

Mental Health Services 2015

Inspection of 24-Hour Nurse-Staffed Community Residences

COMMUNITY HEALTHCARE ORGANISATION	Area 2
MENTAL HEALTH SERVICE	Galway, Roscommon
RESIDENCE	Knockroe House, Castlerea
TOTAL NUMBER OF BEDS	14
TOTAL NUMBER OF RESIDENTS	10
TEAM RESPONSIBLE	Sector
TYPE OF INSPECTION	Unannounced
DATES OF INSPECTION	16 & 17 April 2015 8 June 2015
16 & 17 APRIL 2015 INSPECTED BY	Dr. Fionnuala O'Loughlin MCN 008108, Acting Inspector of Mental Health Services Dr. Enda Dooley MCN004155, Assistant Inspector of Mental Health Services Orla O'Neill, Assistant Inspector of Mental Health Services
8 JUNE 2015 INSPECTED BY	Dr. Fionnuala O'Loughlin MCN 008108, Acting Inspector of Mental Health Services Orla O'Neill, Assistant Inspector of Mental Health Services

Summary

- An inspection of Knockroe House, a 14-bed community residence in Castlerea, Co. Roscommon, was initiated on foot of anonymous information received by the Mental Health Commission (MHC). The information received was of such concern that the Chief Executive (CE) of the MHC requested the Acting Inspector of Mental Health Services to conduct an unannounced inspection. This inspection took place on 16 and 17 April 2015. Two further anonymous complaints were also received by the MHC relating to Knockroe House since the initial complaint. A follow-up inspection took place on 8 June 2015 to ascertain what steps the service had undertaken following the inspection of 16 and 17 April 2015.

Findings relating to the Inspection, April 2015

- Inspection of the Incident Report books in Knockroe House identified three recorded instances of sexual contact between two vulnerable adult residents, one male, one female, over a five month period in 2014 and one incident, also of a sexual nature, involving a female member of staff in 2015.
- The inspection team was concerned that there was a failure to protect vulnerable adults and a failure to manage the incidents appropriately.
- On the afternoon of the 16 April 2015, the inspection team sought a meeting with the relevant senior members of management to inform them of the inspection team's concerns and to ascertain what actions had been taken to ensure the safety of residents and staff.
- The inspection focused on the safety of the residents in Knockroe House and the steps taken by the service in addressing these incidents.
- The response by the service, as seen by the inspection team on 16 and 17 April 2015, to three instances of contact of a sexual nature between two residents did not adequately reflect the serious issues raised by these incidents.
- On the basis of undertakings given by the service to ensure a safe service and to address the incidents described above, both at the meeting with senior managers on 17 April 2015 and by way of subsequent communication between the MHC and the HSE, a re-inspection took place on 8 June 2015.

Findings relating to Re-Inspection June 2015

- A further incident of a sexual nature, involving the same male resident, had occurred.

OTHER ISSUES OF CONCERN IDENTIFIED

- All exit doors were kept locked and could only be opened by a member of staff. This curtailed the liberty of the residents of Knockroe House.
- Five of the residents had an intellectual disability, however, the training record indicated that the majority of the staff working in the house did not have any training in working with people with an intellectual disability.
- There was a very limited schedule of activities for residents and no scheduled activities were evident during the two day inspection visit. The lack of a focus and structure to the day and lack of opportunities to engage in life-enhancing activities appropriate to their assessed needs undermined the quality of life of some residents.

SCHEDULE OF EVENTS and FOLLOW-UP ACTIONS

14 April 2015	Information received by the Mental Health Commission
16 and 17 April 2015	Unannounced inspection of Knockroe House
17 April 2015	Inspectors met with senior management team
21 April 2015	Teleconference between senior management in the MHC and senior management in the Health Service Executive (HSE)
24 April 2015	Letter received by Acting Inspector from Area Manager HSE outlining corrective actions
1 May 2015	Draft Inspection Report sent to HSE for comment
18 May 2015	Comments received from the HSE in relation to the draft Inspection Report
21 May 2015	Letter received by the CE, MHC from the HSE outlining further corrective actions by the service
8 June 2015	Unannounced re-inspection Knockroe House
15 June 2015	Meeting between MHC and senior management HSE

Description

Service description

Knockroe House was a large, extended period house situated on the outskirts of Castlerea town in Co. Roscommon. It was formerly a private residence. It was well-maintained and surrounded by very pleasant grounds. The house had been used as a community residence since 1996 and supported the discharge of a number of residents from St. Patrick's Hospital in Castlerea when it closed that year.

Profile of residents

There were ten residents in Knockroe House at the time of the April inspection. One resident was an in-patient in a nearby general hospital at the time of the inspection.

Of the remaining nine residents, we note:-

- Since August 2014, one of the residents had been accommodated in the Rosalie Unit, another community residence in Castlerea, Monday to Thursday but returns to Knockroe House from Thursday to Monday. This was to facilitate the separation of the two residents, about whom the incidents above had been recorded.
- The second of these two residents went on leave home each week from Thursday to Monday.

Of the ten residents, seven were male and three were female.

Three of the ten residents had been in Knockroe House since 1996, having been transferred from St. Patrick's Hospital, a psychiatric hospital in Castlerea, on its closure in 1996.

None of the residents was a Ward of Court.

The age range of the residents was from 30 years to mid-70s.

Five of the residents had an intellectual disability or learning disability and presented with a complex range of needs.

Quality initiatives and improvements in 2014-2015

The service did not provide details of initiatives for 2014-2015.

Incidents

Incident Report books were maintained in the residence and recorded incidents in triplicate.

These records showed a number of episodes of physical aggression and challenging behaviour between residents and between resident and staff. There was a record of residents taking protective actions on two occasions as a result of these episodes, for example, taking refuge in the kitchen to avoid an episode of physical aggression.

When assistance was required by the staff in Knockroe House, the procedure was for the nurse to raise an alarm on the personal alarm system and this was responded to by staff in the Rosalie Unit. As this residence was located at the other end of Castlerea, a nurse was obliged to drive from there to Knockroe House to assist. This was a wholly unsatisfactory arrangement.

1. A serious incident of a sexual nature, involving a resident and a female member of staff, had been recorded and is the subject of an investigation by the HSE. At the time of inspection in April 2015, an investigation team had been established but not commenced.
2. From March 2014 to date, three incidents of sexual contact between two vulnerable residents, one male, one female, were recorded. On inspection of the clinical files of both these residents, the inspection team was unable to find a record of capacity to make a decision regarding engaging in a sexual relationship. There was no evidence that An Garda Síochána had been notified and no evidence of a risk assessment associated with these incidents. Three of these incidents were recorded in the clinical file of the male resident but only two incidents were recorded in the clinical file of the female resident. Following the third incident in 2014, an arrangement was put in place to physically separate the two residents. However, no rationale was recorded for this decision, other than to facilitate a separation.

The management of these incidents was the subject of immediate further inquiry by the inspection team who met with senior members of staff on the afternoon of the second day of inspection in April 2015. While there was a procedure to escalate incident reports to the appropriate management, there was no record of these incidents being discussed in any risk management or clinical governance forum. Based on information provided at meetings with staff and management, certain members of management were aware of these incidents.

Care standards

Individual care and treatment plan

Residents were under the care of a sector team. The consultant psychiatrist attended the house on a weekly basis and it was reported that all residents were reviewed at a weekly multidisciplinary team (MDT) meeting which was held off-site. No member of the nursing staff from Knockroe House attended these weekly meetings. Minutes of the MDT meetings reviewed by the inspection team did not contain evidence of reviews of all residents on an ongoing basis. Indeed, some residents do not appear in these minutes.

Subsequent to the inspection in April 2015, senior management indicated that the residents of Knockroe House would be reviewed on a monthly basis by the MDT. This had not happened up to the date of the inspection on 8 June 2015 as the minutes reviewed on that date only recorded discussion about the two residents concerned in the above mentioned incidents.

The clinical files of eight residents and one person, who attended the residence on a daily basis, were inspected. All of these residents had an individual care plan (ICP). However, these ICPs were not multidisciplinary in nature and the only team members recorded as attending were the consultant psychiatrist and the nurse. The ICPs recorded needs, goals, actions and person responsible for carrying out the action.

Many of the reviews of the ICPs were recorded as occurring on days when there was no entry in the clinical file that indicated that any member of the MDT attended the residence. The entries in the ICPs were, in effect, completed by the nurse.

The focus of care was largely on medical and nursing interventions. Over the course of the previous six months, two residents had input from an occupational therapist (OT) and a psychologist; one further resident had been seen by the OT to address community living skills and another resident had been seen by a psychologist. Otherwise, there was no evidence in the clinical files of residents having been assessed for occupational functional capacity and occupational interests, with a view to ensuring they had the opportunity to engage in appropriate activities and occupations. There was no evidence in the clinical files of sensory needs assessment or of a coherent programme of planned therapeutic interventions to manage challenging behaviour. Residents were observed by inspectors to be sitting or pacing in the day room or dining room.

Physical Care

All residents were independently mobile and each had their own general practitioner (GP). Eight of the residents were under the care of one GP and two were under the care of a second. Residents attended the GPs at their respective surgeries and were accompanied by a member of staff. An annual physical examination was carried out by the GPs and staff reported that details of all consultations were maintained in the GP surgeries.

Access to community services, such as physiotherapy, were organised by the residents' GPs.

A chiropodist attended Knockroe House on a regular basis and, although the residents paid for this service, it was reimbursed by the HSE to the individual residents.

Therapeutic services and programmes provided to address the needs of service users

Only one resident participated in structured activities outside of the house. This resident attended a Training Centre daily and was brought to and from the house by transport organised by the service.

A schedule of activities was posted in the nurses' office:

- on Monday and Friday evenings, a teacher of arts and crafts facilitated a session in the house
- an art instructor facilitated an art session once each week
- there was a weekly music session in the house
- a session in aromatherapy was held once a week, for which residents paid.

The sessions on arts and crafts and music were delivered under the umbrella of the OT. However, staff in the residence had no information about the qualifications and experience of those providing the sessional activities and there was no evidence that these activities were being provided in response to the assessed needs of the residents.

There was a list posted in the nurses' office entitled 'voluntary duties' for residents, for example, "put out bins and refuse sacks, sweep yard, gather delph". This list of 'voluntary duties' pointed to an institutional approach to care as the predominant culture.

Staff in Knockroe House had access to a people carrier and brought residents on outings, when staff numbers permitted. However, due to the staffing number in Knockroe House, staff reported that it was difficult to leave the house.

How are residents facilitated in being actively involved in their own community, based on individual needs?

The house was within easy walking distance from the town centre. Two residents went into the town unaccompanied to do banking or go for coffee. Other residents could visit the town but only when accompanied by staff. Staff reported that this would happen weekly.

Most residents generally did not do any shopping and items requested by the residents were purchased by staff in a shop which was located in another day facility in the area. A record of discussions at a "focus group" held between residents and staff in Knockroe House recorded expressions of interest in "walks to the vegetable plot, outings to Knock, picnics, and a trip to the seaside". An inspection of the Day Book showed that there was little activity outside the house on any regular basis.

Facilities

Knockroe House was an extended period house. It was well-maintained and situated in pleasant grounds. All exit doors in the house were kept locked; even those residents who could leave unaccompanied had to ask staff to unlock the main door to leave and had to ring the doorbell to enter.

The house was clean and furniture was in good condition. Bathrooms and lavatories throughout the house were clean and could be locked by the person using them.

There were two sitting rooms, one upstairs. These rooms were not very inviting or homely and, in the main sitting room, the chairs were arranged along the walls in a row. A conservatory, located off the sitting room downstairs, was a sunny area.

There was a gate at the bottom of the stairs which was closed and was designed to stop residents from going upstairs. The sitting rooms and many bedrooms were devoid of personal belongings or items.

The kitchen was an industrial type kitchen and residents did not enter that area. The dining room was bright and had sufficient tables and chairs to accommodate the number of residents. There was a water cooler in the dining room.

One bedroom, occupied by two residents, was situated on the ground floor across from the nurses' office. This was a bright, spacious room but was being used by the visiting chiropodist at the time of inspection to attend to any resident who required chiropody.

Upstairs, there were four two-bed rooms and four single bedrooms. Three of the two-bed rooms were occupied by one person only. The shared rooms did not provide any privacy for the residents sleeping in them. All bedrooms had a clear glass observation panel in the external door and, in a number of cases, there was no screening on this panel to allow for privacy. Most of the bedrooms were not personalised in any way but were clean and tidy. Each resident had a wardrobe and bedside locker. There was a supply of new clothes, some still in wrapping, available for residents who needed them.

Staff reported that personal laundry was done on-site.

There was a fire detection system in place but the fire safety training scheduled for February 2015 had been cancelled.

Meals

Breakfast was prepared in the kitchen and usually comprised cereals and toast. Dinner was brought to the house - Monday to Friday - from a nearby community residence, in heated containers. Staff did not know what was due for dinner until it arrived, but there was a choice of main meal. On the second day of the inspection, the meal was smoked fish or savoury mince, as observed by one of the inspectors. At weekends, staff cooked the main meal. Tea was prepared by the multi task attendant (MTA) daily.

Staffing levels

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2	0	0
RPN	2	1
HCA	0	1
MTA	1	0

Clinical Nurse Manager (CNM), Registered Psychiatric Nurse (RPN), Health Care Assistant (HCA), Multi Task Attendant (MTA)

Team input

DISCIPLINE	NUMBER	NUMBER OF SESSIONS
Consultant psychiatrist	1	1
NCHD	1	1
Occupational therapist	1	By arrangement
Social worker	1	None
Clinical psychologist	1	By arrangement

Non Consultant Hospital Doctor (NCHD)

The above staffing number was that on 16 and 17 April 2015.

Staffing of the house varied daily. On some days, there were two nurses on duty, which might be a CNM2 and an RPN, or two RPNs. On other days, the staffing was one nurse and one HCA.

A review of the staffing roster for the 26 days prior to the inspection dates showed that, on 16 days, there were two nurses (RPN/CNM) on duty and, on 11 days, there was one nurse and one HCA on duty by day.

On the second day of the inspection in April, the nurse who was on duty was usually rostered to work in another community residence in Castlereagh.

The sector consultant psychiatrist attended the house each week, usually accompanied by the NCHD. Residents were reviewed with the nursing staff on duty. Other members of the sector team did not visit or provide any sessional therapeutic input in the house, except in the case of one resident who was being seen by the OT. The service reported that the OT had assessed three

residents in Knockroe House in the previous six months.

The clinical psychologist had carried out cognitive assessments on three residents, also within the previous six months.

Complaints

A poster was displayed in the hall of the house with information on *Your Service, Your Say* which is the HSE policy on complaints.

A complaints box was placed on the hall table for receiving complaints and this was empty.

Community meetings were held monthly and a record was maintained of discussions at the meetings.

Medication

There was a good-sized clinical room on the ground floor.

Medication was administered by the nurse on duty. Prescriptions written by the consultant or NCHD were transcribed by the GP onto General Medical Scheme (GMS) forms and dispensed from a local pharmacy. Residents paid their own prescription charges. No resident was on a self-medicating programme.

The fridge contained two injectable medications which had expiry dates of 2009 and 2011 respectively. The inspection team asked that this issue be immediately addressed on the day of inspection in April.

The Residence

Knockroe House was owned by the HSE.

Residents paid a weekly charge which was individually assessed by a financial officer of the HSE. Allowances in respect of charges were made for residents who spent nights away from the residence or who met the criteria in the HSE National Guidelines for Charges.

Groceries were purchased in a local shop and paid for by means of a HSE card. Receipts were examined by the financial officer and audited on a regular basis.

Financial arrangements

Five of the residents had authorised the HSE to collect their weekly allowances and administer their funds. The weekly charges were deducted at source. A small amount of money was available for these residents and kept in the house for their personal use. This was safeguarded in a locked area of the house. On both days of inspection, the key to this area was not available to the nurses on duty. This was because this key was maintained by two individual nurses only and, consequently, if they were not on duty, no resident could access their money if they wished to purchase any items.

Some residents had a family member look after their finances and these residents paid their charges directly to the HSE. The remaining residents looked after their own finances.

There was no 'social fund' in operation in the residence and each resident paid for their own expenses; for example, when going on outings.

Service user interviews

Three residents spoke with inspectors as the inspection was being conducted. One resident spoke of wanting to go home and was prevented from leaving the house when the front door was opened to admit the inspectors. This resident also indicated to staff that they wished to make a telephone call. Staff reported that any resident would be facilitated to make or receive calls on the office phone or the mobile handset. The resident involved had been assessed by the consultant psychiatrist two days previously and was due to be re-assessed on the day of inspection again. This assessment took place and the resident was subsequently discharged home from the residence later that day, having been assessed by the NCHD.

Conclusion

Knockroe House provided care for ten residents. One of these residents was currently being treated in a general hospital, and a second resident resided in an old age community residence in Castlerea for three days each week.

Issue of concern:-

- The Incident Report book recorded a number of incidents which gave rise to concerns for the inspection team. The response by the service to three instances of sexual contact between two residents did not, in the view of the inspection team, adequately reflect the seriousness of these contacts. There was no evidence in the clinical files that either of these residents had been assessed in relation to capacity to engage in a sexual relationship. Neither had they been provided with an appropriate advocate with an expertise in the field of intellectual disability, to assist either resident in decision making. In such circumstances as these, it is vital to ensure that neither resident is placed in a position where they may be exploited. In the absence of these safeguarding measures, the inspection team was of the view that these incidents should have been reported to An Garda Síochána.
- Although there were policies in place on the reporting and investigation of incidents, the written records available to the assistant inspectors did not provide sufficient evidence of an adequate response by the service.
- The residents had a mix of diagnoses and needs and the service facilitated a range of admissions from day respite, overnight and brief admission, alongside people who had been resident for almost 20 years. This practice of admitting residents for crisis admissions to avert an admission or to facilitate early discharge for a two to three week period to hostels in Castlerea was endorsed at the Business Meeting of the Galway Roscommon Area 5 and 6, on 14 November 2014. However, this policy did not meet the needs of the core resident group.
- There was a very limited schedule of activities for residents and no scheduled activities were evident during the two day inspection visit. Most residents remained in the house throughout the day. The lack of a focus and structure to the day and lack of opportunities to engage in life-enhancing activities appropriate to their assessed needs undermined the quality of life of some residents. One long-stay resident went on leave each week for a period of four nights.
- Five residents had an intellectual or learning disability. The record of training for staff showed that only two of the nursing staff who worked in Knockroe House had received training in working with people with an intellectual disability. On the days of inspection in April, none of the nurses on duty had received training. In addition, the record on training on the prevention and management of aggression and violence did not show evidence of regular training for staff.
- There was no evidence in the clinical files inspected that members of the MDT, other than the consultant psychiatrist and NCHD, provided any regular input to the care and treatment of residents in the house. The OT reported that one resident had received input on a weekly

basis since October 2014. Residents had an ICP, but this was not drawn up by the MDT and reviews were carried out by a member of nursing staff alone.

- All the exit doors in the house were locked. This was done to protect vulnerable individuals from wandering out but it also affected other residents, for whom this was not a concern.
- The house was clean and spacious, with many two-bed rooms being occupied by only one resident. However, for those residents sharing a bedroom, there was no facility to provide privacy in these rooms and all bedrooms facilitated external observation without consistent provision for privacy needs.

Recommendations and areas for development

1. *Immediate and appropriate action must be taken to safeguard all residents from interactions which are potentially harmful. All HSE policies should be followed in the event that such incidents arise and all staff and management should be trained and be aware of how to deal with such incidents.*
2. *Residents should have access to an appropriate range of therapeutic activity.*
3. *Each resident must be assessed by an occupational therapist to inform the provision of appropriate occupational engagement.*
4. *Residents in long-term residential care in the community should be under the care of a specialist team appropriate to their needs.*
5. *All members of staff working in Knockroe House must have training or updated training in working with people with an intellectual disability.*
6. *All members of staff working in Knockroe House must have training or updated training in the prevention and management of aggression and violence.*
7. *The service should review the current staffing arrangements for Knockroe House, which alternates a Health Care Assistant with a nurse.*
8. *Residents should not be deprived of their liberty, except in an environment where there are safeguards to protect this deprivation.*
9. *The service should review their policy on the suitability of operating the residence as an overnight and brief stay facility alongside residents who were long-term residents of the service.*
10. *The service must consider the rationale of facilitating a resident who spends four nights a week on home leave every week.*
11. *The nurse on duty and in charge of the residence must have access to all locked areas of the house.*

Follow-up to the Inspection of 16 & 17 April 2015

Following the inspection on 16 and 17 April 2015, a teleconference was convened by the Chief Executive of the Mental Health Commission with senior management of the HSE, and was held on 21 April 2015.

As a result of this teleconference and subsequent correspondence with the HSE, a number of corrective actions were proposed by the service.

A further unannounced inspection of Knockroe House was carried out on 8 June 2015, to verify what actions had been completed and to review progress on the corrective action plan.

During the course of this inspection, the inspection team met with and interviewed the Clinical Nurse Manager (CNM) of Knockroe House and the Assistant Director of Nursing (ADON). In addition, one of the inspection team spoke with the Acting Area Manager of the Roscommon Mental Health Services.

Re-inspection Knockroe House 8 June 2015

The unannounced re-inspection of Knockroe House was carried out by the Acting Inspector and an assistant inspector.

On the day of this inspection, there were eight residents in Knockroe House, one of whom was still an in-patient in a local general hospital; one person attended the residence daily for day care, and one resident, who spent four nights at home each week, continued this arrangement.

In order to follow up on the proposed actions by the service following the inspection of Knockroe House on the 16 and 17 April 2015, inspectors also visited another unit in Castlerea where one resident of Knockroe House was accommodated on four days per week. This was for the purpose of reviewing the accommodation and the resident's clinical file.

Following the inspection of April 2015 one resident, who had been spending three nights each week in another unit had been discharged from Knockroe House and was now residing full-time in this unit. This was an unsuitable residence for this resident, as it was a psychogeriatric residence, and the resident in question was not in this age range. This resident had been transferred to facilitate separation from a resident in Knockroe House, and not for any treatment purpose.

In Knockroe House, the current clinical file of the resident involved in the incidents described above, was available for inspection but previous clinical files of this resident were not available and had been removed from the residence. A referral form for a psychology assessment (dated prior to the inspection of 16 and 17 April 2015) in the current clinical file was not evident in the file at the time of that inspection.

Incidents as of 8 June 2015

A further incident of a sexual nature had been recorded in the Incident Report book, involving the same male resident involved in the incidents noted in the inspection of 16 and 17 April 2015. This was noted to have occurred on 6 June 2015.

Staffing Levels on 8 June 2015

STAFF DISCIPLINE	DAY WTE	NIGHT WTE
CNM2	1	0
RPN	1	1
HCA	0	1
MTA	1	0

Clinical Nurse Manager (CNM); Registered Psychiatric Nurse (RPN); Health Care Attendant (HCA); Multi Task Attendant (MTA)

At the time of the re-inspection, the clinical staff on duty comprised one CNM and one nurse; in addition, one MTA was on duty.

Staffing for Knockroe House alternated between two nurses or one nurse and one HCA.

At night, staffing was one nurse and one HCA.

During the course of the day's inspection, it was reported that an additional nurse was rostered to work due to an incident which had occurred in the residence two days previously.

Corrective Actions Proposed by the Roscommon Mental Health Services in relation to issues raised following the Inspection 16 and 17 April 2015

The following is a list of the proposed corrective actions submitted by the service.

	PROPOSED CORRECTIVE ACTION detailed in Correspondence 24 April 2015	ACTION COMPLETED	INSPECTION TEAM COMMENT
1	Reorganisation of bedroom accommodation to allow for greater observation of a male resident	Yes	This arrangement resulted in the re-location of the two previous occupants of this room to another area of the house
2	Immediate forensic assessment on a named resident has been arranged	Yes	Completed on 26 May 2015; report awaited
3	Immediate mental health and intellectual disability (MHID) assessment on a named resident has been arranged	Yes	Completed on 1 May 2015; report awaited
4	Risk assessment for named resident in both the residence and community	Yes	Risk Assessment forms were completed on 23 April 2015 and 28 May 2015. A review of these forms did not indicate a robust assessment process.
5	Full multidisciplinary (MDT) review, including review of family and community environment	No Consent obtained from resident for the social worker visit to home	Minutes of MDT meetings did not identify reference to any resident of Knockroe House, with the exception of one reference to one resident. No record of date of visit or completion of report.
6	Transfer of resident to accommodation in MHID service to be prioritised	No	Resident remained in psychogeriatric unit

Inspectorate of Mental Health Services

7	Physical examination carried out	Yes	Completed
8	Advocates to be appointed to the residents concerned	Yes	IAN advocate contacted and had visited residents. However, there was no evidence of advocate's expertise in relation to the core issue of capacity, intellectual disability, facilitating communication or decision making.
9	Consultant psychiatrist to contact Gardai in relation to incidents in Knockroe House	No	Gardai contacted by the HSE and a meeting held between the HSE and Gardai on 20 May 2015. Gardai were already aware of the incidents, through another agency.
10	Rehabilitation consultant to assess remaining residents	Partly completed	Two residents have been assessed by the rehabilitation consultant
11	Residents' money inaccessible to nurse on duty	No	Residents facilitated to make purchases and shops were paid by CNM with the residents' money

Inspectorate of Mental Health Services

	PROPOSED CORRECTIVE ACTION detailed in Correspondence 21 May 2015	ACTION COMPLETED	INSPECTORATE COMMENT
1	MHID assessment Forensic assessment	Yes Yes	Await report Await report
2	Multidisciplinary risk assessment is being completed	Yes	A Risk Assessment form was completed on 23 April 2015 and 28 May 2015. A review of these forms did not indicate a robust assessment process
3	Move to MHID services will be completed within two weeks (for one resident)	No	No evidence in clinical file of suitable placement having been identified
4	Follow-up specialist appointment took place	Yes	Completed
5	The ECD has notified the Gardai of the incidents	Yes	However, the Gardai had already been notified by another agency
6	An assessment is to be carried out by the rehabilitation consultant on all remaining residents	Partly	The consultant had carried out an assessment on two of the residents
7	The five residents with an intellectual disability are to be assessed with a view to finding the most suitable placement	Partly	Only one resident had been assessed by the MHID service
8	The MHID consultant is to set up a training day for staff	No	This had not happened as yet
9	Employee supports have been made available to staff	Yes	Staff reported that supports were available.
10	Residents of the hostel (Knockroe House) are now discussed as part of the monthly MDT agenda	No	Since the inspection of 16 and 17 April, two "Meetings with Clinicians" had taken place. These were attended by the ECD, Area Manager and members of the Community Mental Health Team (CMHT), along with the CNM 2 of Knockroe House.

			<p>The minutes of these meetings detail the discussion in relation to the recommendations made in the draft inspection report which followed the inspection in April 2015.</p> <p>Weekly MDT meetings of the CMHT were held. To date, no member of the nursing staff of Knockroe House attended these meetings. There was no evidence in the minutes of these meetings that the incidents reported in Knockroe House had been discussed by the MDT team.</p>
11	Respite and crisis admissions to Knockroe House are to cease	Yes	There have been no admissions to Knockroe House since the inspection of 16 and 17 April 2015

Conclusion

Two unannounced inspections of Knockroe House were carried out in April and June 2015, on foot of anonymous information received by the Mental Health Commission. The inspection confirmed the incidents as reported.

Although incident reports had been completed in each case, this did not result in appropriate action being taken. For one resident, what was intended as a temporary measure to facilitate separation, the transfer to another facility had resulted in this person being located for more than ten months in a wholly inappropriate setting. Even following this arrangement, two further incidents had occurred.

Senior management's response to these four incidents was slow and many corrective actions proposed by the service had not been implemented some eight weeks after the initial inspection. Senior management in the HSE have stated that a review into the incidents and the issues raised in the anonymous complaints will be carried out.

The Mental Health Commission has been in regular correspondence with the HSE since the initial inspection of April 2015 and continues to monitor the steps being taken to address the issues raised as a result of the inspections and correspondence received.

As part of this process, the MHC requested an implementation plan from the service and the HSE has provided the MHC with a number of proposed corrective actions.