Acute Mental Health Unit, Cork University Hospital

ID Number: AC0096

2017 Approved Centre Inspection Report (Mental Health Act 2001)

Acute Mental Health Unit
Cork University Hospital
Wilton
Cork

Approved Centre Type: Acute Adult Mental Health Care
Psychiatry of Later Life

Most Recent Registration Date: 4 February 2015

Conditions Attached: None

Registered Proprietor: HSE

Registered Proprietor Nominee: Ms Sinead Glennon, Head of Mental Services – Cork & Kerry

Inspection Team:
Siobhán Dinan, Lead Inspector
Orla O’Neill
Marianne Griffiths
Donal O’Gorman

Inspection Date: 16 – 19 May 2017

Previous Inspection Date: 8 – 10 November 2016

Inspection Type: Unannounced Annual Inspection

Date of Publication: 28 September 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

COMPLIANCE RATINGS 2017

- **REGULATIONS**
  - Compliant: 22
  - Non-compliant: 8
  - Not applicable: 1

- **RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001**
  - Compliant: 1
  - Non-compliant: 3
  - Not applicable: 2

- **CODES OF PRACTICE**
  - Compliant: 3
  - Non-compliant: 1
  - Not applicable: 0

Legend:
- **Green**: Compliant
- **Red**: Non-compliant
- **Gray**: Not applicable
RATINGS SUMMARY 2015 – 2017

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

Chart 1 – Comparison of overall compliance ratings 2015 – 2017

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

Chart 2 – Comparison of overall risk ratings 2015 – 2017
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1.0 Introduction to the Inspection Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inspector of Mental Health Services

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

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

Safety in the approved centre

The approved centre had a written policy in relation to health and safety, and a safety statement. There were comprehensive risk management policies and processes in place. The person-specific resident identifiers in use in the approved centre consisted of wristbands with details of each resident’s name, address, date of birth, and medical record number. Food safety audits had been completed and hygiene was maintained to support food safety. Catering areas and associated equipment were appropriately cleaned. There were a number of prescription, administration and storage of medication errors. Not all health care professional were up to date with their training in fire safety, Basic Life Support, Professional Management of Aggression and Violence, and the Mental Health Act 2001. At the time of the inspection, the high observation area was not functioning as such and was used for general admission beds.

Areas referred to

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

Appropriate care and treatment of residents

Of concern was that six residents did not have an individual care plan (ICP) and not all ICPs identified the necessary resources or specified appropriate goals for the residents. Not all residents were aware of their individual care plan. There was a wide range of therapeutic services and programmes facilitated by an activities nurse, psychology staff, an art therapist, and community voluntary organisations. Although residents received appropriate general health care as indicated in their individual care plans, one resident had not received a six-monthly general health check. There was no system for organising six-monthly physicals, and records of residents’ completed health checks and the associated results were not consistently maintained.

Clinical files were in poor condition. Almost all of the clinical files in question contained loose pages and investigation/test reports, undated individual care plans and misfiled documents. Records were not maintained in a logical sequence and two appropriate resident identifiers were not recorded on all documentation.
The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

### Areas Referred To

### Respect for Residents’ Privacy and Dignity
Residents could bring personal possessions into the approved centre and were supported to manage their own property. All residents had an adequate supply of individualised clothing, and each had a large lockable wardrobe and bedside locker for the storage of clothing and belongings. Residents’ consent to a search was sought and searches were attended by at least two clinical staff and implemented with due regard to the resident’s dignity, privacy and gender. Residents were informed by those implementing the search of what was happening and why. End of life care was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. Bathrooms, showers, toilets, and single rooms had locks on the inside of the doors. Most of the accommodation comprised single, en suite rooms. The approved centre’s internal courtyard was overlooked by nearby houses. This was an ongoing concern since the 2016 inspection. The inspection team was informed that the estates department intended to erect privacy screening to address the issue.

Residents were facilitated in making and taking private phone calls. There was prominent signage indicating where CCTV cameras were located. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare by a healthcare professional. Cameras were incapable of recording or storing a resident’s image in any format. Seclusion was not used in the approved centre.

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

### Responsiveness to Residents’ Needs
Residents were complimentary about the care received from the nursing staff and the food provided by the approved centre. Food, including modified consistency diets, was presented in an appealing manner and was wholesome and nutritious food choices. There was a lack of laundry facilities for residents who did not have visitors to take home their laundry. There was excellent provision of recreational activities during the week and at weekends. Information about recreational activities was provided to residents via notices and timetables posted up throughout the approved centre and activities were developed, maintained, and implemented with resident involvement. There was a chapel in the general hospital, which residents could visit weekly. Residents also had access to multi-faith chaplains. There were three separate, dedicated visitors’ rooms where residents could meet visitors in private. Residents had access to external communications, including telephone, mail, fax, e-mail, and Internet. Required information was given to residents and/or their representatives at admission in the form of a resident information booklet. Diagnosis- and medication-related information, including risks and potential side-effects, was readily available, and medication leaflets were in an easy-to-read, uncomplicated, and user-friendly format. A new information
leaflet had been developed for family members of residents explaining the admission process, confidentiality, and available support services. There was a robust and well-advertised complaints procedure in place.

The approved centre’s physical environment was of a high standard and there was a documented programme of general maintenance. A daily cleaning schedule was in place.

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

**Governance of the approved centre**

The approved centre was part of the HSE’s Community Healthcare Organisation 4 area. The governance structures included an area executive management team, a local Acute Mental Health Unit management team, a quarterly incident review committee, and a quality initiatives and audit committee. The minutes of executive management team meetings provided outlined an active governance process. Both individual and operational risks were monitored.

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Each clinical discipline had its own governance structure, with clear line management and supervision. Management and staff of the approved centre had an annual audit plan. There was evidence from the audit reports that the approved centre was collecting and analysing data to identify opportunities for improvement.

Operating policies and procedures, which incorporated relevant legislation, evidence-based best practice, and clinical guidelines, were communicated to all relevant staff. Not all policies and procedures required by the regulations had been reviewed at least every three years.

**AREAS REFERRED TO**
Regulations 26 and 32, interviews with heads of discipline, and minutes of area management team meetings.
The following quality initiatives were identified on this inspection:

1. A new information leaflet had been developed for family members of residents explaining the admission process, confidentiality, and available support services.

2. A dual diagnosis group had been developed and took place weekly in the approved centre.

3. A multi-disciplinary team had been established to work with individuals with emotionally unstable personality disorder.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The Acute Mental Health Unit (AMHU) was well signposted and located towards the rear of the Cork University Hospital campus in Wilton, Cork city. This purpose-built, free-standing, two-storey building opened in August 2015. The approved centre comprised of three units; the acute male unit, the acute female unit and the Psychiatry of Later Life (POLL) unit. The acute male and female admission units, each with 18 beds, were located on the ground floor alongside an additional six-bed high observation area. At the time of the inspection, the high observation area was not functioning as such: The six beds were being used as additional beds for the admissions unit. The admissions unit was configured into 21 male and 21 female beds.

The eight-bed Psychiatry of Later Life (POLL) unit was located on the first floor alongside administration offices and therapy rooms. Visitors entered the premises via a large reception area where there was a reception desk staffed 24 hours’ a day by HSE security personnel. The entrance doors to the individual units were locked, and access was via keypad or by staff releasing the electronic door mechanism. The link corridor between the reception hallway and the admissions unit contained interview rooms and three visitors’ rooms. Six general adult sector teams and two POLL teams admitted residents to the AMHU.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>50</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>49</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>16</td>
</tr>
<tr>
<td>Number of Wards of Court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>5</td>
</tr>
</tbody>
</table>

4.2 Conditions to registration

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

4.3 Reporting on the National Clinical Guidelines

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

The approved centre was part of the HSE’s Community Healthcare Organisation 4 area. The approved centre had established governance mechanisms in place. The governance structures included an area executive management team, a local AMHU management team, a quarterly incident review committee, and a quality initiatives and audit committee. The minutes of meetings for these committees were provided to the inspection team. The minutes of executive management team meetings provided outlined an active governance process. Both individual and operational risks were monitored. The minutes demonstrated an action-oriented focus with clear time lines. Ongoing constraints on staff recruitment meant that staff vacancies and the provision of services were the main priorities on the agenda at each area management team meeting.

There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Each clinical discipline had its own governance structure, with clear line management and supervision. Management and staff of the approved centre had an annual audit plan. There was evidence from the audit reports that the approved centre was collecting and analysing data to identify opportunities for improvement.
5.0 Compliance

5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 8 – 10 November 2016 identified the following areas that were not compliant. The approved centre was requested to provide Corrective and Preventative Actions (CAPAs) for areas of non-compliance and these were published with the 2016 inspection report.

<table>
<thead>
<tr>
<th>Regulation/Rule/Act/Code</th>
<th>2017 Inspection Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 7: Clothing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons Working in Mental Health Services with Intellectual Disabilities</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>Non-Compliant</td>
</tr>
</tbody>
</table>
5.2 Non-compliant areas on this inspection

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 28: Register of Residents</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 29: Operating Policies and Procedures</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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

5.3 Areas of compliance rated Excellent on this inspection

The following areas were rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 7: Clothing</td>
</tr>
<tr>
<td>Regulation 9: Recreational Activities</td>
</tr>
<tr>
<td>Regulation 10: Religion</td>
</tr>
</tbody>
</table>
6.0 Service-user Experience

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

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

All those that provided feedback to the inspection team gave permission that their experience could be fed back to the senior management team. The information was used to give a general picture of residents’ experience of the approved centre as outlined below.

Two residents and a family member of a resident provided feedback to the inspection team. All were complimentary about the care received from the nursing staff and the food provided by the approved centre. Staff were described as patient, kind, and helpful. It was felt that the visitors’ room in the Psychiatry of Later Life unit was uninviting and therefore not used often. Residents were invited to complete a questionnaire about their experience in the Acute Mental Health Unit. One questionnaire was returned. Not all residents were aware of their individual care plan (ICP).

The inspection team also met with a representative of the Irish Advocacy Network (IAN). The IAN representative noted some issues relating to the lack of laundry facilities for residents who do not have visitors to take home their laundry. The IAN representative provided feedback that they had previously received from residents that there was a need for a better selection of activities in the acute unit and that activity programmes were repeated, leading to boredom amongst more long-term residents.
7.0 Interviews with Heads of Discipline

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

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

All clinical heads of discipline made themselves available to speak with the inspectors. Representatives from nursing, medical, social work, occupational therapy, and psychology each provided a clear overview of the governance within their respective departments. The Area Director of Nursing visited the approved centre on a regular basis. The clinical director was based in the approved centre and was on site daily. The Occupational Therapy Manager, Principal Psychologist and Social Work Manager had no direct input to the approved centre.

Defined lines of responsibility were evident in each department. Consequently, staff supervision was facilitated within the departments and regular meetings were scheduled with staff to ensure that they were adequately supported.

All heads of discipline identified strategic aims for their teams and discussed potential operational risks with their departments. These were agenda items at senior management meetings. Key performance indicators assisted the organisation to measure how well it was doing in relation to achieving goals. None of the disciplines operated staff performance review appraisals. Clear systems were in place to support quality improvement. Service user input was facilitated by engagement with advocacy within the approved centre.
8.0 Feedback Meeting

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

- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing x 2
- Occupational Therapy Manager
- Principal Social Worker
- Compliance and Regulations Officer
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 x 3
- Area Administrator

Apologies were received on behalf of the registered proprietor nominee and the principal psychologist.

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. A number of clarifications were provided regarding various issues that had arisen during the course of this inspection, and these are incorporated into this report.
The following regulations are not applicable:

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

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: The person-specific resident identifiers in use in the approved centre consisted of wristbands with details of each resident’s name, address, date of birth, and medical record number. The identifiers, which were appropriate to residents’ communication abilities, were used before the administration of medication, the undertaking of medical investigations, and the provision of health care services and therapeutic services and programmes. A caution sticker system was in place to alert staff to the presence of residents with the same or a similar name.

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: A systematic review of menu plans had been undertaken to ensure that residents received wholesome and nutritious food in accordance with their needs. Analysis had been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Menus were nutritionally analysed by a nutritionist/dietician to ensure nutritional adequacy in accordance with residents’ needs. Food, including modified consistency diets, was presented in an appealing manner. Residents were provided with a wide range of wholesome and nutritious food choices, and hot meals were provided on a daily basis. Residents had regular access to hot and cold drinks and to a source of safe, fresh drinking water.

Weight charts were implemented, monitored, and acted upon, where required. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate. The needs of residents identified as having special nutritional requirements were regularly reviewed by a nutritionist. Nutritional and dietary needs were assessed, where necessary, and addressed in the resident’s individual care plan.

The approved centre did not use an evidence-based nutrition tool to assess residents with special dietary requirements.

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

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

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

INSPECTION FINDINGS

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

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

Monitoring: Food safety audits had been completed. Food temperatures were in line with food safety recommendations, and a temperature log sheet was maintained and monitored. Analysis had been completed to identify opportunities for improving food safety processes.

Evidence of Implementation: Appropriate hand-washing areas were provided for catering services, and there was suitable catering equipment, with appropriate facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety, and catering areas and associated equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery, which addressed their specific needs.

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

The registered proprietor shall ensure that:

1. when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;
2. night clothes are not worn by residents during the day, unless specified in a resident’s individual care plan.

**INSPECTION FINDINGS**

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

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

**Monitoring:** An emergency supply of clothing for residents was maintained in the property room and monitored by the clinical nurse manager on an ongoing basis. A record of residents wearing nightclothes during the day was maintained and monitored. At the time of the inspection, one resident had been prescribed night attire during the day.

**Evidence of Implementation:** Residents were supported to keep and wear their personal clothing, and residents’ clothing was observed to be clean and appropriate to their needs. Residents’ clothing was sent home to family members or to the launderette for cleaning.

An emergency supply of clothing was available, which took account of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plan (ICP). All residents had an adequate supply of individualised clothing, and each had a large lockable wardrobe and bedside locker for the storage of clothing and belongings.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 8: Residents’ Personal Property and Possessions

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

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

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

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

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

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to residents’ personal property and possessions, which was last reviewed in October 2016. It included requirements of the *Judgement Support Framework*, with the exception of the process for allowing residents to have access to and control over their personal property, unless this posed a danger to the resident or others, as indicated in their individual care plans (ICPs), following a risk assessment.

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

**Monitoring:** The approved centre monitored personal property logs. Analysis was completed to identify opportunities to improve the processes for residents’ personal property and possessions. This is documented.

**Evidence of Implementation:** Residents could bring personal possessions into the approved centre and were supported to manage their own property, unless this posed a danger to themselves or others, as indicated in their ICPs. All residents’ personal property and possessions were recorded and signed for by both staff and the residents. The approved centre had a duplicate property log book and residents were given copies of their property logs.

Residents’ wardrobes had code-enabled locking mechanisms, which allowed residents to store personal property, safely and securely. There was also a safe in the nurses’ station where residents could secure money, although residents were encouraged to limit the amount of money they brought in to the approved centre.
Two members of staff oversaw the process of providing residents with access to their monies, and signed records of staff issuing the money were retained and, where possible, countersigned by the resident or their representative. Residents’ individual property checklists were kept separately from their ICPs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes pillar.
Regulation 9: Recreational Activities

Compliant

Quality Rating Excellent

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

Inspection Findings

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

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

Monitoring: A record of the occurrence of planned recreational activities, including a log of resident uptake/attendance was maintained. Analysis had been completed to identify opportunities for improving the processes relating to recreational activities.

Evidence of Implementation: Residents had access to appropriate recreational activities. The activities available on the Psychiatry of Later Life (POLL) unit included bingo, music, ball games, newspaper review, radio, knitting, card games, and arts and crafts. Residents in the POLL unit had access to a newly refurbished rooftop patio area, with raised beds and a small space for walking. There was also a lounge area with a TV and a multi-sensory room.

The acute admission unit had three lounges, each with a TV. Residents had access to newspapers, magazines, books, table games, and arts and crafts. There was also a small gym room and outdoor garden space. There was a weekly yoga class, and the activities nurses ran a weekly baking group and brought residents for walks in the hospital grounds.

Recreational activities were scheduled in the approved centre on weekdays and at weekends. Information about recreational activities was provided to residents via notices and timetables posted up throughout the approved centre. Activities were developed, maintained, and implemented with resident involvement. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Documented records of attendance were retained for recreational activities within the residents’ clinical files.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 10: Religion

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

INSPECTION FINDINGS

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

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

Monitoring: The implementation of the policy to support residents’ religious practices was reviewed to ensure it reflects the identified needs of the residents.

Evidence of Implementation: Residents were facilitated in the practice of their religion insofar as was practicable. There was a chapel in the general hospital, which residents could visit weekly. Residents also had access to multi-faith chaplains. Following a risk assessment, residents could attend religious services outside of the approved centre, if deemed appropriate.

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

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the Judgement Support Framework.
Regulation 11: Visits

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to visits, which was last reviewed in February 2017. It included requirements of the Judgement Support Framework, with the exception of required visitor identification methods.

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

Monitoring: Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. Analysis was completed to identify opportunities to improve visiting processes. This was documented.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre. There were three separate, dedicated visitors’ rooms where residents could meet visitors in private, unless there was an identified risk to the resident or to others or a health and safety risk. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits. Children were welcome when accompanied at all times for their safety. Visiting areas had facilities suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities for resident communication processes.
- The process whereby resident communications could be examined by a senior member of staff.
- The individual risk assessment requirements in relation to limiting resident communication activities.

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

Monitoring: There was no evidence that residents’ communications needs and restrictions on communication were monitored on an ongoing basis. Analysis had not been completed to identify opportunities for improving communication processes.

Evidence of Implementation: Residents had access to external communications, including telephone, mail, fax, e-mail, and Internet. Where appropriate, individual risk assessments were completed for residents in relation to risks associated with their external communication. These were documented in their individual care plans. Only the clinical director or a senior staff member could examine incoming and outgoing resident communication where there was reasonable cause to believe that the communication may result in harm to the resident or to others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

Monitoring: The approved centre did not maintain a log of searches. Analysis was not completed to identify opportunities for the improvement of search processes.

Evidence of Implementation: There had been one search in the approved centre since the last inspection, and the relevant clinical file was examined. A risk assessment was completed in advance of the search, and resident consent was sought. The search was attended by at least two clinical staff and was implemented with due regard to the resident’s dignity, privacy and gender. The resident was informed by those implementing the search of what was happening and why. Details of the search were recorded in
the clinical file, including the reasons for the search, the names of the staff members who undertook the search, and details of who was in attendance.

The policy and processes relating to searches were communicated to all residents in the approved centre via the information booklet. Where illicit substances were uncovered during a search, policy requirements were implemented.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the monitoring pillar.
Regulation 14: Care of the Dying

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to care of the dying: Care of the Dying and Do Not Attempt Resuscitation Orders, dated August 2016, and Care of the Dying and Sudden Death in an Approved Centre, dated February 2017. The policies included requirements of the Judgement Support Framework, with the exception of a process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred to another facility.

Training and Education: All relevant staff had not signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to end of life care, as set out in the policies.

Monitoring: End of life care had been systematically reviewed to ensure Section 2 of the regulation was complied with. Systems analysis was undertaken in the event of a sudden or unexpected death in the approved centre. Analysis had been completed to identify opportunities for improving the processes relating to care of the dying.

Evidence of Implementation: The clinical file of one resident who had died in the approved centre was reviewed. It indicated that the end of life care was appropriate to the resident’s physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, insofar as was practicable. Pain management was prioritised and managed with input from the palliative care team from Cork University Hospital. The privacy and dignity of residents at end of life were protected, and representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care. Support was given to other residents and to staff following the deaths of residents.
At the time of the inspection, Do Not Attempt Resuscitation orders were evidenced in clinical files. They were placed at the front of the files and highlighted to all relevant members of staff.

There had been two deaths of residents of the approved centre since the last inspection, and these had been notified to the Mental Health Commission within the required 48-hour time frame.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 15: Individual Care Plan

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in February 2017. It included all of the requirements of the Judgement Support Framework.

Training and Education: All clinical staff had not signed a log indicating that they had read and understood the policy. All clinical staff interviewed could not articulate the processes relating to individual care planning. All multi-disciplinary team (MDT) members had not received training in individual care planning.

Monitoring: ICPs were audited on a quarterly basis to assess compliance with the regulation. Analysis had been completed to identify opportunities for improving the individual care planning process and an action plan was put in place.

Evidence of Implementation: The clinical files of 30 residents were inspected. Six of these did not contain ICPs. The storage of documentation in the other 24 ICPs was disorganised. Three ICPs had been placed in a plastic folder rather than in the relevant clinical files. A number of ICPs were misfiled within clinical files. In each of the files inspected, residents received a comprehensive assessment at admission, which was recorded in a nursing admission pro forma booklet, and an initial care plan was drawn up. Evidence-based assessments were used where possible.

In eight cases, the ICP was not developed by the multi-disciplinary team (MDT) within seven days of admission. Family input was not recorded in six ICPs and four did not record resident involvement in the care planning process. In nineteen ICPs, it was not recorded that residents had not received a copy of their ICPs and a reason for this was recorded in only eight ICPs. Three ICPs did not detail residents’ assessed needs. Five ICPs did not detail appropriate goals for residents, and three did not identify the care and treatment required to meet the goals identified. Six ICPs did not identify the resources required to provide the care and treatment identified.

In all of the clinical files inspected, a key worker was identified to ensure continuity in the implementation of an ICP. The ICPs were reviewed by the MDT weekly.
The approved centre was not compliant with this regulation for the following reasons:

a) Six residents did not have an ICP.
b) ICPs were not recorded in one composite set of documentation.
c) Not all ICPs identified the necessary resources or specified appropriate goals for the residents.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was dated February 2017. It addressed requirements of the Judgement Support Framework, with the exception of the facilities for providing therapeutic services and programmes.

Training and Education: All clinical staff had not signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes for therapeutic activities and programmes, as set out in the policy.

Monitoring: The range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents’ assessed needs were met. Analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes, and an action plan was put in place.

Evidence of Implementation: Thirty clinical files were inspected, and these indicated that the range of available, evidence-based programmes was appropriate to the assessed needs of residents, as outlined in their individual care plans. Therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Residents had access to occupational therapy, social work, and clinical psychology on an individual basis, as required. Dietetics, physiotherapy, and speech and language therapy were also provided when required.

A list of all therapeutic services and programmes provided in the approved centre was available in the form of a weekly timetable and daily notices in each unit. The activities included art therapy, recovery, relaxation, baking, healthy eating, walking group, newspaper review, creative writing, exercise, and communication. Therapeutic services and programmes were facilitated by an activities nurse, psychology staff, an art therapist, and community voluntary organisations.

Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes, and dedicated rooms were available for individual and group therapies, including a kitchen, a group room, an arts and crafts room, a yoga and relaxation room, and individual interview rooms. There was also a lounge area and a Snoezelen room for residents in the Psychiatry of Later Life unit.
A log was maintained of residents’ participation and engagement in therapeutic services and programmes, and outcomes achieved were documented. Where residents required a service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes and training and education pillars.
Regulation 17: Children’s Education

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

INSPECTION FINDINGS

As there had been no child admissions to the approved centre since the last inspection, this regulation was not applicable.
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 in relation to the transfer of residents, which was last reviewed in February 2017. It included requirements of the Judgement Support Framework, with the exception of the process for managing resident medications during transfer from the approved centre.

Training and Education: All relevant staff had not signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes for resident transfer, as set out in the policy.

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

Evidence of Implementation: The clinical files of two residents were inspected in relation to transfers. Both residents were transferred to another facility for treatment, and the decision to transfer was made by the registered medical practitioner and agreed with the receiving facility. Prior to the transfer, an assessment of each resident was undertaken, including a risk assessment.

The clinical files were transferred with the residents along with the medical record of referral and a summary report, and copies of all documentation relevant to the transfer were retained in the clinical files. The required information was included on the resident transfer form, and a checklist was completed to ensure that comprehensive resident records were transferred to the receiving facility.

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

(1) The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of general health care to residents, which was last reviewed in February 2017. There was also a medical emergency response policy, which was dated June 2013. Together, the policies included requirements of the Judgement Support Framework, with the exception of the following:

- The staff training requirements in relation to Basic Life Support.
- The resource requirements for general health services, including equipment needs.
- The protection of resident privacy and dignity during general health assessments.
- The documentation requirements in relation to general health assessments.
- The provisions for accessing national screening programmes through the approved centre.

Training and Education: All clinical staff had not signed a log indicating that they had read and understood the policy. Clinical staff interviewed could articulate the processes for providing general health services and responding to medical emergencies, as set out in the policy.

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

Evidence of Implementation: Each unit in the approved centre had a resuscitation trolley and an Automated External Defibrillator, and these were checked weekly. Records were available of any medical emergency that occurred in the approved centre and of the care provided.

Five residents had been in the approved centre for over six months, and one of these had not received a six-monthly general health check. There was no system for organising six-monthly physicals, and records of residents’ completed health checks and the associated results were not consistently maintained.
Residents received appropriate general health care as indicated in their individual care plans. They could access general health services or be referred to other health services, as required. Residents also had access to age- and gender-appropriate national screening programmes, but no information was provided in relation to the programmes available through the approved centre.

The approved centre was not compliant with this regulation because one resident had not received a six-monthly general health assessment, 19(1)(b).
Regulation 20: Provision of Information to Residents

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to the provision of information to residents, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of the methods for providing information to residents with specific communication needs.

Training and Education: All staff had not signed a log indicating that they had read and understood the policy. Staff interviewed could articulate the procedure for providing information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure the information was appropriate and accurate. Analysis was completed to identify opportunities to improve the processes for providing information to residents. This is documented.

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

Residents were provided with information on their multi-disciplinary team. They also had access to a large diagnosis folder containing evidence-based written information about their diagnosis, unless, in the view of the treating psychiatrist, the provision of such information might be prejudicial to a resident’s physical or mental health. Diagnosis- and medication-related information, including risks and potential side-effects, was readily available, and medication leaflets were in an easy-to-read, uncomplicated, and user-friendly format. Where necessary, residents had access to interpretation and translation services.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
Regulation 21: Privacy

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of the following:

- The approved centre’s layout and furnishing requirements to support resident privacy and dignity.
- The process applied where resident privacy and dignity were not respected by staff.

Training and Education: All staff had not signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

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

Evidence of Implementation: Residents were addressed by their preferred names, and staff members were observed to be courteous and respectful to residents. Staff were appropriately dressed, sought permission before entering residents’ rooms, and conducted all conversations relating to residents’ clinical and therapeutic needs in private. Residents were observed to be wearing clothing that respected their privacy and dignity.

Bathrooms, showers, toilets, and single rooms had locks on the inside of the doors, and these had an override facility. Most of the accommodation comprised single, en suite rooms. There were also two double bedrooms, and adequate and suitable screening was in place between the beds to ensure privacy. Windows and observation panels in doors had appropriate screening. Noticeboards did not display identifiable resident information, and residents were facilitated in making and taking private phone calls.

The approved centre’s internal courtyard was overlooked by nearby houses. This was an ongoing concern since the 2016 inspection. The inspection team was informed that the estates department intended to erect privacy screening to address the issue.

The approved centre was not compliant with this regulation because the internal courtyard was overlooked by nearby houses, which did not afford privacy to residents.
Regulation 22: Premises

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

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

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

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

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the premises, which was last reviewed in October 2016. The policy included requirements of the Judgement Support Framework, with the exception of the approved centre’s utility controls and requirements and its provision of adequate and suitable furnishings.

Training and Education: All relevant staff had not signed a log indicating that they had read and understood the policy. Relevant staff interviewed were unable to articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had completed hygiene and ligature audits. Analysis had been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre’s physical environment provided an opportunity for residents to maintain and improve their mental and general health, with adequate indoor and outdoor spaces available. Residents had access to personal space, including suitable accommodation, and to shared space in the form of bright communal rooms. Communal areas were adequately lit to facilitate reading and other activities. Rooms were bright, comfortably heated, and ventilated, and they were suitably sized and furnished to suit the residents’ needs. Appropriate signage was in place to support resident orientation needs. Hazards were minimised, and a recent ligature audit had identified and risk-rated potential ligature points throughout the approved centre. Where a potential risk was identified, ligature points were minimised.
The approved centre was in a good state of repair, inside and out. There was a programme of general maintenance, which was documented. A daily cleaning schedule was in place, and the approved centre was clean, hygienic, and free from offensive odours. National infection control guidelines were followed.

There were adequate toilet and bathroom facilities, including assisted needs facilities, with at least one assisted toilet per floor. There were designated sluice, cleaning, laundry, and therapy/examination rooms. Residents’ bedrooms were spacious, and furnishings throughout the approved centre supported residents’ independence and comfort. Assisted devices and/or equipment were available, where required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes and training and education pillars.
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in February 2017. It included requirements of the Judgement Support Framework, with the exception of processes for the following:

- Administering controlled drugs.
- Self-administering medication.
- Reconciling medication.
- Reviewing resident medication.

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

Monitoring: Quarterly audits of Medication Prescription and Administration Records (MPARs) were undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication issues. Analysis had been completed to identify opportunities for improving medication management, and action plans were developed.

Evidence of Implementation: An MPAR was maintained for each resident, and 19 of these were inspected. Two appropriate resident identifiers were used when medication was being administered. Names of medications were written in full, and generic names were recorded where applicable. The frequency of administration, the dosage, and the administration route for medications were recorded.

In nine of the MPARs inspected, the allergy section had not been completed. In one MPAR, the date of initiation for medication was omitted. In 13 MPARs, the date of discontinuation of medication was not recorded. In four MPARs, the Medical Council Registration Numbers (MCRNs) of the prescribing medical practitioners had not been recorded. In seven MPARs, no signature or indication of whether medication had been refused or withheld accompanied entries, making it unclear whether medication had been administered.
Residents’ medication was reviewed at weekly multi-disciplinary team meetings, and MPARs were rewritten where necessary. Where there were alterations in the medication order, the medical practitioner rewrote the prescription. Medication was administered by two registered nurses in accordance with the directions of the prescriber, and good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications.

The expiration date of the medication was not checked prior to administration and out-of-date medication was found in the drugs trolley.

Controlled drugs were checked by two staff members against the delivery form and recorded in a controlled drug book. The controlled drug balance corresponded with the balance recorded in the book. Directions to crush medication were only accepted from residents’ medical practitioner.

Medication arriving from the pharmacy was verified against the order. Where medication required refrigeration, a daily log of fridge temperatures was not maintained.

The medication trolley was locked and secured in a locked room, and scheduled controlled drugs were secured separately. Medication storage areas were free from damp and mould and were clean and well maintained. No food or drinks were stored in areas used for storing medication.

A system of stock rotation was in place, and a pharmacist from Cork University Hospital provided support to the approved centre on an as-required basis. An inventory of medications was not completed monthly.

The approved centre was not compliant with Regulation 23(1) for the following reasons:

a) Four MPARs did not record the MCRN of the prescribing practitioner.
b) In one MPAR, the date of initiation of medication was not recorded.
c) In 13 MPARs, the date of discontinuation of medication was not recorded.
d) Staff did not check the expiration date of medication prior to administration and out-of-date medication was observed on the drugs trolley.
e) In seven MPARS, it was not known whether medication had been administered.
Regulation 24: Health and Safety

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to health and safety, dated February 2017, and a safety statement. The policy and safety statement included requirements of the *Judgement Support Framework*, with the exception of details of the following:

- First aid response requirements.
- Vehicle controls.
- The monitoring and continuous improvement requirements for health and safety processes.

Training and Education: All staff had not signed a log indicating that they had read and understood the policy and safety statement. Staff interviewed were able to articulate the processes relating to health and safety, as set out in both documents.

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

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

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

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;
(b) it shall be clearly labelled and be evident;
(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;
(d) it shall be incapable of recording or storing a resident’s image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;
(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

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

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

INSPECTION FINDINGS

Processes: The approved centre had written policy in relation to the use of closed-circuit television (CCTV), which was last reviewed in February 2017. It included requirements of the Judgement Support Framework, with the following exceptions:

- Provisions in relation to the maintenance of CCTV cameras.
- The highlighting of the use of CCTV through signage and communication with residents and/or their representatives.
- The process to end monitoring of a resident using CCTV in certain circumstances.

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

Monitoring: The quality of CCTV images was not checked regularly to ensure that the system was operating appropriately. There was no evidence that analysis had been completed to identify opportunities for improving the use of CCTV.

Evidence of Implementation: There was prominent signage indicating where CCTV cameras were located in the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare. The Mental Health Commission had been informed about the approved centre’s use of CCTV.
Cameras were incapable of recording or storing a resident’s image in any format. CCTV cameras used to observe a resident did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to staffing, which was last reviewed in February 2017. This policy referred to the HSE recruitment policy. Both policies addressed requirements of the Judgement Support Framework, including the following:

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

It did not include details of the following:

- The methods used to communicate rosters to staff.
- Requirements around staff performance and evaluation.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- The required qualifications of training personnel.

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

Monitoring: There was documented evidence that the approved centre had reviewed the implementation and effectiveness of the staff training plan. The number and skill mix of staff had been assessed against the levels recorded in the approved centre’s registration. Analysis had been completed to identify opportunities for improving staffing processes and responding to the changing needs and circumstances of residents.
Evidence of Implementation: There was an organisational chart to identify the leadership and management structure and lines of authority and accountability. Planned and actual staff rotas were in place. The number and skill mix of staffing were sufficient to meet residents’ needs. Staff were recruited, selected, and vetted in line with the approved centre’s policies. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency.

The approved centre did not have a written staffing plan. However, annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile.

Orientation and induction training had been completed by staff, but not all health care professional were up to date with their training in fire safety, Basic Life Support (BLS), Professional Management of Aggression and Violence (PMAV), and the Mental Health Act (MHA) 2001.

At least one staff member was trained in Children First. Staff were trained in accordance with the assessed needs of residents, with training delivered in manual handling, infection control and prevention, dementia care, care for residents with an intellectual disability, end of life care, and risk management. Staff training was documented, and staff training logs were maintained. Resources were available to staff for further training and education, and in-house trainers were appropriately qualified. The MHA 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were available in the nursing offices in each unit.

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

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<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
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<td>HCA</td>
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</tbody>
</table>

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA)
The approved centre was not compliant with this regulation because not all health care professionals had up-to-date training in BLS, fire safety, PMAV, or the MHA 2001, 26(4) and (5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records. Entitled Maintenance of Records, it was dated February 2017. The policy addressed requirements of the Judgement Support Framework, including policies and procedures relating to the following:

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

The policy did not address the following:

- The required resident record content.
- Record review requirements.
- Privacy and confidentiality of resident records and content.

Training and Education: All clinical staff had not signed a log indicating that they had read and understood the policy. Clinical staff and other relevant staff interviewed were able to articulate the processes around creating, accessing, retaining, and destroying records in the approved centre. All clinical staff had not received training in best-practice record keeping.

Monitoring: Resident records had been audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had been conducted to identify opportunities for improving the processes relating to the maintenance of records.
Evidence of Implementation: Records were constructed, maintained and used in accordance with the Data Protection Act (1988) and (2003), the Freedom of Information Act (1997) and (2003), and national guidelines and legislative requirements.

Thirty clinical files were inspected, and these were found not to be in good order: Almost all of the files in question contained loose pages, Mental Health Act (2001) legal forms were often interspersed with individual care plans (ICPs) and progress notes, and the pockets at the back of each clinical file frequently contained loose and unsecured investigation/test reports. Additionally, the size of the clinical files made it difficult to access information in a number of instances.

Records were not developed and maintained in a logical sequence, and it was difficult to access and retrieve data. For example, the current admission record was not kept separately from previous admission notes, making it difficult to find the current admission assessment where there had been multiple admissions.

Two appropriate resident identifiers were not recorded on all documentation. Numerous ICPs noted the residents’ names only, and one ICP recorded two different spellings of the resident’s name, with no other person-specific identifier used. Not all ICPs were dated.

Records were appropriately secured throughout the approved centre. Clinical files were secured in lockable filing cabinets in the nursing offices on each unit or, when not in use, in the medical records office. Records were initiated for every resident and were reflective of the care and treatment being provided. Residents’ records were accessible to authorised staff only, and only authorised staff made entries in them.

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

The approved centre was not compliant with this regulation because not all resident records were maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval, 27(1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It did not contain all of the required information listed in Schedule 1 of the Mental Health Act 2001. Specifically, it did not record residents’ gender.

The approved centre was not compliant with this regulation because the register of residents did not include the gender of residents, as required under Schedule 1 of the Mental Health Act 2001.
Regulation 29: Operating Policies and Procedures

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the development and review of operating policies and procedures, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of processes for the following:

- Collaboration between clinical and managerial teams to provide relevant and appropriate information within the operating policies and procedures.
- Dissemination of operating policies and procedures.
- Making obsolete and retaining previous versions of policies and procedures.
- The standardised layout for operating policies and procedures.

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

Monitoring: There was no documentary evidence that an annual audit was undertaken to determine compliance with review time frames. Analysis had not been completed to identify opportunities for improving the process of developing and reviewing policies.

Evidence of Implementation: Operating policies and procedures, which incorporated relevant legislation, evidence-based best practice, and clinical guidelines, were communicated to all relevant staff. Operating policies and procedures were appropriately approved before being implemented.

Operating policies and procedures were not developed with input from managerial staff. Not all policies and procedures required by the regulations had been reviewed at least every three years. The policies and procedures for responding to medical emergencies, under Regulation 19: General Health, had not been reviewed since 2013. Operating policies and procedures were not presented in a standardised format.

The approved centre was not compliant with this regulation because the medical emergencies policy had not been reviewed at least every three years.
Regulation 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

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

Training and Education: All relevant staff had not signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the process for facilitating Mental Health Tribunals, as set out in the policy.

Monitoring: There was documentary evidence that analysis had been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: To support the tribunal process, the approved centre provided a dedicated tribunal room, waiting room, and bathroom facilities. Adequate resources were provided in support of the tribunal process. Staff assisted and supported residents to attend and participate in Mental Health Tribunals, where necessary.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

- The communication of the complaints policy and procedures to residents, their representatives, family, next of kin, and visitors.
- The time frames for complaint management.
- The appeal process available where a complainant was dissatisfied with the outcome of the complaint investigation.

Training and Education: All staff had not signed a log indicating that they had read and understood the policy. All relevant staff had not received formal training on complaints management processes. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policy.

Monitoring: There was no documented evidence that audits of the complaints log were completed. Complaints data had not been analysed for the purpose of identifying and implementing required actions to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated complaints officer in the approved centre, and all complaints were dealt with in a consistent and standardised manner. The ways in which residents and their representatives could lodge verbal or written complaints were detailed in the complaints policy. The approved centre’s management of complaints processes was well publicised and accessible to residents.
and their representatives. Information on complaints procedures was included in the resident information booklet and in notices in the approved centre.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

A method for addressing minor complaints in the approved centre was in place, and minor complaints were documented. Where minor complaints could not be addressed locally, they were dealt with by the nominated person. All non-minor complaints were addressed by the complaints officer and recorded in the complaints log. Details of complaints, subsequent investigations, and outcomes were fully documented and kept distinct from the resident’s individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring.
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 written policy in relation to risk management procedures, which was last reviewed in February 2017. It addressed requirements of the Judgement Support Framework, including processes for the following:

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

The policy did not specify the responsibilities of the registered proprietor or the process for maintaining and reviewing the risk register.

Training and Education: All relevant staff had signed a log indicating that they had read and understood the policy. Staff interviewed were able to articulate the risk management processes, as set out in the policy. Relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management, and management staff were trained in organisational risk management. All staff had been not received training in incident reporting and documentation.
Monitoring: The risk register had not been audited at least quarterly to determine compliance with the approved centre’s risk management policy. All incidents in the approved centre were recorded and risk rated. Analysis of incident reports was completed to identify opportunities for improvement of risk management processes.

Evidence of Implementation: The approved centre had a designated risk manager, and responsibilities were allocated at management level to ensure the effective implementation of risk management. Risk management procedures actively sought to reduce identified risks to the lowest practical level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register. Health and safety risks were identified, assessed, treated, reported, and monitored, and structural risks, including ligature points, were removed or mitigated.

An examination of 25 clinical files indicated that the approved centre completed resident risk assessments at admission to identify individual risk factors. Assessments were also completed before and during the use of physical restraint, prior to resident transfer and discharge, and in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) had input into the development, implementation, and review of risk management processes, as did residents and/or their representatives. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

Incidents were recorded and risk-rated using a standardised form, and clinical incidents were reviewed by the MDT at weekly meetings. Six-monthly summary reports of all incidents were forwarded to the Mental Health Commission. The approved centre had an emergency plan that included evacuation procedures.

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

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

INSPECTION FINDINGS

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

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

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

**INSPECTION FINDINGS**

The approved centre had an up-to-date certificate of registration, which was prominently displayed in the entrance/reception area of the approved centre.

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

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

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.

The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

### INSPECTION FINDINGS

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

Mental Health Act 2001
Bodily restraint and seclusion

Section 69

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

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

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

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

INSPECTION FINDINGS

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

Mental Health Act 2001  
Bodily restraint and seclusion  
Section 69

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

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

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

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

### INSPECTION FINDINGS

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of two residents who had been in the approved centre for more than three months and in continued receipt of medication were examined. The first patient had been assessed by the responsible consultant psychiatrist as having the capacity to consent and had signed a Consent to Continuous Administration of Medication Form. It detailed the following:

- The name of the medications prescribed.
- Confirmation of the patient’s ability to understand the nature, purpose, and likely effects of the medication(s).
- Details of discussions with the patient.
- Supports provided to the patient in relation to the discussion and their decision-making.
The second patient had been deemed unable to consent to treatment following a capacity assessment. A Form 17: Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent had been completed, and a copy of same was in the clinical file. It detailed the following:

- The name(s) of the medication prescribed.
- Confirmation of an assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medication.
- Discussions with the patient in terms of the nature and purpose and effects of the medication.
- Views expressed by the patient.
- Supports provided to the patient in terms of the discussion and their decision-making process.
- Authorisation by a second consultant psychiatrist.

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

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

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

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

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

Processes: The approved centre had a written policy on the use of physical restraint. Entitled *Prevention and Management of Violence and Aggression*, it was dated January 2017. The policy addressed the provision of information to residents and the training requirements in relation to the use of physical restraint, including details of those who should receive training, areas to be addressed during training, alternatives to the use of physical restraint, and the mandatory nature of training. The policy did not identify those authorised to initiate and implement restraint or address the frequency of training. It did not include the child protection process, in the event that a child was restrained.

Training and Education: There was no written record to indicate that all staff involved in the use of physical restraint had read and understood the policy. A record of staff attendance at training on the use of physical restraint was maintained. Restraint was never used to ameliorate staff shortages.

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

Evidence of Implementation: The files of three residents were examined in relation to physical restraint. These indicated that the use of physical restraint was exceptional and had been initiated by staff to prevent immediate and serious harm to the residents or others. Physical restraint was initiated after staff had first considered other interventions and following a risk assessment. The episodes of physical restraint were not prolonged beyond the period necessary. Gender sensitivity was demonstrated during each episode of physical restraint.

In each case, the consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner reviewed the residents within three hours of the start of physical restraint and conducted a physical examination. The consultant psychiatrist signed and dated the clinical practice forms within 24 hours. There was documentary evidence that members of the multidisciplinary team reviewed the episodes of physical restraint within two working days.

The approved centre was not compliant with this code of practice for the following reasons:

a) The policy did not identify those authorised to initiate and implement physical restraint, 9.2.

b) The policy did not include the child protection process, in the event that a child was restrained, 11.3.

c) The policy did not identify the frequency of training, 10.1(c).

d) There was no written record indicating that all staff involved in physical restraint had read and understood the policy, 9.2(b) and 9.2(c).
### 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 no child had been admitted to the approved centre since the last inspection, this code of practice was not applicable.

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**NOT APPLICABLE**
Notification of Deaths and Incident Reporting

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

INSPECTION FINDINGS

Processes: The approved centre had a risk management policy in place in relation to the notification of deaths and incident reporting to the Mental Health Commission (MHC), dated February 2017: *Care of the Dying and Sudden Death in an Approved Centre*. The policy met all the criteria of this code of practice. It specified the risk manager, and it outlined the roles and responsibilities of staff in relation to the following:

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

Training and Education: Staff interviewed were able to articulate the processes relating to the notification of deaths and incident reporting.

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

Evidence of Implementation: The approved centre was compliant with Regulation 32: Risk Management Procedures. It had an incident reporting system in place and used a standardised incident report form. A six-monthly summary of all incidents was sent to the MHC.

There had been two deaths of resident(s) of the approved centre since the last inspection, and these had been notified to the MHC within the required 48-hour time frame.

The approved centre was compliant with this code of practice.
INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to working with people with an intellectual disability and a separate policy on the management of problem behaviours. The policies reflected person-centred treatment planning, presumption of capacity, and least restrictive interventions. They contained details of the following:

- The roles and responsibilities of staff.
- The process for ensuring appropriate and relevant communication and liaison with relevant external agencies.

The policies did not contain procedures for the training of staff in working with people with an intellectual disability.

Training and Education: Staff had received training in person-centred approaches, relevant human rights principles, and preventative and responsive approaches to problem behaviours.

Monitoring: The policies had been reviewed within the required three-year time frame. There was no evidence that the use of restrictive practices was reviewed periodically.

Evidence of Implementation: During the inspection, there was one resident in the approved centre who was diagnosed with an intellectual disability. There was an appropriate individual care plan in place, which included details of the following:

- The levels of support and treatment required.
- Assessed needs and available resources and supports.
- Consideration of the environment.

The resident had a comprehensive assessment. This included an evaluation of performance capacities and difficulties; communication issues; medication history; medical, psychiatric, and psychosocial history; and social, interpersonal, and physical environment issues. The resident’s preferred way of giving and receiving information was established, and information provided was appropriate and accessible. Opportunities were made available for the resident’s engagement in meaningful activities.

The approved centre was not compliant with this code of practice for the following reasons:
a) The policies did not include procedures for the training of staff in working with people with an intellectual disability, 6.2.
b) There was no evidence that the use of restrictive practices was periodically reviewed, 5.3(b).
Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

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

INSPECTION FINDINGS

As the approved centre did not use Electro-Convulsive Therapy, this code of practice was not applicable.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

Processes: The approved centre had separate policies in relation to admission, transfer, and discharge, all dated February 2017.

Admission: The admission policy included all of the criteria of this code of practice, including processes relating to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. It contained protocols for urgent referrals, self-presentation individuals, and timely communication with primary care teams. There was a policy on confidentiality, privacy, and consent.

Transfer: The transfer policy included all of the criteria of this code of practice. It detailed how a transfer was arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary and emergency transfer and transfer abroad, and it addressed the safety of the resident and staff during a transfer.

Discharge: The discharge policy addressed prescriptions and supply of medication on discharge and documented the roles and responsibilities of staff in relation to providing follow-up care. Details were included of when and how much follow-up contact residents should have and of relapse prevention strategies and crisis management. Procedures were included for managing discharge against medical advice and discharging people with an intellectual disability and older persons. The policy did not include procedures for managing the discharge of involuntary patients or following up and managing missed appointments.

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

Monitoring: There was no documented evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.

Evidence of Implementation:

The admission, transfer, and discharge processes were compliant under Regulation 32: Risk Management Procedures.
**Admission:** A review of 30 clinical files in individual care plans indicated that the approved centre had a key worker system in place and the entire MDT record was contained in a single clinical file. Admission was made on the basis of mental illness or disorder, and the decision to admit was taken by the registered medical practitioner (RMP). A comprehensive nursing admission assessment was completed and documented in all of the clinical files inspected, and assessments and examinations were documented in the clinical files. Family members/carers were involved in the admission process. Residents were admitted to the unit most appropriate to their needs.

The approved centre’s admission process was compliant under Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, and Regulation 20: Provision of Information to Residents.

The admission process was not compliant under Regulation 15: Individual Care Plan and Regulation 27: Maintenance of Records.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents. The files of two recently transferred residents were inspected. The decision to transfer was made by the RMP and a pre-transfer assessment was undertaken. Family members/carers/advocates were involved in the transfer process, as were members of the MDT. Referral letters were sent to the receiving facility, and copies were retained in the clinical files. One case was the transfer of an involuntary patient, and the appropriate Form 10: Notice of Patient Transfer to Another Approved Centre (Other than the Central Mental Hospital) had been completed in accordance with the Mental Health Act 2001.

**Discharge:** The files of two recently discharged residents were inspected. In each case, the decision to discharge was taken by the RMP. Both files indicated that the residents had a comprehensive assessment prior to their discharge and that there was appropriate MDT input into discharge planning. In both cases, the discharge was coordinated by the key worker. Efforts were made to inform primary care/community mental health care teams of the discharge within 24 hours, and preliminary discharge summaries were issued within three days. Both files evidenced the involvement of family/carers/advocates in the discharge process.

The approved centre was not complaint with this code of practice for the following reasons:

a) The discharge policy did not reference the discharge of involuntary patients, 4.2.

b) The discharge policy did not detail a way of following up and managing missed appointments, 4.14.

c) There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge, 9.1.

d) There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission or discharge policies, 4.19.

e) The admission process was non-compliant under Regulation 15: Individual Care Plan, 17.1.

f) The admission process was non-compliant under Regulation 27: Maintenance of Records, 22.6.
### Appendix 1 – Corrective and Preventative Action Plan

**Regulation 15: Individual Care Plan**

*Report reference: Page 32-33*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taken from the inspection report</strong></td>
<td><strong>Reoccurring(^1) or New(^2) area of non-compliance</strong></td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>1. Six residents did not have an ICP.</td>
<td>New</td>
<td>Corrective Action(s): Review all clients to ascertain that they have an ICP</td>
<td>Monthly Audit: CNM2 will complete monthly audit to ensure all clients have an ICP</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: CNM3, Ms Michelle Murphy and ward CNM2’s</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Review all clients monthly to ensure that they all have an ICP and follow up if not with team.</td>
<td>Monthly Audit: CNM2 will complete monthly audit to ensure all clients have an ICP</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: CNM3, Ms Michelle Murphy and ward CNM2’s</td>
<td>Audit reviewed at the Management meetings.</td>
<td></td>
</tr>
<tr>
<td>2. ICPs were not recorded in one composite set of documentation.</td>
<td>New</td>
<td>Corrective Action(s): Review all clients to ascertain that they have an ICP. Following inspection, James O Mahony ADON emailed (19-05-2017, attached) Madeline Murnane Staff Officer in relation to MHC inspection findings pertaining to files. Meeting held with same, ward clerk and Michelle Murphy CNM3 of unit to devise a system/protocol regards ensuring that files were kept in a logical sequence, and ICP are recorded in one composite set of documentation. Protocol devised and awaiting sign off. Ward clerk</td>
<td>Monthly Audit: CNM2 will complete monthly audit to ensure all clients have an ICP</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Immediate on ongoing monthly audits. Sign off of protocol week of Monday 28th August</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Area of non-compliance reoccurring from 2016

\(^2\) Area of non-compliance new in 2017
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
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</tr>
</thead>
<tbody>
<tr>
<td>and CNM’s reviewing all client files on unit to ensure compliance and continued compliance</td>
<td>完成了所有客户的文件审查，以确保遵守并持续遵守。</td>
<td>成功</td>
<td>成功</td>
<td>完成并持续每周。</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: CNM3, Ms Michelle Murphy and ward CNM2’s</td>
<td>预防措施(s):</td>
<td>月度审核: CNM2将完成每月审核，以确保所有客户都有ICP。审核将在管理会议上进行。</td>
<td>成功</td>
<td>9月2017年</td>
</tr>
<tr>
<td>Preventative Action(s): Review all clients monthly to ensure that they all have an ICP and follow up if not with team.</td>
<td>月度审核: CNM2将完成每月审核，以确保所有客户都有ICP。审核将在管理会议上进行。</td>
<td>成功</td>
<td>成功</td>
<td>9月2017年</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: CNM3, Ms Michelle Murphy and ward CNM2’s</td>
<td></td>
<td>月度审核: CNM2将完成每月审核，以确保所有客户都有ICP。审核将在管理会议上进行。</td>
<td>成功</td>
<td>9月2017年</td>
</tr>
<tr>
<td>3. Not all ICPs identified the necessary resources or specified appropriate goals for the residents.</td>
<td>预防措施(s):</td>
<td>季度审核</td>
<td>成功</td>
<td>立即</td>
</tr>
<tr>
<td>CNM2’s identified all client notes where goals and resources are not clearly identified and ADON James O Mahony/ Michelle Murphy CNM3 will meet with all MDT teams to discuss same and following monthly audit James O Mahony ADON/ Michelle Murphy CNM3 will meet with teams to highlight difficulties and support adherence to ICP document completion. Further teaching sessions on the ICP to be delivered for all MDT staff. These will specifically include goals, required interventions. Resources required will be identified on the ICP. To be included in staff induction pack for all MDT staff. The ICP reference guide to be taken to MDT meetings.</td>
<td>季度审核</td>
<td>成功</td>
<td>成功</td>
<td>立即</td>
</tr>
<tr>
<td>Post-holder(s): CNM3, CNM2, ADON, NCHD, S/N, Psychology, OT and SW.</td>
<td>预防措施(s):</td>
<td>季度审核</td>
<td>成功</td>
<td>立即</td>
</tr>
<tr>
<td>Preventative Action(s): Quarterly monitoring and auditing of ICP audit against the JSF requirements for regulation 15 (MHC, 2017).</td>
<td>季度审核</td>
<td>成功</td>
<td>成功</td>
<td>NCHD Dr Grozdana or designate will complete monthly audit in collaboration with identified staff nurses on the ward</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
<td>Measureable</td>
<td>Achievable / Realistic</td>
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<td>from September 2017.</td>
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<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>4. One resident had not received a six-monthly general health assessment.</td>
<td>New</td>
<td>Corrective Action(s): Review of all residents six-monthly general health assessment undertaken on the unit by the Assistant Director of Nursing and Clinical Nurse Manager 3, following inspection and again in June, July and August and all resident in the unit 6 months and over have had six-monthly general health assessment as of August 16th 2017. Post-Holder(s) responsible: Assistant Director of Nursing Dr James O Mahony and Clinical Nurse Manager 3, Ms Michelle Murphy</td>
<td>Review of all residents six monthly general health assessment has been undertaken in June, July and August. All residents have now had six monthly health assessment as at 16th Augst 2017. This objective has been achieved</td>
<td>Complete 16.08.2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): All clients on the unit will be reviewed in terms of length of time on the unit at the Delayed Discharge Meetings held every 2 months. The names of clients and length of stay is forwarded to the Chair of the group and at the group, clients over 5 months will be identified and the Social Worker on the group will liaise with the CNM2’s/ Team to ensure 6 monthly general health assessment is completed. Post-Holder(s) responsible: Ms Jayne Crowley or designate, Social Worker and Clinical Nurse Manager 2 on duty.</td>
<td>Minutes of Delayed Discharge Meetings will be available to the MHC Inspection teams which will demonstrate that review of clients 6 months or over on the unit. Achievable</td>
<td>From next meeting in September 2017</td>
</tr>
</tbody>
</table>
## Regulation 21: Privacy

**Report reference: Page 42**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td><strong>5.</strong> The internal courtyard was overlooked by nearby houses, which did not afford privacy to residents.</td>
<td>Reoccurring since 2015</td>
<td>Corrective Action(s): Privacy screen being erected by estates to shield garden from being overlooked. Post-Holder(s) responsible: Engineer, CNM3, ADON.</td>
<td>Email from engineer confirming date of completion available for review.</td>
<td>Achievable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Quarterly audit against the JSF requirements for regulation 21 (MHC, 2017). Post-holder(s): CNM3, CNM2, NCHD, S/N, Psychology, OT and SW.</td>
<td>Quarterly Audits</td>
<td>Achievable</td>
</tr>
</tbody>
</table>
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

Report reference: Page 45-46

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>6. Four MPARs did not record the MCRN of the prescribing practitioner.</td>
<td>New</td>
<td>Corrective Action(s): Information session regards policy and procedure for best practice. Post-Holder(s) responsible: Dr Eamonn Maloney Clinical Director</td>
<td>Included in NCHD induction training in July 2017</td>
<td>Achievable</td>
</tr>
<tr>
<td>7. In one MPAR, the date of initiation of medication was not recorded.</td>
<td>Preventative Action(s): Training Sessions for prescribing practitioners and nurses administering medication 6 monthly. Monthly monitoring and auditing against the JSF requirements for regulation 23 (MHC, 2017). Post-Holder(s) responsible: Dr Eamonn Maloney Clinical Director or designate for prescribing practitioners and Ms Michelle Murphy CNM3 and Dr James O Mahony ADON for nursing staff.</td>
<td>Training materials Monthly Audits</td>
<td>Achievable</td>
<td>September 2017</td>
</tr>
<tr>
<td>8. In 13 MPARs, the date of discontinuation of medication was not recorded.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>9. In seven MPARS, it was not known whether medication had been administered.</td>
<td>New</td>
<td>Corrective Action(s): All medications checked for expiry date following inspection. Post-Holder(s) responsible: Pete Tinsley CNM2</td>
<td>Medication reviewed on drug trolley and in storage.</td>
<td>Achievable</td>
</tr>
<tr>
<td>10. Staff did not check the expiration date of medication prior to administration and out-of-date medication was observed on the drugs trolley.</td>
<td>Preventative Action(s): System devised where medication expiry dates are checked weekly by nursing staff and a record signed that this has taken place.</td>
<td>Signed log pertaining to weekly check by registered nurse</td>
<td>Achievable</td>
<td>August 2017</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: CNM2/ CNM</td>
<td>Change in process documented in policy</td>
<td></td>
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</tbody>
</table>
### Regulation 26: Staffing

#### Report reference: Page 50-52

<table>
<thead>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
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11. **Not all health care professionals had up-to-date training in BLS, fire safety, PMAV, or the MHA 2001.**

   **Reoccurring since 2016**

   **Corrective Action(s):**
   - There will be a training needs analysis for all staff completed for 2017.
   - Heads of discipline to continue to endeavour to ensure that staff have up to date mandatory training.

   **Post-Holder(s) responsible:**
   - Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine

   **Preventative Action(s):** Quarterly audit against the JSF requirements (MHC, 2017).

   **Post-holder(s):** Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine

   **Achievable**

   **October 2017**
### Area(s) of non-compliance

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<tr>
<td>12. Not all resident records were maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval.</td>
<td>Reoccurring since 2015</td>
<td><strong>Corrective Action(s):</strong> Following inspection, James O Mahony ADON emailed (19-05-2017, attached) Madeline Murnane Staff Officer in relation to MHC inspection findings pertaining to files. Meeting held with same and ward clerk to devise a system/protocol regards ensuring that files were kept in a logical sequence, data was filed consistent with ease of access, and that this was undertaken daily and signed for. Protocol devised and awaiting sign off. In relation to resident identifiers, resident names and dated ICP’s, CNM3 Michelle Murphy has reviewed all files on the ward and all ICP’s now have all required information and are dated. This will be monitored by monthly audit with medicine and nursing identified to undertake same at the MDT audit committee meeting.</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
<td>Email sent 19-05-2017, meeting completed, protocol final draft completed and awaiting sign off week of 28th August 2017. All files reviewed in relation to names and dated completed by CNM3 Michelle Murphy. Monthly Audits commenced with next audit scheduled for week of 28th August 2017 with intern doctors identified to undertake same this month.</td>
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<tr>
<td>Corrective Action(s): (a) New method of shelving and storing the clinical files is being planned.</td>
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<td>Achievable</td>
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<tr>
<td>(b) A review of the quality of the materials used is being undertaken.</td>
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<td>Achievable</td>
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<td></td>
<td>Post-holder(s): Ward Clerk, CNM3, CNM2 and all MDT staff with access to clinical records.</td>
<td>Audits will be undertaken on a quarterly basis.</td>
<td>Achievable</td>
<td>Quarterly Audit September 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Quarterly audit against the JSF requirements (MHC, 2017). Post-holder(s): CNM, Principal SW, CD, OT, ADON and psychology and ward clerk.</td>
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</table>
### Regulation 28: Register of Residents

#### Report reference: Page 55

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<tr>
<td>13. The register of residents did not include the gender of residents.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): New resident register has been ordered to add gender to the list of information taken for the register. The current separate male and female register will be discontinued. Post-holder(s): CNM 3 Ms Michelle Murphy</td>
<td>Email available to demonstrate same ordered. Also register will be available for review on inspection.</td>
<td>Achieved</td>
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<td></td>
<td></td>
<td>Quarterly audit against the JSF requirements (MHC, 2017). Post-holder(s): CNM 2 Ms Lucy Helen</td>
<td>Quarterly audit against the JSF requirement.</td>
<td>Achievable</td>
</tr>
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<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>Preventative Action(s): Quarterly audit against the JSF requirements (MHC, 2017). Post-Holder(s) responsible: Nursing Michelle Murphy CNM3; Dr Eamonn Maloney Medicine</td>
<td>Quarterly audits against the JSF requirements. Quarterly audits against the JSF requirements.</td>
<td>The Medical Emergencies policy will be available for inspection.</td>
<td>Achievable</td>
<td>Quarterly audits</td>
</tr>
</tbody>
</table>
### Code of Practice: The Use of Physical Restraint

**Report reference: Page 72**

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<td>Provide details of any barriers to the implementation of the action(s)</td>
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<tr>
<td>15. The policy did not identify those authorised to initiate and implement physical restraint.</td>
<td>New</td>
<td>Corrective Action(s): Policy reviewed and amended. Post-Holder(s) responsible: HOD and Ms Micheel Murphy CNM3/ James O Mahony ADON Jayne Crowley Social Work</td>
<td>The Use of Physical Restraint Policy has been amended and will be available for inspection once signed off by Clinical Director.</td>
<td>Achievable</td>
</tr>
<tr>
<td>16. The policy did not include the child protection process, in the event that a child was restrained.</td>
<td>New</td>
<td>Preventative Action(s): Quarterly audits Post-Holder(s) responsible: HOD and Ms Micheel Murphy CNM3/ James O Mahony ADON Jayne Crowley Social Work</td>
<td>Quarterly audits</td>
<td>Achievable</td>
</tr>
<tr>
<td>17. The policy did not identify the frequency of training.</td>
<td>New</td>
<td>Corrective Action(s): All HOD of discipline have informed their staff to read and sign that they have read and understand policy. Quarterly audit Post-Holder(s) responsible: Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine</td>
<td>Quarterly audits</td>
<td>Achievable</td>
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<tr>
<td>18. There was no written record indicating that all staff involved in physical restraint had read and understood the policy.</td>
<td>New</td>
<td>Preventative Action(s): Quarterly audits Post-Holder(s) responsible: Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine</td>
<td>Quarterly Audit</td>
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<tr>
<td><strong>19.</strong> The policies did not include procedures for the training of staff in working with people with an intellectual disability.</td>
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<td></td>
<td>Reoccurring since 2016</td>
<td>Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
<td>Achievable</td>
<td>September 2017</td>
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<tr>
<td></td>
<td>Corrective Action(s): Policy reviewed and amended. Post-Holder(s) responsible: Ms Michelle Murphy CNM3 &amp; HOD Preventative Action(s): Quarterly audits Post-Holder(s) responsible: Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine</td>
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<td>Quarterly Audits</td>
<td>Achievable</td>
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<td><strong>20.</strong> There was no evidence that the use of restrictive practices was periodically reviewed.</td>
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<tr>
<td>New</td>
<td>Corrective Action(s): Policy reviewed and amended All HOD to email staff regards addressing at ICP meetings and document same in ICP Post-Holder(s) responsible: Dr James O Mahony ADON; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine Preventative Action(s): Quarterly audits Post-Holder(s) responsible: Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine</td>
<td>Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities</td>
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<td>September 2017</td>
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### Code of Practice: Admission, Transfer and Discharge

**Report reference: Page 78-79**

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<td>21. The discharge policy did not reference the discharge of involuntary patients.</td>
<td>New</td>
<td>Corrective Action(s): Discharge Policy has been reviewed and amended. Post-Holder(s) responsible: Ms Jayne Crowley Social Worker and HOD</td>
<td>To be finalised at next Policy Committee Meeting in September</td>
<td>Achievable</td>
</tr>
<tr>
<td>22. The discharge policy did not detail a way of following up and managing missed appointments.</td>
<td>New</td>
<td>Preventative Action(s): Quarterly audits Post-Holder(s) responsible: Ms Jayne Crowley Social Worker and HOD</td>
<td>Quarterly audits</td>
<td>Achievable</td>
</tr>
<tr>
<td>23. There was no documentary evidence that all staff had read and understood the policies on admission, transfer, and discharge.</td>
<td>New</td>
<td>Corrective Action(s): Nursing complete Occupational Therapy Complete Other disciplines actively following up. Post-Holder(s) responsible: Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine Preventative Action(s): Quarterly audits Post-Holder(s) responsible: Nursing Michelle Murphy CNM3; James Creasy OT manager; David Hughes Social Work Manager; Dr Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine</td>
<td>Quarterly Audits</td>
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<td>Edgar Lonergan Psychology Manager; Dr Eamonn Maloney Medicine</td>
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<tr>
<td>24. There was no documentary evidence that an audit had been completed on the implementation of and adherence to the admission or discharge policies.</td>
<td>New</td>
<td>Corrective Action(s): CNM3 Ms Michelle Murphy to conduct audit</td>
<td>Quarterly Audits</td>
<td>Achievable</td>
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<td></td>
<td>Post-Holder(s) responsible: CNM3 Ms Michelle Murphy</td>
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<td>Preventative Action(s): Quarterly audits</td>
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<td>Post-Holder(s) responsible: Michelle Murphy CNM3 and ward CNM2's</td>
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