, if necessary.

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 32: Risk Management Procedures

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written policies in relation to risk management: a risk management policy dated May 2015, the HSE’s safety incident management policy dated 2014, and the HSE’s 2016 occupational safety, health and welfare statement. Together, the policies covered all of the requirements of the Judgement Support Framework, including processes for the following:

- Identification, assessment, treatment, reporting, and monitoring risks throughout the approved centre.
- Rating identified risks.
- Controlling resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Managing incidents involving residents.
- Responding to emergencies.
- Protecting children and vulnerable adults in the care of the approved centre.

Training and Education: Relevant staff had received training in the risk management policy and procedures and their implementation, including training in the identification, assessment, and management of risk and health and safety risk management. All training was documented. Clinical staff did not have up-to-date training in individual risk management, but training was scheduled. Managerial staff were trained in organisational risk management. Not all staff had training in incident reporting and documentation. Not all staff had signed a log indicating that they had read and understood the policies. Staff interviewed were able to articulate the risk management processes, as set out in the policies.
**Monitoring:** The risk register, which was set up in January 2017, was reviewed quarterly by the Clinical Governance Group. All incidents were documented using the National Incident Management System (NIMS) and risk-rated.

**Evidence of Implementation:** The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management processes. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Health and safety risks were identified, assessed, treated, reported, and monitored.

Ligature points had not been minimised and while the approved centre’s resident profile was deemed low risk, there was no ligature audit completed since 2015.

The approved centre completed risk assessments of residents at admission, before and during the use of physical and mechanical restraint, and prior to resident transfer and discharge. Multi-disciplinary teams (MDTs) had continuous input into the development, implementation, and review of individual risk management processes as part of individual care planning meetings. Residents and/or their representatives were involved in the risk management process. Guidelines for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated using a standard NIMS form, and clinical incidents were reviewed by the MDT as part of the approved centre’s monthly governance meetings. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. On foot of last year’s inspection findings, the approved centre now had an emergency plan that included evacuation procedures.

The approved centre was not compliant with this regulation because ligature points had not been minimised, indicating that the risk management policy was not implemented throughout the approved centre, 31(1).
Regulation 33: Insurance

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

INSPECTION FINDINGS

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

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was prominently displayed. Two conditions relating to the certificate of registration were documented and displayed.

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

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

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
   (a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
   (b) where the patient is unable to give such consent –
      (i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist
         responsible for the care and treatment of the patient, and
      (ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant
         psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-
     convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this rule was not applicable.
Section 69: The Use of Seclusion

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

INSPECTION FINDINGS

As the approved centre did not use seclusion, this rule was not applicable.
Section 69: The Use of Mechanical Restraint

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.

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

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

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

INSPECTION FINDINGS

The use of mechanical restraint in the approved centre was compliant with Part 5 of the Code of Practice: Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others.

The file of one resident was inspected in relation to the use of mechanical restraint. It indicated that mechanical restraint was used to address an identified clinical need, only after less restrictive alternatives had been unsuccessful and following a risk assessment indicating that there was an enduring risk of harm to the resident or others. The restraint was ordered by a registered medical practitioner under the supervision of the treating consultant psychiatrist. The clinical file indicated the situation in which mechanical restraint was applied, the duration of the restraint and of the order, and the review date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

As there were no detained patients in the approved centre for a continuous period of three months, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
12.0 Inspection Findings – Codes of Practice

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

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

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

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

NON-COMPLIANT
Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the use of physical restraint, which was reviewed in February 2017. It outlined responsibilities in relation to initiating and implementing restraint, and it referenced the provision of information to residents undergoing restraint. The policy did not include the areas to be addresses during training in the use of physical restraint.

Training and Education: There was no written record indicating that staff had read and understood the policy. A record of staff attendance at training on the use of physical restraint was maintained.

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

Evidence of Implementation: The file of one resident was examined in relation to two episodes of physical restraint. It indicated that the use of physical restraint was exceptional and was initiated in the resident's best interests after staff had first tried other interventions.

The episodes were not prolonged beyond the period necessary to prevent immediate and serious harm to the patient or others, and they were initiated by appropriate staff and followed a risk assessment. Cultural awareness and gender sensitivity were demonstrated. Restraint was not used to ameliorate staff shortages.

The consultant psychiatrist was notified of the use of restraint as soon as was practicable and saw the resident on the same day. However, it was not recorded for either episode whether physical examinations were completed within three hours after the initiation of restraint. The consultant psychiatrist signed and dated the clinical practice form within 24 hours.

There was documentary evidence that the resident was informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. Next of kin were informed as soon as was practicable.

There was no evidence that members of the multi-disciplinary team (MDT) reviewed the episodes of restraint and recorded them the clinical file within two working days. In each case, the resident was afforded an opportunity to discuss the episode with members of the MDT as soon as was practicable. All uses of physical restraint were recorded in the clinical file and in a clinical practice form.
The approved centre was not compliant with this code of practice for the following reasons:

a) There was no written record indicating that staff had read and understood the policy on the use of physical restraint, 9.2(b).

b) The policy did not include information on the areas to be addressed during training, including alternatives to physical restraint, 10.1(b).

c) In the episodes examined, it was not recorded whether physical examinations were completed no later than three hours after the start of the physical restraint, 5.4.

d) There was no evidence that the MDT reviewed the episodes of physical restraint and recorded them in the clinical file within two working days, 9.3.
Admission of Children

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

INSPECTION FINDINGS

As the approved centre did not admit children, this code of practice was not applicable.
Notification of Deaths and Incident Reporting

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

INSPECTION FINDINGS

Processes: The approved centre had a risk management policy in place in relation to the notification of deaths and incident reporting to the Mental Health Commission (MHC). The policy met all the criteria of this code of practice. It specified the risk manager, and it outlined the roles and responsibilities of staff in relation to the following:

- The reporting of deaths and incidents.
- The completion of death notification forms.
- The submission of forms to the MHC.
- The completion of six-monthly incident summary reports.

Training and Education: Staff were aware of and understood the policy and this was documented. Staff interviewed were able to articulate the processes relating to the notification of deaths and incident reporting.

Monitoring: Deaths and incidents were discussed at team review meetings to identify and correct any issues as they arose and to improve quality.

Evidence of Implementation: The approved centre was not compliant with Regulation 32: Risk Management Procedures. It used the National Incident Management System for reporting incidents. The standardised incident report form was made available to inspectors. A six-monthly summary of all incidents was sent to the MHC.

There had been two deaths of residents of the approved centre since the last inspection, and each was notified to the MHC within the required 48-hour time frame.

The approved centre was not compliant with this regulation because it was not compliant with Regulation 32: Risk Management Procedures.
### INSPECTION FINDINGS

**Processes:** The approved centre had a policy in relation to working with people with intellectual disabilities. It reflected person-centred treatment planning and least restrictive interventions. The policy contained details of the following:

- The roles and responsibilities of multi-disciplinary team members.
- The management of problem behaviours.
- The process for ensuring appropriate and relevant communication and liaison with relevant external agencies.

The policy did not reference presumption of capacity, nor did it contain procedures for training staff in working with people with an intellectual disability.

**Training and Education:** There was no documentary evidence that education and training were provided to support the principles and guidance of this code of practice. Staff were not trained in person-centred approaches, relevant human rights principles, and preventative and responsive approaches to problem behaviours.

**Monitoring:** The approved centre’s policy on working with people with an intellectual disability had been reviewed within the required three-year time frame. There was evidence that the use of restrictive practices was reviewed periodically.

**Evidence of Implementation:** The file of one resident of the approved centre who had an intellectual disability was inspected. It contained evidence of interagency collaboration to ensure the smooth transition from one service to another. There was an appropriate individual care plan in place, which included details of the following:

- Information on the levels of support and treatment required.
- Available resources and supports and assessed needs.
- The provision of appropriate and accessible information.
- The resident’s preferred ways of receiving and giving information.
- The involvement of the individual’s family.
- The resident’s opportunities for engagement in meaningful activities.
The resident had been evaluated in terms of performance capacities and difficulties; communication issues; medication history; medical, psychiatric, and psychosocial history; and social, interpersonal, and physical environment issues. The resident’s preferred way of receiving and giving information was established, and the information provided was appropriate and accessible.

Opportunities were made available for the resident to engage in meaningful activities. The resident was accommodated in the least restrictive environment to meet their needs.

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

a) The policy did not reference presumption of capacity, 5.1.

b) There was no documentary evidence that education and training were provided to support the principles and guidance of this code of practice, 6 and 6.1.

c) The policy did not contain procedures for the training of staff in working with people with an intellectual disability, 6.2.
# Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

## INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.
INSPECTION FINDINGS

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

**Admission:** The admission policy, dated May 2016, included a process for involuntary admission and a protocol for planned admission, with reference to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. There was a policy in place in relation to confidentiality, privacy, and consent.

The policy did not cover the following:
- a protocol for urgent referrals.
- a protocol for self-presenting individuals.
- a protocol for timely communication with primary care and community mental health teams.

**Transfer:** The transfer policy, dated April 2016, detailed how a transfer is arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary, emergency, and overseas transfer, and it addressed the safety of residents and staff during a transfer. Details were included of the staff roles and responsibilities in relation to resident transfers.

**Discharge:** The approved centre had a discharge policy, which was last reviewed in May 2016. It included procedures for discharging involuntary patients, older persons, and homeless people. The policy outlined a follow-up care plan, which referenced relapse prevention strategies and the roles and responsibilities of staff in providing follow-up care.

The policy did not cover the following:
- Prescriptions and the supply of medication on discharge.
- When and how much follow-up contact residents should have.
- Following up and managing missed appointments.
- Crisis management planning.
- Managing discharge against medical advice.
- Discharging people with an intellectual disability.

**Training and Education:** There was documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge.
**Monitoring:** There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.

**Evidence of Implementation:**

**Admission:** The approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was made by the registered medical practitioner. Comprehensive admission assessments were completed, and assessments and examinations were documented in the clinical files. Family members/carers were involved in the admission process. Residents were admitted to the unit most appropriate to their needs.

The approved centre’s admission process was compliant with Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, Regulation 15: Individual Care Plan, Regulation 20: and Provision of Information to Residents. It did not comply with and Regulation 27: Maintenance of Records and Regulation 32: Risk Management.

**Transfer:** The transfer process was not compliant with Regulation 18: Transfer of Residents. The files of two recently transferred residents were inspected. Both residents were transferred to A&E in Our Lady of Lourdes Hospital, Drogheda in an emergency situation. The clinical file was inspected and showed that the decision to transfer was made on the basis of the resident receiving appropriate care and treatment. In one case, the decision to transfer was made by the consultant psychiatrist. It was not documented who made the decision to transfer the second resident. Both files indicated that the residents’ family members/carers were involved in the transfer process.

**Discharge:** As no residents had been discharged since the 2016 inspection, the discharge policy was not inspected against the evidence of implementation pillar for this code of practice.

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

a) The admission policy did not include a protocol for urgent referrals, 4.4.

b) The admission policy did not include a protocol for self-presenting individuals, 4.5.

c) The admission policy did not include a protocol for timely communication with primary care and community mental health teams, 4.9.

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

e) The approved centre was non-compliant with Regulation 27: Maintenance of Records, 22.6.

f) The approved centre was non-compliant with Regulation 18: Transfer of Residents in respect of information transfer, 30.1.

g) The discharge policy did not reference prescriptions and the supply of medication on discharge, 4.10.

h) The discharge policy did not include procedures for managing discharge against medical advice, 4.15.
i) The discharge policy did not include a protocol for discharging people with an intellectual disability, 4.16.

j) The post-discharge follow-up procedure did not reference crisis management, follow-up contact with residents, or the follow-up and management of missed appointments, 4.14.

k) There was no documented evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies, 4.19.
## Appendix 1 – Corrective and Preventative Action Plan

### Regulation 6: Food Safety

*Report reference: page 21*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring(^1) or New(^2) area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td><strong>1.</strong> The kitchen in the approved centre was not clean. In addition, three tables in the dining room had not been properly cleaned.</td>
<td>New</td>
<td>Corrective Action(s): A full review of cleaning schedules have taken place with specific times and individual responsibilities now identified for deep cleaning and cleaning throughout the unit. Post-Holder(s) responsible: Assistant Director of Nursing. External cleaning specialist company utilised to provide training for staff. Post-Holder(s) responsible Business Manager</td>
<td>Daily signing of cleaning schedules will occur by line manager of the unit. Training records will be maintained in relation to attendance at training.</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): A programme of food safety audits is in place on a 3 monthly basis which will be carried out by an external food safety specialist. Recent audit carried out in July 2017</td>
<td>Audit reports will be provided and reviewed by the localised hygiene group established for St. Ita’s.</td>
<td>Achievable</td>
</tr>
</tbody>
</table>

---

1. Area of non-compliance reoccurring from 2016
2. Area of non-compliance new in 2017
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
|                          | Business Manager  
A localised committee is established to focus specifically on hygiene and monitor action plans following audits and review ongoing practices with regard to cleaning  
Post-Holder(s) responsible: Quality and Risk Manager | Minutes will be kept with a report provided to area management team on workings of committee | Achievable | Monthly |
### Regulation 9: Recreational Activities


<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
</tbody>
</table>
| **2.** Residents did not have access to appropriate recreational activities. | New | Corrective Action(s):  
A daily schedule of activities is established and reviewed on a weekly basis  
Post-Holder(s) responsible: Clinical Nurse Manager II  
A horticulturist has been provided to carry out scheduled weekly programme of gardening with the residents  
Post-Holder(s) responsible: Business Manager/Occupational Therapist | A record of attendance and schedule will be maintained by the CNM2  
A evaluation report will be provided to the local governance group regarding progress of group and resident’s view on group and outcomes | Achievable but dependent on daily staffing levels | Daily |
| | | Preventative Action(s):  
A record will be maintained of attendance of activities  
Post-Holder(s) responsible: CNM2 | A review of activity level and analysis on opportunities for improvement and new activities will be carried out by CNM11 and reported to local governance group | Achievable | Monthly |
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Reoccurring or New area of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Provides corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provides the method of monitoring the implementation of the action(s)</td>
<td>Provides details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
<td></td>
</tr>
<tr>
<td>3. Did not provide specific therapeutic programmes in support of maintaining the optimal levels of physical and psychosocial function of residents.</td>
<td>Reoccurring from 2016</td>
<td>Update on the 2016 plans: A Social Work and Occupational Therapist commenced on the newly established rehabilitation team in February 2017 with Senior Psychologist commencing in June 2017. As part of the re-configuration of layout in St. Ita’s, a therapeutic area is identified on the unit and refurbishment work has now commenced for this specific area, planned completion end of September 2017. Individual therapeutic programmes are identified based on the specific needs of the resident as per the MDT Care Plan.</td>
<td>Corrective action(s): As part of the transfer of care, a full Camberwell assessment of needs was completed to identify individual specific needs and outline appropriate therapeutic interventions associated to need. Post-holder(s): Rehabilitation Multi-Disciplinary Team</td>
<td>Preventative action(s): A dedicated planned therapeutic room will be provided as part of the redesign and layout of St. Ita’s. Costing’s currently being identified. Post-holder(s): Business Manager</td>
<td>Preventative action(s): Posts in process of completion for rehabilitation team and to commence in February include Social Work and Occupational therapy. Post-holder(s): Lead in Mental Health CHO8</td>
</tr>
</tbody>
</table>
### Regulation 18: Transfer of Residents

**Report reference: Page 37**

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

4. There was no evidence that all relevant information about the resident was forwarded to the receiving facility.

- **New**
  - **Corrective Action(s):** Staff informed of the necessary information which requires forwarding to the receiving facility with policy reviewed to specify this requirement
    - Post-Holders responsible: Assistant Director of Nursing
  - **Preventative Action(s):** Scheduled audit to take place in relation to transfer process and requirements
    - Post-Holders responsible: Assistant Director of Nursing-Training Co-ordinator

- **Audit of transfers to take place to monitor practice**
  - **Achievable**
  - **Complete**

- **Report to be provided to St. Ita’s Governance Committee**
  - **Achievable**
  - **6 monthly (Feb 2018)**
### Regulation 21: Privacy
**Report reference: Page 42-43**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| **5. Not all male staff were professionally attired.** | New | Corrective Action(s): Work attire policy developed  
Post-Holder(s) responsible: Quality and Risk Manager  
Preventative Action(s):  
CNM2 to ensure staff are professionally attired on daily basis  
Post-Holder(s) responsible: CNM2 | Feedback on implementation of policy will be provided to services infection control committee | Achievable | Complete |
| | | | CNM2 to monitor daily | Realistic | Daily |
| **6. The inadequate cleaning of a unisex bathroom was not respectful of residents’ dignity.** | New | Corrective Action(s):  
A full review of cleaning schedules have taken place with specific times and individual responsibilities now identified for deep cleaning and cleaning throughout the unit  
Post-Holder(s) responsible: Assistant Director of Nursing  
Preventative Action(s):  
External cleaning specialist company utilised to provide training for staff and conduct cleaning audits  
Post-Holder(s) responsible  
Business Manager | Daily signing of cleaning schedules will occur by line manager of the unit | Achievable | Complete |
<p>| | | | Training records will be maintained in relation to attendance at training. Audit report to be provided to localised hygiene group | Achievable | Complete |</p>
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| One shared bedroom had inadequate privacy screening. | Corrective Action(s): New privacy screening provided  
Post-Holder(s) responsible: | Weekly walk of unit by CNM2 to identify any areas which require maintenance | Realistic | Complete |
| Preventative Action(s):  
Weekly walk of unit by CNM2 to identify any areas which require maintenance  
Post-Holder(s) responsible: CNM2 | Log maintained of areas which require maintenance and when reported | Achievable | Complete |
### Regulation 22: Premises

*Report reference: Page 44-45*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Toilet and bathroom facilities and a kitchenette were inadequately cleaned on the first day of the inspection.</td>
<td>New Monitored as per Condition³</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. The premises were not maintained in a good structural and decorative condition.</td>
<td>Reoccurring from 2016 Monitored as per Condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. A programme of routine maintenance had not been implemented in full.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. The condition of the physical structure and the overall approved centre environment had not been developed and maintained with due regard to the specific needs of residents and patients and the well-being of residents, staff, and visitors.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

³ To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy, and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

**Report reference: Page 46-47**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>12. There were gaps in the administration records in 7 of the 16 MPARs inspected.</td>
<td>New</td>
<td>Corrective Action(s): A monthly schedule of medication audits takes place as part of the nurse metric programme with specific criteria around entering of omission codes examined. Post-Holder(s) responsible: CNM1</td>
<td>Monthly audit with reports provided to St. Ita’s governance group</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): On-going schedule of medications audits to take place through the nurse metric programme</td>
<td>Monthly audit with reports provided to St. Ita’s governance group</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
### Regulation 26: Staffing

*Report reference: Page 50-51*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>13. Not all staff had up-to-date training in fire safety, BLS, TMAV, and the MHA 2001.</td>
<td>Reoccurring from 2016</td>
<td><strong>Update on the 2016 plans:</strong> Training schedule developed for 2017, specialist programme of PMAV developed specifically for staff in St. Ita’s, 4 fire training courses provided for staff in St. Brigid’s in first 6 months of 2017. AN interim training co-ordinator has updated and revised training database.</td>
<td><strong>Corrective action(s):</strong> An Assistant Director of Nursing is now designated part of their role as a training co-ordinator since the 9th of January to develop a service mandatory training schedule for 2017</td>
<td><strong>Preventative action(s):</strong> Mandatory training will be made available to all staff on a monthly basis</td>
</tr>
</tbody>
</table>

**Post-holder(s):** Assistant Director of Nursing (Training Co-Ordinator)

A training schedule will be developed to ensure training is available on a monthly basis in the following courses BLS, Fire training, PMAV and Mental Health Act Training

A database will be maintained and distributed on a quarterly basis to all Heads of Disciplines informing them of staff current mandatory training levels

Achievable | Complete
## Regulation 27: Maintenance of Records

*Report reference: Page 52-53*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14. Records were not maintained in a good order, as evidence by loose pages.</strong></td>
<td>Reoccurring from 2016</td>
<td>Corrective Action(s): Further review of chart layout to take place with samples to be obtained from other areas</td>
<td>Achievable</td>
<td>End of September 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: Assistant Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): An Annual audit in relation to the maintenance of records will be carried out with specific criteria identifying whether documents are filed appropriately</td>
<td>Achievable</td>
<td>January 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: CNM1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>15. Records contained misfiled elements and were not arranged to ensure easy retrieval.</strong></td>
<td>New</td>
<td>Corrective Action(s): All staff informed of the importance ensuring documents are filed appropriately</td>
<td>Achievable</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: CNM2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): An annual audit in relation to the maintenance of records will be carried out with specific criteria identifying whether documents are filed appropriately</td>
<td>Achievable</td>
<td>January 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: CNM1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 32: Risk Management Procedures (Code of Practice: Notification of Deaths and Incident Reporting)

**Report reference: Page 59-60**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>16. Ligature points had not been minimised, indicating that the risk management policy was not implemented throughout the approved centre.</td>
<td>New</td>
<td>Corrective Action(s): Ligature audit completed (July 2017) Post-Holder(s) responsible: CNM2</td>
<td>On-going review of ligature findings through St. Ita’s Governance Group</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Scheduled ligature audit to take place on yearly basis or when room/area re-defined Post-Holder(s) responsible: CNM11</td>
<td>Preventative Action(s): Scheduled ligature audit to take place on yearly basis or when room/area re-defined Post-Holder(s) responsible: CNM11</td>
<td>On-going reporting mechanism to St. Ita’s governance group</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
## Code of Practice: The Use of Physical Restraint

**Report reference: Page 70-71**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| **17.** There was no written record indicating that staff had read and understood the policy on the use of physical restraint. | New Corrective Action(s): Information sessions in relation to the Codes of Practice on Physical Restraint to be facilitated to inform staff of the requirements incorporating key requirements of policy  
Post-holder(s): Assistant Director of Nursing-training Co-ordinator | Record sheets maintained of staff attendance and inputted on staff training database       | Achievable              | September         |
|    Preventative Action(s): On-going information sessions on the key requirements of policy  
Post-Holder(s) responsible: Assistant Director of Nursing-training Co-ordinator | Record sheets maintained of staff attendance and inputted on staff training database       | Achievable              | On-going           |
| **18.** The policy did not include information on the areas to be addresses during training, including alternatives to physical restraint. | New Corrective Action(s): Policy revised to incorporate training requirements including alternatives to physical restraint  
Post-Holder(s) responsible: St. Ita’s governance Group | Review at St. Ita’s Governance group                                                                 | Achievable             | Complete          |
| Preventative Action(s): Yearly review of policy to ensure policy in line with requirements | Review at St. Ita’s Governance group                                                                 | Achievable             | Yearly            |
19. In the episodes examined, it was not recorded whether physical examinations were completed no later than three hours after the start of the physical restraint.

| New | Information sessions in relation to the Codes of Practice on Physical Restraint to be facilitated to inform staff of the requirements Post-holder(s): Assistant Director of Nursing-training Co-ordinator | Record sheets maintained of staff attendance and inputted on staff training database | Achievable | September |

Preventative Action(s):
A audit will be conducted in relation to the use of physical restraint which will examine whether physical examinations were carried out within specific timeframe
Post-Holder(s) responsible: CNM1

Report provided to St. Ita’s governance Group | Achievable | Yearly |

20. There was no evidence that the MDT reviewed the episodes of physical restraint and recorded them in the clinical file within two working days.

| Reoccurring from 2016 | Corrective Action(s):
Information sessions in relation to the Codes of Practice on Physical Restraint to be facilitated to inform staff of the requirements Post-holder(s): Assistant Director of Nursing-training Co-ordinator | Record sheets maintained of staff attendance and inputted on staff training database | Achievable | September |

Preventative Action(s):
A audit will be conducted in relation to the use of physical restraint which will examine whether physical examinations were carried out within specific timeframe
Post-Holder(s) responsible: CNM1:

Report provided to St. Ita’s governance Group | Achievable | Yearly |
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>21.</strong> The policy did not contain all requirements of the code of practice.</td>
<td>New</td>
<td>Corrective Action(s): A sub Group is formed to review current policy Post-Holder(s) responsible: Assistant Director of Nursing</td>
<td>Draft policy will be forwarded to Governance group as part of final consultation</td>
<td>Achievable End of September 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): An annual review of admission and discharge policies will be carried out in relation to the practices of admission and discharge to ensure compliance with code of practice requirements Post-Holder(s) responsible: Assistant Director of Nursing-Training Co-ordinator</td>
<td>Report to be provided to St. Ita’s governance group</td>
<td>Achievable Yearly</td>
</tr>
<tr>
<td><strong>22.</strong> There was no documentary evidence that education and training were provided to support the principles and guidance of this code of practice.</td>
<td>New</td>
<td>Corrective Action(s): A memo was sent out to all Heads of Disciplines informing staff of current module on HSeland in relation to Code of Practice and for staff to avail of this training module Post-Holder(s) responsible: Heads of Disciplines</td>
<td>Database to be maintained with regular reports provided to St. Ita’s governance Group on uptake of training</td>
<td>Achievable Complete</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Further training currently being organised by service from ID specialist in relation to training of principles and requirements of Code of Practice</td>
<td>Training report to be provided to governance group</td>
<td>Achievable-dependant on availability of external instructor</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
<td>Time-bound</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. The admission and discharge policies did not contain all requirements of the code of practice</td>
<td>Corrective Action(s): A sub group is formed to review existing policies</td>
<td>Draft policies will be forwarded to Governance group as part of final consultation</td>
<td>Achievable</td>
<td>End of October 2017</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Assistant Director of Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): An annual review of admission and discharge policies will be carried out in relation to the practices of admission and discharge to ensure compliance with code of practice requirements</td>
<td>Report to be provided to St. Ita’s governance group</td>
<td>Achievable</td>
<td>Yearly</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Assistant Director of Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. There was no documented evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.</td>
<td>Corrective Action(s): On completion of review of admission and discharge policies, audit to be carried out in relation to the implementation of and adherence to the policies</td>
<td>Report provided to the St. Ita’s governance group</td>
<td>Achievable</td>
<td>November 2017</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Training Co-ordinator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): On-going planned schedule of audits in relation to admission and discharge process to take place on 6 monthly basis</td>
<td>Report provided to the St. Ita’s governance group</td>
<td>Achievable</td>
<td>November 2017</td>
</tr>
</tbody>
</table>