Mental Health Commission

Approved centre **Inspection Report**

(Mental Health Act 2001)

APPROVED CENTRE NAME	St Gabriel's Ward, St Canice's Hospital
IDENTIFICATION NUMBER	AC0017
APPROVED CENTRE TYPE	Psychiatry of Later Life Mental Health Rehabilitation
REGISTERED PROPRIETOR	Health Service Executive (HSE)
REGISTERED PROPRIETOR NOMINEE	Mr David Heffernan
MOST RECENT REGISTRATION DATE	1 March 2014
NUMBER OF RESIDENTS REGISTERED FOR	20
INSPECTION TYPE	Unannounced
INSPECTION DATE	26, 27 and 28 July 2016
PREVIOUS INSPECTION DATE	27 and 28 July 2015
CONDITIONS ATTACHED	None
LEAD INSPECTOR	Ms Noeleen Byrne
INSPECTION TEAM	Dr Susan Finnerty, MCRN 009711 Dr Ann Marie Murray, MCRN 363031
THE INSPECTOR OF MENTAL HEALTH SERVICES	Dr Susan Finnerty, MCRN 009711

Contents

1.0 Mental Health Commission 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, and
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 shall 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 shall 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 shall be assessed.

The Inspector will also assess the quality of services provided against the criteria of the Judgment 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. 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 Approved centre **Inspection - Overview**

2.1 **Overview of the** Approved centre

The approved centre was a 20-bed facility, located on the grounds of St Canice's Hospital in Kilkenny. The unit is named as St Gabriel's Ward and is a modern single storey brick façade building erected in the 1980s.

The centre comprised a number of corridors of moderate length branching out from a central hub. Sleeping accommodation was in two or three bedded rooms with toilet and shower facilities en suite. A single room with no en suite was in use at the time of the inspection. Fifteen beds were occupied on the first day of the inspection and 14 thereafter. The approved centre accommodated residents under the Psychiatry of Later Life (POLL) and Rehabilitation and Recovery teams. The age range of residents varied from early 60s to 100 years. There were ten residents under the care of the POLL team and five residents were under the care of the Rehabilitation and Recovery team.

There was good, picture-based signage on most doors and each resident had a picture board which included personal mementos. Staff interacted with residents in a noticeably caring, dignified, empathic and highly professional manner. This was consistent with the declared philosophy of the approved centre which aimed "to provide a patient centred approach to care with emphasis on individuality and autonomy".

A garden initiative was completed and the new garden was opened in June 2016. This involved transition year students working with staff to create a suitable environment for residents to enjoy the outdoor areas of the approved centre. Flower beds were planted with colourful flowers and shrubs and seating had been arranged in addition to the patio area. Some new pathways were created and residents could take short walks.

2.2 Conditions to Registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

2.3 Governance

The inspection team reviewed the minutes of the monthly meetings of the Executive Management Team (EMT) which had been held since the last inspection. The meetings covered the whole of the Carlow/Kilkenny/South Tipperary Mental Health Services area and were not dedicated solely to governance at the approved centre. The Executive Management Team comprised the Executive Clinical Director, senior members of the administration of the wider Carlow/Kilkenny/South Tipperary service, Director of Nursing (DON), heads of health and social care professionals (HSCP). Other senior nursing and HSCPs attended as required. The monthly reports indicated a thoughtful and considered overview of the service as well as a focus on specific items of concern by the members of the SMT.

2.4 Inspection scope

This was an unannounced annual inspection. All aspects of the Regulations, Rules and Codes of Practice were inspected against.

The inspection was undertaken onsite in the approved centre on

- 26 July 2016 from 09:00 to 17:00
- 27 July 2016 from 09:00 to 17:00
- 28 July 2016 from 09:00 to 14:30

2.5 Non-compliant areas from 2015 inspection

The previous inspection of the approved centre on 27 and 28 July 2015 identified the following areas that were not compliant:

Regulation/Rule/Act/Code	Inspection Findings 2016
Regulation 15 Individual Care Plan	Compliant
Regulation 18 Transfer of Residents	Compliant
Regulation 28 Register of Residents	Non-compliant
Regulation 31 Complaints Procedures	Non-compliant

2.6 Corrective and Preventative Action plan

The approved centre was required to submit details of Corrective and Preventative Actions (CAPAs) to address areas of non-compliance as a result of the inspection of 2015.

- Regulation 15 Individual Care Plans – deficits in the care planning documentation had been addressed and training on care planning was complete.
- Regulation 18 Transfer of Residents – the policy was amended and staff had received communication regarding updating risk assessments prior to transferring a resident.
- Regulation 28 Register of Residents – remained non-compliant because country of birth, diagnosis on admission and diagnosis on discharge were not documented.
- Regulation 31 Complaints – remained non-compliant because complaints were not documented in the complaints log and there was no evidence that they were closed out.

2.7 Non-compliant areas on this inspection

Regulation/Rule/Act/Code	Risk Rating
Regulation 5 Food and Nutrition	Moderate
Regulation 6 Food Safety	Moderate
Regulation 8 Resident's Personal Property and Possessions	Moderate
Regulation 19 General Health	High
Regulation 21 Privacy	Moderate
Regulation 22 Premises	Moderate
Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines	Moderate
Regulation 26 Staffing	Moderate
Regulation 27 Maintenance of Records	Moderate
Regulation 28 Register of Residents	Moderate
Regulation 31 Complaints Procedures	Moderate
Rules Governing the Use of Mechanical Means of Bodily Restraint	Low
Code of Practice on the Use of Physical Restraint in Approved centres	High
Code of Practice for Mental Health Services on Notification of Deaths and Incidents	Low
Code of Practice - Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved centre	High

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.

2.8 Areas of compliance rated Excellent on this inspection

No areas were rated as Excellent on this inspection.

2.9 Areas not applicable

The following areas were not applicable as the rule, regulation, code of practice or Part of the Mental Health Act 2001 was not relevant to this approved centre at the time of inspection.

Regulation/Rule/Act/Code
Regulation 17 Children's Education
Regulation 25 Use of Closed Circuit Television
Regulation 30 Mental Health Tribunals
Rules Governing the Use of Electro-Convulsive Therapy
Rules Governing the Use of Seclusion
Part 4 of the Mental Health Act 2001 - Consent to Treatment
Code of Practice relating to the Admission of Children under the Mental Health Act 2001
Code of Practice on the Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

2.10 Areas of good practice identified on this inspection

- The garden initiative with local transition year students.
- The arranging of a birthday party that was a fitting tribute for a centenarian.
- The preparation of a folder containing documents required for inspection by the Mental Health Commission.
- The recreational and therapeutic programmes which included a variety of indoor and outdoor activities.

2.11 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.

2.12 Section 26 Mental Health Act 2001 - Absence with Leave

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

2.13 Resident Interviews

Residents were invited to speak with the inspectors through individual contact and a poster. Two residents chose to speak with the inspectors and both confirmed they were happy with residing in the approved centre. They complimented the food and the activities.

2.14 Resident Profile

		Less than 6 months	Longer than 6 months	Children	TOTAL
DAY 1	Voluntary Residents	4	11	0	15
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 2	Voluntary Residents	3	11	0	14
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0
DAY 3	Voluntary Residents	3	11	0	14
	Involuntary Patients	0	0	0	0
	Wards of Court	0	0	0	0

2.15 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. Attendees from the approved centre were:

- Registered proprietor nominee
- Clinical director
- Executive clinical director
- Director of nursing
- General manager
- Occupational therapy manager
- Principal psychologist
- Service manager
- Social worker
- Locum psychiatrist
- Clinical nurse specialist
- Risk manager
- Acting clinical nurse manager III
- Acting clinical nurse manager II

3.0 Inspection Findings and Required Actions - Regulations

PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND PART 4 OF THE MENTAL HEALTH ACT 2001

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

3.1 Regulation 1: Citation

Not Applicable

3.2 Regulation 2: Commencement

Not Applicable

3.3 Regulation 3: Definitions

Not Applicable

3.4 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 policy on the identification of residents. The roles and responsibilities in relation to the identification of residents were not addressed. The policy did not outline the required use of two resident identifiers when prescribing care and treatment to a resident.

Training and Education: There was no evidence available that staff had signed that they had read and understood the policy. Staff could articulate the processes for identifying residents.

Monitoring: A "walk through review" was completed by management of the approved centre, which showed that it did not conform with having two identifiers recorded on all healthcare records and drug administration charts. The analysis stated that a quality improvement plan was to be developed within one week on completion of the audit.

Evidence of Implementation: Photographs and date of birth were the identifiers used in the approved centre. The identifiers were evident in the clinical files inspected.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and training, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.5 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: There was a policy in place. The policy did not contain the roles and responsibilities of staff. There was no reference to monitoring of food and water intake.

Training and Education: Staff had not signed that they read and understood the policy. Staff were able to articulate the processes for food and nutrition as set out in the policy.

Monitoring: Menu plans had been reviewed to ensure residents were provided with wholesome and nutritious food.

Evidence of Implementation: Residents were provided with a variety of food choices and hot and cold drinks were served regularly. A water cooler was in place but there were no cups available as it had been deemed that they were a risk to some residents. Residents were provided with cups on request and provided with drinks throughout the day. Hot meals were provided on a daily basis. Modified consistency diets were delivered to the approved centre in plastic trays and inspectors observed residents being served food in the plastic tray which was unattractive in appearance.

Weight charts were implemented but they were not always acted upon. An evidence-based nutritional assessment tool was not in use and the needs of residents identified as having special nutritional requirements were not reviewed regularly. Intake and output charts were maintained for residents, where appropriate.

One resident had unmet nutritional needs for dietetic input. The Rehabilitation and Recovery team made a referral, on behalf of a resident, for an expert opinion on their diet management. This was rejected due to the fact that the referral pathway only accepted referrals from the Primary Care Team. Inspectors were informed that arrangements had been made for a dietician to commence working in the approved centre in September 2016.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all residents were provided with special dietary requirements that were adequate for their needs.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.6 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: There was a policy and the roles and responsibility in relation to food safety were clearly defined within it. The policy contained details of the processes required for food preparation including, handling, storage, distribution and disposal controls. The management of catering and food safety equipment was addressed in the policy as were the requirements to adhere to food safety legislative requirements.

Training and Education: Staff had signed that they had read and understood the policy on food safety and could articulate the processes as set out in the policy. Staff handling food had up to date training in the application of Hazard Analysis and Critical Control Point (HACCP).

Monitoring: There was evidence that food safety audits were completed regularly and analysis identified opportunities to improve food safety processes. The inspectors observed that the temperature of the fridge in the approved centre was not recorded on a daily basis.

Evidence of Implementation: Appropriate hand-washing areas were provided and there was suitable and sufficient catering equipment. The Environmental Health Officers (EHO) reported brown staining in grouting and the utensil drawer was deemed to be unclean. These matters had not been attended to and food was observed on the floor surrounding the bin in the kitchen.

Food was prepared in a manner that reduced the risk of contamination, spoilage and infection. Residents were provided with crockery suitable to their specific needs.

The approved centre was non-compliant with this regulation because hygiene was not maintained to support food safety:

(a) food was observed on the floor;
(b) there was an open bin in the kitchen;
(c) there was brown staining in the grouting;
(d) the utensil drawer was unclean.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	
Risk Rating				
Low	Moderate	High	Critical	
	X			

3.7 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: There was a policy on clothing. While reference was made to having due regard to the residents dignity and bodily integrity, it did not address the residents' preferences with regard to religious and cultural practices or specific requirements in the event of allergies. The policy addressed the use of day and night clothes but did not state that the use of night clothes during the day should be recorded in the individuals' care plan.

Training and Education: Staff had not signed that they had read and understood the policy. They could articulate the processes as set out in the policy.

Monitoring: A "walk through review", completed by management of the approved centre, showed residents clothes were clean, in good repair and adequate for the resident's needs.

Evidence of Implementation: All residents were dressed and out of bed throughout the duration of the inspection. Personal clothing was laundered in the main building close to the approved centre. Staff reported that emergency clothing was not required but clothing would be purchased if the need arose.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and processes and training as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.8 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: There was a policy on residents' personal property and possessions in the approved centre. The roles and responsibilities of staff were outlined as was the process to record, secure and manage the personal property of residents, including money. There was no clear documentation of the process to inform residents of their entitlement to bring personal property and possessions into the approved centre.

Training and Education: Staff had not signed that they had read and understood the policy and could not articulate the processes as set out in the policy.

Monitoring: Property logs had been completed on admission but there was no evidence of monitoring and review on discharge. No analysis had been carried out.

Evidence of Implementation: The approved centre maintained a signed property checklist. When the approved centre assumed responsibility for the resident's property and possessions, money and valuables it was safeguarded and kept in a locked press. The log was not reviewed or reconciled on discharge and monies that belonged to two residents who had been discharged remained in the approved centre. The log accommodated a staff signature and a column for countersigning, however, 10 out of 40 entries in one resident's log were not countersigned by staff, residents or their representatives. A resident's bank statement was observed in their clinical file.

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

(a) The registered proprietor did not ensure that residents' maintained control of their property as money was retained in the approved centre after two residents were discharged.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.9 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 did not have a policy outlining the process in place for the provision of recreational activities. There was no documented process to risk assess residents for indoor or outdoor recreational activities. There was a process for communicating the available recreational activities to residents and for identifying recreational spaces within the approved centre for these activities.

Training and Education: The activity nurse and the Occupational Therapist (OT) had received specific training. Staff could articulate the processes for recreational activities.

Monitoring: A "walk through review" was completed by management of the approved centre. A record of the schedule of activities and resident attendance was maintained. Analysis was not completed to identify residents that did not attend recreational activities or to improve the processes for recreational provision.

Evidence of Implementation: There was a schedule of recreational activities posted each day on a notice board in the day room. An activity nurse led the recreational programme which included both indoor and outdoor activities. As part of the outdoor activities, residents had the opportunity to attend Mass, go on nature walks and dine out in local restaurants on a weekly basis. The activities within the approved centre included card and board games, table quizzes and live music.

An enclosed garden was recently developed with the assistance of local transition year students. Seating had been arranged at different locations around the garden including a patio area. An attractive arrangement of flowers provided much colour and residents took pride in the garden and attended to light gardening.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and processes, training and monitoring and implementation as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.10 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: There was a policy on Religion which included the process for identifying residents' religious beliefs. Roles and responsibilities in relation to supporting residents in observing their religious practices were not outlined. Respecting a resident's religious beliefs and values within the routine of daily living was not addressed in the policy, nor was the resident's freedom of choice regarding their involvement in religious practice.

Training and Education: Staff had read and understood the policy and could articulate processes for facilitating residents in the practice of their religion.

Monitoring: A "walk through review" was completed by management of the approved centre.

Evidence of Implementation: Residents attended Mass in the local church on Wednesdays and prayer groups were held in the approved centre for those who could not attend Mass. There were no dedicated facilities in the approved centre to practice religion and as some residents were immobile it was appropriate to hold prayer groups in the day room/activities room. Ministers of other faiths were available to attend the approved centre on request. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and processes as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.11 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 policy in place that described the process relating to visits. The policy did not contain the roles and responsibilities of staff in terms of accommodating visits. A visitors' room was available as required. There was a process in place for restricting visitors when required. The arrangements for child visitors were included in the policy. The required visitor identification methods, including contractors, was not contained in the policy.

Training and Education: Staff had not signed that they read and understood the policy. Staff were able to articulate the processes for visits as set out in the policy.

Monitoring: A "walk through review" was completed by management of the approved centre.

Evidence of Implementation: Visiting times were displayed at the front door and the information leaflet stated that relatives were free to visit at any time except meal times and after 21.00 hours. No residents had requested any visitor restrictions and no visitors had been assessed as posing a risk. A visitors' room was made available as required and this included an en suite bathroom. The day room was used for large groups attending for, example, birthday parties. Children were welcome if accompanied by an adult.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and processes and training as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.12 Regulation 12: Communication

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

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

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

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

Inspection Findings

Processes: The approved centre had a policy on communication and it outlined all the modes of communication available in the approved centre. The circumstances in which resident communications may be examined by senior staff were outlined. The roles and responsibilities were not included in the policy and there was no reference to assessing residents' communication needs. The policy did not detail the requirements in relation to risk assessing individual's communications.

Training and Education: Staff had not signed that they read and understood the policy. Staff were able to articulate the processes for communication as set out in the policy.

Monitoring: Residents' communication needs were monitored and the need for a portable phone was identified. There was no evidence of analysis to improve the communication processes.

Evidence of Implementation: Residents had access to telephone, mail, email and fax. Telephone was the residents preferred means to communicate with family and calls were facilitated in the nurse's station. There was no private area to use the telephone.

The approved centre was compliant with this regulation. Not all of the criteria for the policy, processes and training and monitoring as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.13 Regulation 13: Searches

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

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy on searches which included 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 requirement was included as was the process for carrying out a search without consent. The process for finding illicit substances was included in the policy as was the process for informing the resident being searched of what was happening and why. The policy contained the processes for communicating the approved centre's search policies and procedures to residents and staff and the consideration provided in relation to the residents privacy, dignity and gender during searches. The roles and responsibilities were outlined in the policy which also included the requirement to record searches and the reason for the search. The policy did not include the application of individual risk assessment.

Training and Education: Staff had not signed that they read and understood the policy. Staff were able to articulate the processes for searches as set out in the policy

Monitoring: As no searches were carried out in the approved centre there was no requirement to monitor this regulation.

Evidence of Implementation: As no searches were carried out evidence of implementation was non-applicable.

The approved centre was compliant with this regulation. Not all of the criteria for the policy, processes and training, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.14 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: There was a policy on care of the dying. The policy addressed end of life care, including the identification and implementation of the resident's physical, emotional, social, psychological, spiritual and pain management needs. The privacy and dignity requirements for a resident were addressed in the policy. The policy also outlined the requirements to communicate with the resident or their representative and the need to involve them and support them. The policy did not outline the specific roles and responsibilities of staff and did not include advance directives, Do Not Attempt Resuscitation orders (DNAR's) or residents' religious and cultural end of life preferences. The supports available to other residents and staff following a resident's death were addressed in the policy. The arrangements for communicating the death of a resident who had passed away while out on transfer to another healthcare facility were not outlined in the policy.

Training and Education: Staff had not signed that they read and understood the policy. Staff were able to articulate the processes for end of life care as set out in the policy

Monitoring: Residents had an end of life care plan and analysis was completed to identify opportunities for improvements.

Evidence of Implementation: The file of a resident who required end of life care since the last inspection was examined. A priest or minister attended when requested. A large single room, with en suite facilities was available for families. Pain management was prioritised and the palliative care/hospice team called on request. There were no sudden deaths since the last inspection. All deaths had been reported to the Mental Health Commission within the required timeframe.

The approved centre was compliant with this regulation. Not all of the criteria for the policy, processes and training, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.15 Regulation 15: Individual Care Plan

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

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

Inspection Findings

Processes: There was a policy which outlined the roles and responsibilities relating to the development of individual care plans (ICP). The policy addressed the process to complete a comprehensive assessment at admission and on an ongoing basis. The required content for inclusion in the ICP documentation was outlined and reviews and updates were incorporated as part of the implementation requirements. The policy outlined the residents' involvement in ICP planning and indicated that they should have access to their ICP. The timeframes for assessment planning, implementation and evaluation of the ICP was not included.

Training and Education: Staff had not signed that they read and understood the policy. Staff could articulate the processes relating to ICPs. Multi-Disciplinary Team (MDT) members had not received training in individual care planning.

Monitoring: An audit of ICPs had been completed in June 2016 and improvements were identified and documented.

Evidence of Implementation: All residents recently admitted had assessments but some residents had been in hospital for many years so it was not possible to locate all admission assessments. All 15 ICPs were inspected and all had MDT input including that of a Social Worker and Occupational Therapist. The MDTs did not include a psychologist. Efforts were made with all residents to involve them in their care plan and this was documented.

Appropriate goals were identified for each resident and actions were documented. The resources required were documented and a key worker was identified to ensure continuity in the implementation of residents' ICPs. Risk assessments on admission were observed in all files and one file had a discharge plan.

The ICPs were reviewed weekly by the MDT and included the residents in so far as was practicable. The ICP was contained in one composite document and was located in the clinical file.

The approved centre was compliant with this regulation. Not all of the criteria for the policy, processes and training, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.16 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: There was no written policy in relation to therapeutic services in the approved centre.

Training and Education: Staff were able to articulate the processes for therapeutic activities and programmes.

Monitoring: There was evidence that the range of therapeutic activities and programmes was monitored but there was no analysis completed to identify opportunities for improvement.

Evidence of Implementation: A list of therapeutic services and programmes included cognitive stimulation therapy, reminiscence therapy, creative writing and imagination therapy to meet the needs of the residents. The activity nurse confirmed she had a monthly budget to provide therapeutic interventions which were kept in a dedicated activities room. Therapeutic programmes were provided within the approved centre and in external locations. Records were kept of resident's participation in therapeutic activities and programmes.

The approved centre was compliant with this regulation. Not all of the criteria for the policy, processes and training and monitoring as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.17 Regulation 17: Children's Education

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

Inspection Findings

Children were not admitted to St Gabriel's Ward and this regulation was not applicable.

3.18 Regulation 18: Transfer of Residents

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

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

Inspection Findings

Processes: The approved centre had a written policy on the transfer of residents and this was in date and approved. The policy outlined the roles and responsibilities of various staff in the transfer process. Included in the policy was the criteria for transfer, risk assessment processes, consent requirements, the management of resident medications during transfer and communication with the receiving centre. Processes for safeguarding resident privacy during transfer were outlined, as were the processes for the involvement of family in the process, where feasible. Specific requirements concerning the transfer of an involuntary patient were addressed. The policy also addressed the management of resident's property on transfer and the processes involved in emergency transfers. The policy specifically outlined processes for the retention of copies of essential documentation on transfer.

Training and Education: Staff had not signed that they read or understood the policy. When interviewed, staff articulated the processes for the transfer of residents.

Monitoring: The approved centre did not maintain a log of transfers. Systematic reviews of transfers to ensure that all relevant information was provided to the receiving facility were not conducted. There was no analysis documented to identify opportunities for improvement in the processes.

Evidence of Implementation: The clinical file of a resident transferred to a general hospital was reviewed and found to contain the necessary documentation in terms of the communication records with the receiving facility. The resident was unresponsive at the time of transfer so consent was non-applicable. The medical practitioner had completed a physical assessment and full information accompanied the resident. A nurse accompanied the resident and brought a letter containing medical information and transfer form to the Emergency Department. It was documented that an initial phone call was made as it was an emergency transfer. The key worker assembled and checked all details were given to the receiving facility. All records were retained in the resident's clinical file.

The approved centre was compliant with this regulation. Not all of the criteria for the training and monitoring, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.19 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: There was a policy on Medical Emergencies. The policy stated that all healthcare staff must be trained in cardiopulmonary resuscitation (CPR) and outlined how to activate medical response, however, no defined roles and responsibilities relevant to the approved centre were contained in it. The management response of a medical emergency was outlined but there was no reference to cardiac arrest or anaphylaxis.

Access to a registered medical practitioner for residents of the approved centre was not included in the policy. The ongoing assessment of residents' general health needs was documented in the policy. The detail of resources required, including equipment, was not included. The protection of resident's privacy and dignity was covered and the policy referred to the use of chaperones during general health assessments. The incorporation of general health needs into the residents' individual care plans was not outlined in the policy. The policy referenced access to general health services but did not refer to the process. Included in the policy were the documentation requirements for general health assessments, the access to national screening programmes and the support of healthy life style choices.

Training and Education: Staff had not signed that they read and understood the policy. One of two staff members interviewed was not able to articulate the process for the provision of general health services.

Monitoring: There was no monitoring of residents take-up of national screening programmes and it was unclear if residents that were eligible for screening programmes were registered for them. The approved centre took part in the Healthcare Associated infection in Long Term care project (HALT), a survey in all long-term facilities, which identified opportunities for improvement.

Evidence of Implementation: The approved centre had a resuscitation trolley. Weekly checks were not filled in consistently. Records of medical emergencies were available through the incident reporting pathway.

A consultant psychiatrist assessed residents before admission and all admissions were planned. A medical practitioner from the team completed an admission assessment. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than six-monthly. Adequate arrangements were not in place for access by residents to dietetics. Residents did not have access to a general practitioner or a primary care team. Laboratory results were documented in the resident's

clinical file. There was no record that residents were provided with information on national screening programmes.

A Consultant Geriatrician and surgeon attended the unit as required. Urgent reviews were processed through the Emergency Department and Medical Assessment Unit in St Luke's Hospital. The Community Intervention Team and Home Care Team visited St Gabriel's Unit when requested as did physiotherapists and Speech and Language Therapists (SLTs).

Residents received annual influenza vaccinations and other preventative treatments. Opportunities to pursue healthy lifestyle choices were available to residents and fresh fruit was delivered twice-weekly. Residents had access to an outdoor garden for walking. The activity nurse held two chair exercise sessions a week.

The approved centre was not compliant with this regulation because adequate arrangements were not in place for access by residents to general health services and for referral to other health services as required.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
		X	

3.20 Regulation 20: Provision of Information to Residents

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

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

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

Inspection Findings

Processes: There was a policy in place which addressed the roles and responsibilities in relation to the provision of information. Information was provided to residents in an on-going basis. The policy did not address the residents' preferred ways to receive information. Advocacy services and the availability of interpreter services were not included in the policy.

Training and Education: Staff had not signed that they had read and understood the policy. Staff could articulate the process for providing information when interviewed.

Monitoring: A "walk through review" was completed by management of the approved centre and it identified opportunities for improvements.

Evidence of Implementation: The information booklet for residents and their representatives did not include information on the complaints procedure and housekeeping arrangements including arrangements for personal property. Residents received information about the MDT on their second week following admission. The residents received verbal and written information on their diagnosis from the staff. A folder containing written information was available and included easy-read leaflets. Medication information sheets were available as requested.

The approved centre was compliant with this regulation. Not all of the criteria for the policy, processes and training, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.21 Regulation 21: Privacy

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

Inspection Findings

Processes: There was a policy on privacy which contained the methods for identifying and ensuring each residents' privacy and dignity expectations, and preferences. The roles and responsibilities were not outlined in the policy. The policy did not address the process to be applied where resident privacy and dignity was not respected by staff.

Training and Education: Staff had not signed that they read or understood the policy. When interviewed, staff were able to articulate the process for ensuring resident privacy and dignity.

Monitoring: A "walk through review" was completed by management of the approved centre.

Evidence of Implementation: Residents were addressed by their preferred name. Staff were respectful to residents and the behaviour of staff demonstrated a respect for resident dignity. Staff did not discuss residents within the hearing of others. All residents were dressed in appropriate day clothes. All toilets and bathrooms had locks to provide privacy for the occupant, except one, which could not be locked from the inside. A single bedroom had no blinds or curtains and privacy was not provided as the room was overlooked from a public area. There was no area where residents could use the approved centre's phone in private and no public phone was available.

The approved was non-compliant with this regulation because it did not ensure privacy:

(a) In the single bedroom;
(b) In one toilet; and
(c) When residents were using the telephone.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	
Risk Rating				
Low	Moderate	High	Critical	
	X			

3.22 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.*

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

Inspection Findings

Processes: There was a written policy with regard to premises in the approved centre. The roles and responsibilities for the maintenance of the premises were not outlined in the policy. The policy did not contain the approved centres maintenance, cleaning and infection control programmes. The legislative requirements relating to premises were not detailed in the policy and there was no reference to the approved centre's utility controls and requirements. The policy did not outline the processes and procedures for identifying hazards and ligature points.

Training and Education: Staff had signed that they read and understood the policy and they could articulate the processes.

Monitoring: A hand-hygiene audit was presented to inspectors, however, there was no full infection control audit. There was no ligature audit. A "walk through review", completed by management of the approved centre, identified deficiencies and a corrective action plan was presented to the inspectors. Approval had been sought to commence painting and other areas were identified as needing improvement.

Evidence of Implementation: There was sufficient access to personal space and the approved centre provided adequate communal rooms. The day room was also used for meals, it was bright and provided adequate seating for all the residents. The sitting room was in need of repair as skirting boards had been removed. There was no temperature control in the approved centre.

There was a maintenance requisition book, however the response from the maintenance workers was poor and they did not sign off when work had been completed. There was no lighting in one corridor, and on examination, was found to have been reported 13 days previously. The walls in the approved centre were marked and areas around the skylights were badly stained as there had been leaks. The paint was chipped on bedroom doors.

The approved centre had a dedicated activities room and a private room was provided when required for chiropodist or other services. There was adequate provision of assisted devices and wheelchair accessible toilets and bathrooms.

The approved centre was not compliant with this regulation because:

(a) A programme of routine maintenance was not maintained and work completed was not recorded;
(b) There was no temperature control in the approved centre and lighting was inadequate in one corridor;
(c) The sitting room was not in good repair; and
(d) The premises was not in good decorative order.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.23 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.*

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

Inspection Findings

Processes: The approved centre had a policy on medication management. The policy outlined the responsibility of staff to comply with legal and professional requirements in the management of medication. It documented processes to be followed in prescribing, administering and storing medication including the management of controlled drugs and medication reconciliation. The policy outlined the processes for self-administration of medication and the processes to follow where medication was withheld or refused. The procedure for crushing medication and reviewing medication was not outlined in the policy. The processes for medication management at admission, transfer and discharge were outlined. Procedures to be followed in cases of error, and adverse effects, including external reporting requirements were also outlined.

Training and Education: Staff had not signed that they read and understood the policy. Staff interviewed were able to articulate the processes for ordering, prescribing, storing and administering medicines. Staff stated that they had not received training on the importance of reporting medication incidents, or near misses.

Monitoring: Quarterly audits of Medication Prescription and Administration records (MPARs) were systemically undertaken to determine compliance with the policies and procedures and with the applicable legislation and guidelines. Inspectors observed the recording of an incident report where wrong medication was given. An analysis was complete and identified opportunities for improvement of medication management processes.

Evidence of Implementation: Fourteen MPARs were inspected. All had the appropriate resident identifiers and the generic names of medication were written in full. In two cases there was no documentation as to whether there were known allergies. The frequency, dose and administration routes of all medication administered had been completed correctly. Four MPARs had blank administration so it was unknown if the resident refused the medication or if it was withheld. Five MPARs had no Medical Council Registration Numbers (MCRNs) of the medical practitioner prescribing the medication on the MPARs.

All prescriptions were renewed at least six-monthly. The inspectors observed that all medicines were administered by a registered nurse as prescribed and in accordance with any advice given from the resident's pharmacist. Nurses administering medication were aware of the residents' Individual Care Plans (ICPs) and how they related to the medication prescribed if the resident had swallowing difficulties. The expiration date of the medication was checked prior to administration and the medication was administered as prescribed in the MPAR. Good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications.

Controlled drugs were checked by two staff, one being a registered nurse. The amount of medication corresponded with the controlled drug log and the balance corresponded with the amount of drugs stored in the press. A medical practitioner directed when medication was crushed and the reason was recorded in the individual care plan.

Stock was received in a pharmacy box twice a week and the contents were checked by nursing staff. Medication was stored appropriately in a locked drugs trolley or fridge and the fridge temperature was logged. The clinical storage area was incorporated in the cleaning schedule. A system of stock rotation was implemented and the pharmacist completed an inventory of medication fortnightly.

The approved centre was not compliant with the regulation because:

(a) The Medical Council Registration Number (MCRN) was not present on all the MPARS;
(b) Documentation of refused or withheld medication was not complete;
(c) Not all MPARs recorded allergy status
(d) The policy did not include processes for reviewing and crushing medication.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.24 Regulation 24: Health and Safety

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

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

Inspection Findings

Processes: There was a health and safety policy and a safety statement. These identified roles and responsibilities and referred to the specific roles of the registered provider and the safety representative. Compliance with health and safety legislation and the content of the Health and Safety statement were included. There was a fire management plan and health and safety risk management processes were outlined.

Included in the policy were first aid response requirements, vehicle controls, staff training requirements in relation to health and safety, and monitoring and continuous improvements requirements for health and safety processes. The policy contained some details of infection control measures including the management of spillages, hand washing, handling linen and covering cuts and abrasions.

The policy did not outline the response to sharps or needle stick injuries, raising the awareness of residents and visitors to infection control measures and specific infection control measures in relation to MRSA or *C. Difficile* infection types. Fall prevention initiatives were not addressed in the policy.

Training and Education: Staff had signed that they read and understood the policy. Staff were able to articulate the requirements of the policy and their role in this.

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

Evidence of Implementation: The written operational policies in relation to health and safety were reflected in practice within the approved centre.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and processes, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.25 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 anytime on request.*

Inspection Findings

As the approved centre did not use closed circuit television cameras, this regulation was not applicable.

3.26 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: There was a written policy on recruitment, selection and vetting of staff dated 2016. The roles and responsibilities of staff were outlined in the policy. Staff planning requirements, staff rota details and the requirement for staff training were in the policy. The required qualifications of training personnel were included in the policy. The policy did not include an organisational chart showing lines of responsibility.

Training and Education: Relevant staff had signed that they had read and understood the staffing policies. Staff could articulate the processes in relation to staffing.

Monitoring: The staff training plan had been reviewed and updated on an ongoing basis. Analysis had been completed to identify areas for improvement.

Evidence of Implementation: There was an organisational chart encompassing all staff and divisions. A staff rota had been completed for each week. There was a staffing plan that took into consideration the assessed needs of the resident profile group. At all times there was an appropriately qualified member of staff on duty. There was central rostering which meant there was no continuity of staff. There was a complaint received from a relative that the staff were always changing. All staff had been Garda vetted to include agency staff within the approved centre.

There was a training plan in operation. Orientation was provided for all new staff but there was no formal induction programme. Not all healthcare professionals had the necessary training. The Occupational Therapist was not trained in fire safety or the Mental Health Act. Only 50% of the nurses had Basic Life Saving training, 5% Manual Handling, 5% Fire Safety and 33% PMAV. Staff were also trained in dementia care, including end of life care. Not all health care assistants had received necessary training. Inspectors did not receive the training records of the social worker or medical staff. In-service training was documented and training facilities were also available in St Luke's General Hospital and on the campus of St Canice's. Staff were given opportunities for further education such as diplomas and degrees and staff were availing of this.

Inspectors observed that The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, the *Judgement Support Framework* and all other relevant Mental Health Commission documentation and guidance were available to staff in the nurses' office.

The approved centre was not compliant with this regulation as not all healthcare professionals had been trained in Basic Life Support, Fire Safety, the Mental Health Act and Therapeutic Management of Violence and Aggression or equivalent (26(4)).

The following is a staffing table of based in the approved centre on a 24-hour basis.

Ward or Unit	***Staff Grade***	***Day***	***Night***
Unit A	CNM3 CNM2 RPN HCA	* 0.75 * 1.00 * 3.00 * 2.00	* 0.00 * 0.00 * 2.00 * 1.00

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

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.27 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*.*

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

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

Inspection Findings

Processes: There was an up-to-date policy on the maintenance of records. While it stated that the staff had the responsibility for reading and complying with the policy, it did not define roles and responsibilities. The policy did not outline the creation and content of records or specify who was authorised to access and make entries in the record. There was no reference to privacy and confidentiality or the residents' access to records. Retention and destruction periods were not outlined in the policy and there was no reference to correcting entries or to making retrospective entries. General safety and security measures in relation to the storage of records was outlined. The retention of inspection reports relating to food safety, health and safety and fire inspections was not documented in the policy.

Training and Education: Staff had not signed that they had read and understood the policy. Staff could articulate the processes with regard to creation, access to, retention and destruction of records when interviewed.

Monitoring: The walk through review carried out by management of the approved centre established that an audit had not been completed on the maintenance of records.

Evidence of Implementation: Records were not maintained in a logical sequence. Two files examined had no section for clinical notes and loose pages were observed. Four files examined were not in good order and they contained too many documents Filing was inconsistent and weight charts were not filed in the same location of each file.

Documentation in relation to fire safety inspection, food safety inspection and health and safety inspections were maintained in the approved centre and made available to the inspectors.

The approved centre was not compliant with this regulation as:

(a) records were not kept in good order;
(b) the processes for creation of, access to, retention of and destruction were not outlined in the policy.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.28 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

There was a register of residents which was made available to the inspectors. The register did not meet the compliance criteria of Schedule 1 of the Regulations.

The approved centre was not compliant with this regulation because:

(a) The register did not record the country of birth of 11 residents;
(b) The register did not record the diagnosis on admission of 15 residents;
(c) The register did not record the diagnosis on discharge of five residents who had been discharged.

	Compliant	Non-Compliant
Compliance with Regulation		X

Risk Rating			
Low	Moderate	High	Critical
	X		

3.29 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: There was no written policy or documented roles and responsibilities in relation to the development, management and review of operating policies and procedures.

Training and Education: Staff gave details of a new process whereby five or six policies were read and discussed at a quiet time. Once this had been completed staff signed the policies to indicate that they had read and understood them.

Monitoring: There was no evidence of an annual audit or completed analysis on the development and reviewing of policies.

Evidence of Implementation: An amalgamated Community Healthcare Organisation 5 (CHO5) Mental Health Service Policy group identified by the Executive Management Team (EMT) was working on the development of policies. There was evidence that a new process had commenced to ensure that staff read and understood the policies.

The operational policies and procedures incorporated relevant legislation, evidence-based best practice and were appropriately approved and reviewed within three years. There was no process to remove obsolete versions of policies which resulted in inspectors receiving two versions of some of the policies. There was no documentation available that indicated that the approved centre had adopted some local and national policies. There was a policy in place for each regulation that required such.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and processes, training and monitoring and implementing, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.30 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

Detained patients were not admitted to St Gabriel's Ward. Therefore, this regulation was non-applicable.

3.31 Regulation 31: Complaints Procedures

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

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

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

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

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

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

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

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

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

Inspection Findings

Processes: There was a policy that outlined the complaints process. The roles and responsibilities of staff were outlined in the policy. The process for managing the complaint was outlined as were the methods available to the complainant. How the complaints policy was communicated to the resident and their next-of-kin was not documented. The confidentiality requirements in relation to complaints and the timeframes for complaint management were not detailed in the policy. The maintenance of the complaints log was not documented. The process to communicate progress with the complainant, the process to escalate the complaint and the appeals process were not contained in the policy.

Training and Education: Staff had not signed to say they had read and understood the policy and there was no evidence that staff had been trained on complaint management. Staff articulated different processes for making, handling and investigating complaints when interviewed.

Monitoring: There was no evidence of the monitoring of complaints.

Evidence of Implementation: There was a nominated person who was responsible for dealing with all complaints. Complaints were recorded in the clinical file and not in the complaints log. The information leaflet gave incorrect information in so far as it said to contact the Clinical Nurse Manager or Director of Nursing and not the complaints officer. The advocacy service was clearly documented. There was no evidence of complaints being closed out.

Minute-taking and record-keeping of residents' meetings was inconsistent and minor complaints were not documented. A complaint log was available in the nurses' station but it

contained no entries. A complaint of a serious nature from a family member was recorded in a clinical file but there was no evidence that the complaint was closed.

The approved centre was not compliant with this regulation because the registered proprietor did not ensure that:

(a) A record of all complaints was not maintained;
(b) Complaints were recorded in the clinical file and not in the complaints log;
(c) Information leaflets gave correct information.

	Compliant		Non-Compliant	
Compliance with Regulation			X	
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment			X	

Risk Rating			
Low	Moderate	High	Critical
	X		

3.32 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 comprehensive risk management policy. Roles and responsibilities in relation to risk management and implementation were in the policy. This included the responsibilities of the registered proprietor and the multi-disciplinary team (MDT). The risk manager was not named. The processes for identification, assessment, treatment and reporting risk were outlined in the policy as well as the processes for rating identified risks. The requirements relating to the methods for controlling specified risks including resident absence without leave; suicide and self-harm; assault and accidental injury to residents or staff, were in the policy. The policy included arrangements for the protection of children and vulnerable adults from abuse. There was no process for maintaining and reviewing the risk register.

The policy referenced the HSE Incident Management Policy for managing incidents was included in the policy. There was a policy and procedures for responding to specific emergencies.

Training and Education: Relevant staff were trained in specific risk management practices. Training records showed that 100% of Healthcare Managers had received health and safety training but not all nurse managers confirmed they had received training. Management staff were trained in organisational risk management and all healthcare staff had been trained in incident reporting and documentation. Staff had signed that they read and understood the policy and could articulate the processes.

Monitoring: The risk register was audited at least quarterly. All incidents were recorded in the incident folder and risk rated. An analysis of all incident reports was completed and escalated accordingly.

Evidence of Implementation: There was an identified risk manager known by staff within the approved centre. There were risk management procedures and practices that actively reduced identified risk in so far as was practicable. Clinical risks were identified and documented in the risk register on an ongoing basis. Health and safety risks had been identified and included in the risk register. The risk register was actively managed and reviewed monthly by the Quality and Safety Executive Committee.

There were a number of ligature points throughout the centre and the risk manager confirmed that a ligature audit was planned.

Risk assessments were completed prior to physical or mechanical restraint and documented. Individual risks were not documented for the transfer and discharge of residents from St Gabriel's Ward. The requirements for the protection of children and vulnerable adults were implemented and staff were aware of the risk of elder abuse.

Incidents were recorded in the standard NIMS format and reviewed by the MDT weekly. The risk manager documented any trends detected and provided six-monthly reports to the Mental Health Commission. There was an emergency plan that incorporated evacuation procedures.

The approved centre was compliant with this regulation. Not all of the criteria for the policy and processes, training and implementation, as outlined in the *Judgement Support Framework*, were in place and the quality rating for the approved centre was satisfactory.

	Compliant		Non-Compliant	
Compliance with Regulation	X			
	Excellent	Satisfactory	Requires Improvement	Inadequate
Quality Assessment		X		

3.33 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 was covered for public liability, employers' liability, clinical indemnity and property, and there was a statement to this effect.

	Compliant	Non-Compliant
Compliance with Regulation	X	

3.34 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

There was an in-date certificate of registration displayed prominently in the front hall.

	Compliant	Non-Compliant
Compliance with Regulation	X	

4.0 Inspection Findings and Required Actions - Rules

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

4.1 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

Electro-Convulsive Therapy (ECT) was not provided in the approved centre and no resident was currently receiving it elsewhere. Therefore, this rule was not applicable.

4.2 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 provide Seclusion, this rule was not applicable.

4.3 Section 69: The Use of Mechanical Restraint

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

Inspection Findings

Processes: There was a policy on the use of mechanical restraint but it did not outline who would receive training, the areas staff were to be trained in, the frequency of training, identify the appropriately trained staff to give the training and the mandatory nature of the training.

Training and Education: A record of training was maintained.

Evidence of Implementation: There were two orders of mechanical restraint and both were under the supervision of the consultant psychiatrist. Restraint was only used after assessment by an Occupational Therapist in terms of seating and was always a decision of the MDT. It was documented that there was an enduring risk of harm. All the relevant information that specified the type of mechanical restraint, and the situation where mechanical restraint was applied, was documented. The duration of the restraint and the duration of the order were documented. The review date was not specified in the file.

The approved centre was not compliant with the Code of Practice because:

(a) The policy did not include the required training needs pursuant to section 11 of the Code;
(b) The review date was not specified pursuant to section 21 of the Code.

	Compliant	Non-Compliant
Compliance with Rule		X

Risk Rating			
Low	Moderate	High	Critical
X			

5.0 Inspection Findings and Required Actions - The Mental Health Act 2001

5.1 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 Part 4 of the Mental Health Act was not applicable.

6.0 Inspection Findings and Required Actions – 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.

6.1 The Use of Physical Restraint

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

Inspection Findings

Processes: The approved centre had a written policy on physical restraint that was reviewed annually. The policy included the requirement on provision of information. The requirement on who can initiate and carry out a restraint was included in the policy. There was a provision for child protection if a child was restrained. Training requirements were included, however, they were not complete.

Training and Education: Nine staff signed that they had read and understood the policy. The policy outlined the mandatory nature of training and who should receive the training. Areas to be addressed during training, alternatives to physical restraint, training in PMVA, breakaway techniques, the frequency of training and the identification of persons qualified to give training were not documented in the policy.

Monitoring: The approved centre had no annual report on physical restraint as there had been no episodes of physical restraint.

Evidence of Implementation: The Clinical Practice Form book was reviewed. Four episodes of physical restraint were reviewed. Physical restraint had been used in rare circumstances in the best interests of the resident and was based on a risk assessment. In one case, there was no documentation to indicate that all other interventions had been considered first. There was a discrepancy between the notes and the Clinical Practice Form book regarding the time necessary for restraint.

Physical restraint had been initiated by nursing staff and there was a designated staff member leading each episode. In one episode reviewed there was no documentation that the Consultant Psychiatrist was notified as soon as practicable.

There was no record of a physical examination having been carried out within three hours of an episode of physical restraint for one of the residents. All episodes were documented as having lasted less than three hours and one had a renewal order made by the Registered Medical Practitioner. In all four episodes, there was no evidence that the resident was informed of the reason, likely duration and circumstances which would lead to the discontinuation of physical restraint. There was inconsistency regarding the next-of-kin being informed and consent being documented.

Episodes of physical restraint were reviewed by the MDT in three out of four cases. Staff were aware of the considerations in the ICP pertaining to specific requirements/needs. It was documented in three out of four files that residents were afforded the opportunity to discuss episodes of PR as soon as was practicable.

The approved centre was not compliant with the Code of Practice because:

(a) Staff training requirements as specified in section 10 of the Code of Practice had not been observed;
(b) The notifications required under sections 5.3 of the Code were not documented;
(c) The physical examination required pursuant to section 5.4 of the Code had not been documented;
(d) It was not documented that the information pursuant to section 5.8 was given to the residents and their representatives;
(e) It was not documented that the information pursuant to section 5.9 was given to the residents and their representatives
(f) One episode of physical restraint was not reviewed by members of the multi-disciplinary team pursuant to section 9.3;
(g) The requirement to afford the resident to discuss the restraint episode was not met pursuant to section 7.2.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
		X	

6.2 Admission of Children

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

Inspection Findings

As the approved centre did not admit child residents, this Code of Practice was not applicable.

6.3 Notification of Deaths and Incident Reporting

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

Inspection Findings

Processes: There were policies on risk management and the management of deaths which outlined the notification of deaths and incident processes. The policy did not identify the risk manager. The roles and responsibilities for staff reporting deaths and incidents and the completion of death notification forms was clearly outlined. The policy did not include the role and responsibility for completing and submitting six monthly incident summary reports to the Mental Health Commission.

Training and Education: Staff were aware and understood the policies. Staff were able to articulate the policies.

Monitoring: Deaths and incidents were reviewed to identify and correct problems as they arose and to improve quality.

Evidence of Implementation: There was an incident reporting system in place. A six-monthly summary of all incidents was provided to the Mental Health Commission (MHC). Deaths were notified within 24 hours.

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

(a) The policy did not identify a risk manager pursuant to section 4.2 of the Code;
(b) The policy did not include the roles and responsibilities pursuant to section 4.3 of the Code.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
X			

6.4 Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

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

Inspection Findings

Processes: There was a policy which had not been reviewed since June 2013. The roles and responsibilities were outlined and the policy stated reflected least restrictive interventions. There was no policy on the management of problem behaviours and there was no policy for training staff working with people with intellectual disability.

Training and Education: There was no record of training but staff reported that training had taken place and training slides were presented to the inspectors.

Monitoring: The policy was reviewed every three years.

Evidence of Implementation: The file of a resident with intellectual disability who was in the approved centre since the last inspection was examined. The resident had an individual care plan that detailed a person-centred approach to care. A comprehensive assessment was completed every six-months. Staff were aware of the residents' preferred ways of receiving and giving information. Least restrictive practices were observed and the resident was free to walk around the approved centre as desired. The activities nurse ensured that there were ample opportunities to engage in meaningful activities.

The approved centre was non-compliant with this Code of Practice because:

(a) There was no policy on the management of problem behaviours pursuant to section 5.3 of the Code;
(b) There was no policy for training staff pursuant to section 6.2 of the Code.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
	X		

6.5 The 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 provide Electro-Convulsive Therapy (ECT), this Code of Practice was not applicable.

6.6 Admission, Transfer and Discharge

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

Inspection Findings

Processes: The approved centre had admission, transfer and discharge policies. The admission policy outlined the procedure for involuntary admissions and specified the protocol with reference to pre-admission assessments and eligibility for admission. The policy did not indicate the roles and responsibilities of the MDT staff in relation to assessment after admission. The protocol for timely communication with the primary care team and Central Mental Hospital team was not included. Privacy, confidentiality and consent were not contained in the policy.

There was a transfer policy which included the procedure for involuntary transfer. The policy included how a transfer was arranged and included the safety residents and staff. Provisions for emergency transfer and the transfer of a resident abroad were not included in the policy. The roles and responsibilities of staff were included.

A policy on discharge was in place and included the discharge of involuntary patients following a mental health tribunal. The policy made reference to issuing prescriptions on discharge but not the supply of medicines. A protocol for discharging homeless people was included. There was a follow-up policy in place which included reference to relapse prevention strategies, crisis management plans, follow-up care and contact. A way to manage missed appointments was not included in the follow-up policy. The policy included procedures for the management of discharge against medical advice and a protocol for discharging older persons. A protocol for discharging people with intellectual disability was not included in the policy.

Training and Education: There was no evidence that staff had read and understood the admission or transfer policy. Staff had signed that they read and understood the discharge policy.

Monitoring: There was no evidence of monitoring of admission and discharge.

Evidence of Implementation:
Admission: The files of three residents who were admitted were reviewed. The approved centre was compliant with Regulation 32 Risk Management Procedures; Regulation 20 Provision of Information to Residents; Regulation 15 Individual Care Plans, and Regulation 7 Clothing. Non-compliance with Regulation 27 Maintenance and Regulation 8 Personal Property and Possessions were recorded.

There was a key worker system in place. Admission was confirmed on the basis of a mental illness, the decision to admit was made by a Registered Medical Practitioner (RMP) and the residents were admitted to the unit most appropriate to their needs. An admission assessment was carried out in each case and all records including those of the MDT were filed in the clinical file.

Transfer: The approved centre was compliant with Regulation 18 and the resident transferred was in need of specialised treatment in another facility. The decision to transfer was made by a RMP and was agreed with the receiving facility.

Discharge: The community mental health team and the key workers from the ward conducted a joint MDT which included discharge planning, contact with family and other care facilities as appropriate. The records of two discharges were reviewed. There was no discharge plan as part of the ICPs in place. For one resident there was an estimated date of discharge, a follow-up plan and it was documented that there was a risk of falls. There were no early warning signs of relapse documented. The second resident's discharge notes included the estimated date of discharge and a follow-up plan. There was no documentation relating to early warning signs of relapse or risk.

Both residents had an MDT team review. One resident did not have a comprehensive risk assessment prior to discharge. The discharges were co-ordinated by a key worker. The discharge summaries included diagnosis, prognosis, medication, mental state examination, outstanding health or social issues, follow-up arrangements and the names and contact details of key people for follow-up. Two days' notice of discharge was given and the family were involved when appropriate.

The approved centre was not compliant with this code of practice because:

(a) The admission policy did not include roles and responsibilities pursuant to section 4.7 of the Code;
(b) The admission policy did not detail protocols for timely communication with Primary Care Teams pursuant to section 4.9 of the Code;
(c) The admission policy did not include privacy, confidentiality and consent pursuant to section 4.18 of the Code;
(d) There was no documented evidence that staff had read and understood the policy as required under section 9.1 of the Code;
(e) There was no audit of admission of implementation and of adherence to the admission policy as pursuant to section 4.19 of the Code;
(f) The Approved centre was not compliant with Regulation 27 Maintenance of Records as required by Section 22.6 of the Code;
(g) The transfer policy did not include provision for emergency transfer and transfer abroad pursuant to section 4.13 of the Code;
(h) The follow-up policy did not include a way of following up and managing missed appointments pursuant to section 4.14 of the Code;
(i) There was no protocol for discharge of people with intellectual disability pursuant to section 4.16 of the Code;
(j) There was no discharge plan as part of the ICPs in place pursuant to section 34.1 of the Code;
(k) A comprehensive risk assessment prior to discharge was not conducted pursuant to section 35.1/42.1.

	Compliant	Non-Compliant
Compliance with Code of Practice		X

Risk Rating			
Low	Moderate	High	Critical
		X	

Appendix 1: Corrective action and preventative action (CAPA) plans for areas of non-compliance 2016

Completed by approved centre: St Gabriel's Ward, St Canice's Hospital **Date submitted:** 17th November 2016

For each finding of non-compliance the registered proprietor was requested to provide a corrective action and preventative action (CAPA) plan. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPA plans submitted by the registered proprietor were reviewed by the Commission to ensure that they are **specific, measurable, achievable, realistic** and **time-bound** (SMART). Following the finalisation of the inspection report the implementation of CAPA plans are routinely monitored by the Commission.

The Commission has not made any alterations or amendments to the returned CAPA plans, including content and formatting.

Regulation 5: Food and Nutrition (inspection report reference 3.5)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
1. The registered proprietor did not ensure that all residents were provided with special dietary requirements that were adequate for their needs.	Corrective action(s): Ward staff will implement the MUST tool. Submit a request to EMT for dietetic input and complete a risk assessment Post-holder(s): Nursing staff and Consultant Psychiatrist	Needs assessment	Achievable and realistic	Spring 2017
	Preventative action(s): Ward staff will implement the MUST tool. Submit a request to EMT for dietetic input and complete a risk assessment Post-holder(s):Nursing staff and Consultant Psychiatrist	Needs assessment and implementation of the MUST Tool On the minutes of EMT and QSEC	Achievable and realistic Achievable and realistic	December 2016

Regulation 6: Food Safety (inspection report reference 3.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
2. Food was observed on the floor.	Corrective action(s): Catering staff are reminded of the required food safety standards as outlined in HACCP guidelines Post-holder(s):Catering staff	A yearly hygiene audit will be conducted.	Achievable and realistic	Yearly hygiene audit
	Preventative action(s): Catering staff are reminded of the required food safety standards as outlined in HACCP guidelines Post-holder(s):Catering staf	A yearly hygiene audit will be conducted.	Achievable and realistic	Yearly hygiene audit
3. There was an open bin in the kitchen.	Corrective action(s): Catering staff are reminded of the required food safety standards as outlined in HACCP guidelines Post-holder(s):Catering staff	A yearly hygiene audit will be conducted	Achievable and realistic	Yearly hygiene audit
	Preventative action(s): Catering staff are reminded of the required food safety standards as outlined in HACCP guidelines Post-holder(s):Catering staff Post-holder(s):	A yearly ygiene audit will be conducted	Achievable and realistic	Yearly hygiene audit

4. There was brown staining in the grouting.	Corrective action(s): Cleaning schedules are revised to address hygiene concerns Post-holder(s): CNM2	A hygiene audit will be conducted yearly	Achievable and realistic	Yearly hygiene audit
	Corrective action(s): Cleaning schedules are revised to address hygiene concerns Post-holder(s):CNM2	A hygiene audit will be conducted yearly	Achievable and realistic	Yearly hygiene audit
5. The utensil drawer was unclean.	Corrective action(s): Catering staff are reminded of the required food safety and hygiene standards as outlined in HACCP guidelines Post-holder(s):Catering staff	A hygiene audit will be conducted yearly	Achievable and realistic	Yearly hygiene audit
	Corrective action(s): Catering staff are reminded of the required food safety and hygiene standards as outlined in HACCP guidelines Post-holder(s):Catering staff	A hygiene audit will be conducted yearly	Achievable and realistic	Yearly hygiene audit

Regulation 8: Residents' Personal Property and Possessions (inspection report reference 3.8)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
6. The registered proprietor did not ensure that resident's retained control of their property as money was retained in the approved centre after two residents were discharged.	Corrective action(s): Monies belonging to two residents retained on the ward after their discharge has been returned. Post-holder(s): Nursing staff	Documentation review	Achievable and realistic	Annual audit
	Preventative action(s): A discharge checklist will be introduced Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	Annual audit

Regulation 19: General Health (inspection report reference 3.19)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
7. Adequate arrangements were not in place for access by residents to general health services and for referral to other health services as required.	Corrective action(s) Determine which patients are eligible for each screening programme and enrol them on the relevant programmes. Patients are referred to other health services as required. A system is in place to check the defibrillator weekly. Post-holder(s):Service Manager, Nursing staff	Based on national guidelines for screening programmes - monitor as part of care plans Weekly check	Achievable and realistic Achievable and realistic	December 2016 Weekly checks
	Preventative action(s): As above Post-holder(s):	N/A	N/A	N/A

Regulation 21: Privacy (inspection report reference 3.21)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
8. The approved centre could not ensure privacy in the single room.	Corrective action(s): Contact screening will be placed on the viewing panel of the single room. Post-holder(s):CNM2	Walk through review	Achievable and realistic	November 2016
	Preventative action(s): N/A Post-holder(s):	N/A	N/A	N/A
9. The approved centre could not ensure privacy in one toilet.	Corrective action(s): A lock will be fitted to the toilet door Post-holder(s):Technical services	Walk through review	Achievable and realistic	November 2016
	Preventative action(s): N/A Post-holder(s):	N/A	N/A	N/A
10. The approved centre could not ensure privacy when residents were using the telephone.	Corrective action(s): The unit has installed a cordless phone for residents use. Post-holder(s):Technical Services	Walk through review	Achievable and realistic	Completed
	Preventative action(s): N/A Post-holder(s):	N/A	N/A	N/A

Regulation 22: Premises (inspection report reference 3.22)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
11. A programme of routine maintenance was not maintained and work completed was not recorded.	Corrective action(s): A routine maintenance programme is in place with the maintenance department. Maintenance requests are submitted via a maintenance request form A weekly monitoring of maintenance requirements will be put in place. Post-holder(s): Technical services and CNM2	Walk through review Check list system	Achievable and realistic Achievable and realistic	November 2016 November 2016
	Preventative action(s): A routine maintenance programme has been put in place with the maintenance department. A weekly monitoring of maintenance requirements will occur Post-holder(s): Technical services and CNM2	Walk through review Check list system	Achievable and realistic Achievable and realistic	November 2016 November 2016
12. There was no temperature control in the approved centre and lighting was inadequate in one corridor.	Corrective action(s): The unit temperature control issue has been referred to technical services. The lighting issue is resolved.	Walk through review	Achievable and realistic	November 2016

	Post-holder(s): Technical services			
	Preventative action(s): N/A Post-holder(s):	N/A	N/A	N/A
13. The sitting room was not in good repair.	Corrective action(s): A routine maintenance programme has been put in place with the maintenance department Post-holder(s): Technical services	Walk through review	Achievable and realistic	Spring 2017
	Preventative action(s): A routine maintenance programme has been put in place with the maintenance department Post-holder(s): Technical services	Walk through review	Achievable and realistic	Spring 2017
14. The premises was not in good decorative order.	Corrective action(s) A routine maintenance programme has been put in place with the maintenance department Post-holder(s): Technical services	Walk through review	Achievable and realistic	Spring 2017
	Preventative action(s) A routine maintenance programme has been put in place with the maintenance department Post-holder(s): Technical services	Walk through review	Achievable and realistic	Spring 2017

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines (inspection report reference 3.23)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
15. The Medical Council Registration Number (MCRN) was not present on all the MPARS.	Corrective action(s): The Medical Council Registration Numbers are now present on all of the MPARs Post-holder(s):Clinical Director	Annual audit	Achievable and realistic	Annual audit
	Preventative action(s): NCHD's are reminded of their requirement to comply with the Ordering, Prescribing,Storing and Administration of Medicines policy. Post-holder(s):Clinical Director	Annual audit	Achievable and realistic	Annual audit
16. Documentation of refused or withheld medication was not complete.	Corrective action(s): Nursing staff are reminded to properly complete the refused or withheld medication section in the medication kardex Post-holder(s):Nursing staff	Medication audit	Achievable and realistic	Annual audit
	Preventative action(s): Nursing staff are reminded to properly complete the refused or withheld medication section in the medication kardex Post-holder(s):Nursing staff	Medication audit	Achievable and realistic	Annual audit

17. Not all MPARs recorded allergy status.	Corrective action(s): The allergy section is now recorded in the MPAR for each resident. Post-holder(s):Clinical Director	Medication audit	Achievable and realistic	Completed
	Preventative action(s): Medical staff are reminded of their requirement to comply with the Ordering, Prescribing,Storing and Administration of Medicines policy. Post-holder(s):Clinical Director	Medication audit	Achievable and realistic	Completed
18. The policy did not include processes for reviewing and crushing medication.	Corrective action(s): This policy will be reviewed by the CHO5 policy group and will be revised to include a process for reviewing and crushing medication. Post-holder(s): CHO5 policy group	Review of policy	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017

Regulation 26: Staffing (inspection report reference 3.26)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
19. Not all healthcare professionals had been trained in Basic Life Support, Fire Safety, the Mental Health Act and Therapeutic Management of Violence and Aggression or equivalent (26(4)).	Corrective action(s): A unit specific data base for training is in place. Staff of the approved centre are prioritised for the autumn 2016 and spring 2017 mandatory training. Post-holder(s):Heads of Discipline	Audit of staff training records	Achievable and realistic	Spring 2017
	Preventative action(s): Staff of the approvevd centre are prioritised for the autum 2016 and spring 2017 mandatory training. Post-holder(s):Heads of Didcipline	Audit of the staff training records	Achievable and realistic	Spring 2017

Regulation 27: Maintenance of Records and Code of Practice: Admission, Transfer and Discharge (inspection report references 3.27 and 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
20. Records were not kept in good order.	Corrective action(s) Files are now maintained in a logical sequence. Loose pages have been secured. Filing practices have been addressed. Post-holder(s): Heads of Discipline	Documentation audit	Achievable and realistic	Quarter 1 2017
	Preventative action(s) Staff are reminded of the importance of maintaining clinical files in good order.. Post-holder(s): Heads of Discipline	Documentation audit	Achievable and realistic	Quarter 1 2017
21. The processes for creation of, access to, retention of and destruction were not outlined in the policy.	Corrective action(s): This policy will be reviewed by the CHO5 policy group and will be revised to include a process relating to the creation, access to, retention of and destruction of records. Post-holder(s): CHO5 policy group	Review of policy	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017

Regulation 28: Register of Residents (inspection report reference 3.28)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
22. The register did not record the country of birth of 11 residents.	Corrective action(s): The register now records the country of birth for all residents. Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	Completed
	Preventative action(s): As above Post-holder(s):	N/A	N/A	N/A
23. The register did not record the diagnosis on admission of 15 residents.	Corrective action(s): The register now records the diagnosis on admission for all residents. Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	Completed
	Preventative action(s): As above Post-holder(s):	N/A	N/A	N
24. The register did not record the diagnosis on discharge of five residents who had been discharged.	Corrective action(s): Staff are aware of need to update register on the discharge of a resident Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	Completed
	Preventative action(s): As above	N/a	N/A	N/A

	Post-holder(s):			

Regulation 31: Complaints Procedures (inspection report reference 3.31)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
25. A record of all complaints was not maintained.	Corrective action(s): Records of all complaints are recorded in the complaints book Post-holder(s):MDT	Documentation review	Achievable and realistic	Completed
	Preventative action(s): Records of all complaints are now recorded in the complaints book Post-holder(s):MDT	Documentation review	Achievable and realistic	Completed
26. Complaints were recorded in the clinical file and not in the complaints log.	Corrective action(s): Staff are aware of the requirement to record complaints in the log book. Post-holder(s):MDT	Documentation review	Achievable and realistic	Completed
	Preventative action(s) Staff are aware of the requirement to record complaints in the log book. Post-holder(s):MDT	Documentation review	Achievable and realistic	Completed

27. Information leaflet gave incorrect information.	Corrective action(s): Information leaflet will be corrected Post-holder(s): CNM2	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): As above Post-holder(s):	Documentation review	Achievable and realistic	November 2016

Section 69: The Use of Mechanical Restraint (inspection report reference 4.3)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
28. The policy did not include the required training needs pursuant to section 11 of the Code.	This policy will be reviewed by the CHO5 policy group and will be revised to include the required training needs pursuant to section 11 of the Code. Post-holder(s) CHO5 policy group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
29. It was not documented on the clinical files that the least restrictive alternatives were implemented pursuant to section 21.5 of the Code.	Corrective action(s): Clinical staff are reminded to document on the clinical file the least restrictive alternatives were implemented pursuant to section 21.5 of the Code. Post-holder(s):MDT	Documentation audit	Achievable and realistic	November 2016
	Preventative action(s): This matter will be prioritised by the clinical team Post-holder(s):MDT	Documentation audit	Achievable and realistic	November 2016

30. The review date was not specified pursuant to section 21 of the Code.	This policy will be reviewed by the CHO5 policy group and will be revised to include the appropriate review date Post-holder(s): CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017

Code of Practice: The Use of Physical Restraint (inspection report reference 6.1)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
31. Staff training requirements as specified in section 10 of the Code of Practice had not been observed.	This policy will be reviewed by the CHO5 policy group and will be revised to include reference to the training programme as required by 10.1 (b) Post-holder(s) CHO5 policy group.	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017

32. The notifications required under sections 5.3 of the Code were not documented.	Corrective action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 5.3 Post-holder(s): Nursing staff	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): Staff are informed of steps necessary following a physical restraint episode. Post-holder(s): Nursing staff	Documentation review	Achievable and realistic	November 2016
33. The physical examination required pursuant to section 5.4 of the Code had not been documented.	Corrective action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 5.4 of the code Post-holder(s): Nursing staff	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): Staff are informed of steps necessary following a physical restraint episode. Post-holder(s): Nursing staff	Documentation review	Achievable and realistic	November 2016
34. It was not documented that the information pursuant to section 5.8 was given to the residents and their representatives.	Corrective action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 5.8 Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): Staff are informed of steps necessary following a physical	Documentation review	Achievable and realistic	November 2016

	restraint episode pursuant to section 5.8 Post-holder(s):Nursing staff			
35. It was not documented that the information pursuant to section 5.9 was given to the residents and their representatives.	Corrective action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 5.9 Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 5.9 Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	November 2016
36. One episode of physical restraint was not reviewed by members of the multi-disciplinary team pursuant to section 9.3.	Corrective action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 9.3 Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 9.3 Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	November 2016
37. The requirement to afford the resident to discuss the	Corrective action(s): Staff are informed of steps necessary following a physical	Documentation review	Achievable and realistic	November 2016

restraint episode was not met pursuant to section 7.2.	restraint episode pursuant to section 7.2 Post-holder(s):Nursing staff			
	Preventative action(s): Staff are informed of steps necessary following a physical restraint episode pursuant to section 7.2 Post-holder(s):Nursing staff	Documentation review	Achievable and realistic	November 2016

Code of Practice: Notification of Deaths and Incident Reporting (inspection report reference 6.3)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
38. The policy did not identify a risk manager pursuant to section 4.2 of the Code.	This policy will be reviewed by the CHO5 policy group and will be revised to identify the risk manager pursuant to section 4.2 of the Code Post-holder(s) CHO5 policy group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
39. The policy did not include the roles and responsibilities pursuant to section 4.3 of the Code.	This policy will be reviewed by the CHO5 policy group and will be revised to include the roles and responsibilities pursuant to section 4.3 of the Code. Post-holder(s) CHO5 policy group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017

Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities (inspection report reference 6.4)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
40. There was no policy on the management of problem behaviours pursuant to section 5.3 of the Code.	This policy will be developed by the CHO5 policy group and will be revised to include the management of problem behaviours pursuant to section 5.3 of the Code. Post-holder(s) CHO5 policy group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
41. There was no policy for training staff pursuant to section 6.2 of the Code.	Preventative action(s): This policy will be developed by the CHO5 policy group and will be revised to include training of staff pursuant to section 6.2 of the Code. Post-holder(s) CHO5 policy group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017

Code of Practice: Admission, Transfer and Discharge (inspection report reference 6.6)				
Area(s) of non-compliance	**Specific** *Define corrective and preventative action(s) to address the non-compliant finding **and** post-holder(s) responsible for implementation of the action(s)*	**Measurable** *Define the method of monitoring the implementation of the action(s)*	**Achievable/ Realistic** *State the feasibility of the action(s) (i.e. barriers to implementation)*	**Time-bound** *Define time-frame for implementation of the action(s)*
42. The admission policy did not include roles and responsibilities pursuant to section 4.7 of the Code.	Corrective action(s): The admission policy will be reviewed by the CHO5 policy group and will be revised to include roles and responsibilities pursuant to section 4.7 of the Code Post-holder(s):CHO5 Policy Group	Review by CHO5 Policy Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
43. The admission policy did not detail protocol for timely communication with Primary Care Teams pursuant to section 4.9 of the Code.	Corrective action(s): Guidance have been issued to clinical staff on their requirement of timely communication with Primary Care Teams pursuant to section 4.9 of the Code.The admission policy will be reviewed by the CHO5 policy group and will be revised to include a protocol for timely communication with primary care and CMHTs as required by section 4.9. Post-holder(s):CHO5 Policy Group	Review by CHO5 Policy Group	Achievable and realistic	Quarter 1 2017

	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
44. The admission policy did not include privacy, confidentiality and consent pursuant to section 4.18 of the Code.	Corrective action(s): The admission policy will be reviewed by the CHO5 policy group and will be revised to include a protocol for timely communication with primary care and CMHTs as required by 4.9 Post-holder(s):CHO5 Policy Group	Review by CHO5 Policy Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): This matter will be prioritised by the policy review group Post-holder(s):CHO5 Policy Group	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
45. There was no documentary evidence that staff had read and understood the policy as required under section 9.1 of the Code.	Corrective action(s): All staff are reminded to sign off that they have read the policy. Post-holder(s): Head of Disciplines	CHO Policy Review Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): The requirement to read and sign policies is emphasised in the staff induction programme Post-holder(s):Head of Disciplines	N/A	N/A	N/A
46. There was no audit of admission of implementation and of adherence to the	Corrective action(s): The admission policy will be reviewed by the CHO5 policy group and will be revised to include a protocol for timely communication			

admission policy as pursuant to section 4.19 of the Code.	with primary care and CMHTs as required by 4.9 Post-holder(s): CHO5 Policy Group			
	Preventative action(s): As above Post-holder(s):	N/A	N/A	N/A
47. The transfer policy did not include provision for emergency transfer and transfer abroad pursuant to section 4.13 of the Code.	Corrective action(s): The transfer policy will be reviewed by the CHO5 policy group and will be revised to include provisions for emergency transfer or transfer abroad as required by 4.13. Post-holder(s):CHO5 Policy Group	Review by CHO5 Policy Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s) As above	N/A	N/A	N/A
48. The follow-up policy did not include a way of following up and managing missed appointments pursuant to section 4.14 of the Code.	Corrective action(s): The discharge policy will be reviewed by the CHO5 policy group and will be revised to include a way of following up and managing missed appointments as required by 4.14. Post-holder(s):CHO5 Policy Group	Review by CHO5 Policy Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): As above Post-holder(s):	N/A	N/A	N/A

49. There was no protocol for discharge of people with intellectual disability pursuant to section 4.16 of the Code.	Corrective action(s) The discharge policy will be reviewed by the CHO5 policy group and will be revised to include a protocol for discharge of people with intellectual disability as required by 4.16. Post-holder(s): CHO5 Policy Group	Review by CHO5 Policy Group	Achievable and realistic	Quarter 1 2017
	Preventative action(s): As above Post-holder(s):	N/A	N/A	N/A
50. There was no discharge plan as part of the ICPs in place pursuant to section 34.1 of the Code.	Corrective action(s): This will be put in place as part of MDT meeting Post-holder(s):MDT	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): This will be put in place as part of MDT meeting Post-holder(s):MDT	Documentatio review	Achievable and realistic	November 2016
51. There was no comprehensive risk assessment prior to discharge pursuant to section 35.1/42.1.	Corrective action(s): This will be completed as part of final MDT meeting Post-holder(s):MDT	Documentation review	Achievable and realistic	November 2016
	Preventative action(s): This will be completed as part of final MDT meeting Post-holder(s):MDT	Documentation review	Achievable and realistic	November 2016