St. Catherine's Ward, St. Finbarr's Hospital

ID Number: AC0044

2017 Approved Centre Inspection Report (Mental Health Act 2001)

St. Catherine’s Ward
St. Finbarr’s Hospital
Douglas Road
Cork

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

Most Recent Registration Date:
17 May 2016

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Sinéad Glennon, Head of Mental Health Service – Cork and Kerry

Inspection Team:
Noeleen Byrne, Lead Inspector
David McGuinness
Leon Donovan
Carol Brennan-Forsyth

Inspection Date:
16 – 19 May 2017

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
1 – 4 November 2016

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
28 September 2017

COMPLIANCE RATINGS 2017

REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001

CODES OF PRACTICE

Compliant
Non-compliant
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.
Inspector of Mental Health Services

Dr Susan Finnerty

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

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

Safety

The approved centre had two written documents in relation to health and safety: a safety statement and an infection control and hygiene plan. Food safety processes were excellent. The risk management policy was not comprehensive and did not address the identification and assessment of risks throughout the approved centre, including organisational risks, structural risks, capacity risks, health and safety risks, and risks to the residents during the provision of general care and services and the delivery of individualised care. The policy did not include arrangements for the protection of children and vulnerable adults. The number and skill mix of staff did not meet resident needs. There was insufficient nursing staff as there were only two nurses on duty at night. It was not possible for residents to retire early because there was insufficient staff to have both floors open at the same time. Not all health care professionals had received training in fire safety, Basic Life Support, Therapeutic Management of Aggression and Violence, and the Mental Health Act 2001. At least one staff member was trained in Children First. Not all staff were trained in accordance with the assessed needs of residents, and staff said they had difficulty getting time off to attend training. The approved centre did not have a documented register of residents. Ordering, prescribing, storage and administration of medication was in order.

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

The approved centre did not use an evidence-based nutrition assessment tool, and the needs of residents identified as having special nutritional requirements were not regularly reviewed. Residents on soft food diets did not have access to a dietitian or a speech and language therapist.

Each resident had a care plan but these were not adequate. The residents interviewed were not aware of their individual care plans. The approved centre was undertaking functional needs assessments for all residents and a discharge pathway was being prepared. A social worker attended for six hours per month and occupational therapy and psychology services were accessed on a referral only basis. Four residents attended external rehabilitation programmes. There was an activities nurse who provided therapeutic
programmes. There was no speech and language therapist or dietician, despite residents having an assessed need for these services. The multi-disciplinary team (MDT) did not function well as many members did not attend regularly. In addition, the MDT did not develop and review care plans. A list of the therapeutic services and programmes provided by the approved centre was available to the residents. Adequate and appropriate programmes, resources and facilities were available to provide therapeutic services and programmes, and a dedicated room was available for individual and group therapies. Residents received appropriate general health care and their physical needs were assessed every six months and earlier if indicated. Not all residents’ records were secure or maintained in good order. The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment. No resident had been physically restrained.

Despite the fact that the approved centre had residents with an intellectual disability, the relevant policy did not reference least restrictive practices, there was no process for managing problem behaviours, there were no policy or procedures for training staff in working with people with an intellectual disability, no key worker had been identified, and capacity assessment using a functional approach had not been undertaken. There were 17 areas of non-compliance with the code of practice on admission, transfer and discharge.

**RESPECT FOR RESIDENTS’ PRIVACY AND DIGNITY**

Residents were supported to keep and wear their personal clothing, which could be stored in secure, locked wardrobes. Residents’ clothing was observed to be clean and appropriate to their needs. Residents could bring personal possessions into the approved centre and were supported to manage their own property. A safe was used for monies. Bathrooms, showers, toilets, and single rooms had locks on the inside of the doors, and these had an override facility. All observation panels on doors of bedrooms and treatment rooms were appropriately screened. Residents were facilitated in making and taking private phone calls. The noticeboards in the nurses’ station displayed identifiable resident information and were in full view of the public. There was no privacy screen around one of the beds in a shared bedroom, which compromised the resident’s privacy. Multiple boxes of old clinical files for archiving were stored in the staff toilet area, and some of these contained clinical entries medication prescription and administration records relating to current residents. This breached confidentiality.

**RESPONSIVENESS TO RESIDENTS’ NEEDS**

Menus were approved by a dietitian/nutritionist and there was a variety of wholesome and nutritious food choices. A number of residents were on modified consistency diets, but the food was not presented in an attractive manner in terms of both texture and appearance.
There was a practice of locking bedrooms in the morning until 22.00 hours; this was restrictive and resulted in residents not being able to retire to bed early. Residents stated that they unhappy that they couldn’t go to bed before 10pm. Residents had access to appropriate timetabled activities, and recreational activities were scheduled on weekdays and at weekends. Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. Residents were facilitated in the practice of their religion. Visiting times were appropriate and reasonable. A separate visitors’ room had opened which was suitable for visiting children. Residents were permitted to use their mobile phones without restriction.

There was no information booklet for residents and they did not routinely receive written and verbal information about their diagnosis or medications. The upper level of the approved centre was in an excellent state of repair because it had recently been refurbished. By contrast, there were problems on the lower level, including holes in walls, peeling floor covering, scratched walls, and peeling paint. The approved centre did not, however, have a programme of renewal of the fabric and decoration for this area. The facility was clean, hygienic, and free from offensive odours. There was a robust complaints procedure which was communicated to residents.

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 (CHO) 4 area. The approved centre had established governance mechanisms in place. The governance structures included an area executive Cork Mental Health management team, a heads of discipline management meeting, and a quarterly incident review committee. There was no organisational chart to identify the leadership and management structure and lines of authority and accountability in the approved centre. Senior management did not attend the approved centre on a regular basis.

The nursing line management structure involved the assistant directors of nursing holding a weekly conference call with the director of nursing and the area director of nursing. Heads of discipline from occupational therapy, social work, and psychology confirmed that defined lines of responsibility and supervision were organised through the line management structure. Departmental staff meetings were held every four to six weeks. The strategic aims included developing the discharge pathway by completing functional needs assessments for all residents. None of the heads of discipline were aware of any key performance indicators relating to the service provided in St. Catherine’s Ward. Operational risks included a shortage of medical and nursing staff.

Operating policies and procedures were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders and were communicated to all relevant staff. Operating policies and procedures were appropriately approved before they were implemented. All operating policies and procedures required by the regulations were reviewed within the required three-year time frame.

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

The following quality initiatives were identified on this inspection:

1. A general health initiative focusing on residents’ physical health was under way in the approved centre. The initiative included cardio-metabolic screening to assess residents’ risk of having diabetes, heart disease, or stroke. The team comprised a specialist nurse, a community health nurse, and a clinical nurse specialist in nutrition management.

2. The approved centre was undertaking functional needs assessments for all residents and a discharge pathway was being prepared.
4.0 Overview of the Approved Centre

4.1 Description of approved centre

The approved centre was located in the grounds of St. Finbarr’s Hospital, Douglas Road, Cork. St Catherine’s Ward was on the right of the campus and was adjacent to a continuing care facility for the elderly: St. Stephen’s Unit. St. Catherine’s Ward comprised two floors, with the bedrooms and a small sitting room downstairs and day facilities upstairs, with a lift to transport the residents between floors. It operated as a continuing care facility and a rehabilitation unit. The upstairs living accommodation had been extensively renovated and included a multifunctional room and two sitting rooms. The inspection team attended the approved centre in the evening and confirmed that the practice of locking bedrooms in the morning until 22.00 hours. This was restrictive and resulted in residents not being able to retire to bed early.

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><strong>Number of registered beds</strong></td>
<td>21</td>
</tr>
<tr>
<td><strong>Total number of residents</strong></td>
<td>21</td>
</tr>
<tr>
<td><strong>Number of detained patients</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>Number of Wards of Court</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Number of residents in the approved centre for more than 6 months</strong></td>
<td>20</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 Cork Mental Health management team, a heads of discipline management meeting, and a quarterly incident review committee. The minutes of meetings for these committees were provided to the inspection team. Minutes of executive management team meetings were provided, and these outlined an active governance process. 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 no organisational chart to identify the leadership and management structure and lines of authority and accountability in the approved centre. Senior management did not attend the approved centre on a regular basis. A social worker attended for six hours per month and occupational therapy and psychology services were accessed on a referral only basis. There was no speech and language therapist or dietician, despite residents having an assessed need for these services. The multi-disciplinary team (MDT) did not function well as many members did not attend regularly. In addition, the MDT did not develop and review care plans, rather they were reviewed and updated by one member of the team.
5.1 Non-compliant areas from 2016 inspection

The previous inspection of the approved centre on 1 – 4 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 5: Food and Nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Residents’ Personal Property and Possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 11: Visits</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 16: Therapeutic Services and Programmes</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>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>Regulation 29: Operating Policies and Procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Notification of Deaths and Incident Reporting</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice Guidance for Persons working in Mental Health with People with Intellectual Disabilities</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from Approved Centres</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>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 20: Provision of Information to Residents</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 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>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 31: Risk Management 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>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Code of Practice on Notification of Deaths and Incident Reporting</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 Approved Centres</td>
<td>X</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 6: Food Safety</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. The IAN representative is only available to residents following a referral for advocacy.

Three residents of the approved centre met with the inspection team. They stated that the food was good, that they were comfortable, and that staff were nice. In relation to the care and services provided, residents observed that they could attend a doctor who came in to the approved centre and had access to eye tests and a dentist. The residents referred to therapeutic programmes, including painting and gardening, and they stated that they visited restaurants at weekends. They observed that the upstairs of the approved centre was lovely following building works, but they were not entirely happy that they couldn’t go to bed before 10pm. The residents interviewed were not aware of their individual care plans.
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
- Principle Psychology Manager
- Head Social Worker
- Representative of Occupational Therapy 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 structure within their respective departments. The heads of discipline were not based in the approved centre, and all heads of discipline confirmed that they only attended the approved centre occasionally. The nursing line management structure involved the assistant directors of nursing holding a weekly conference call with the director of nursing and the area director of nursing. The clinical director confirmed that the strategic aims for the medical department was to ensure the admission strategy was implemented and that it was supported by a discharge pathway.

Heads of discipline from therapeutic services, occupational therapy, social work, and psychology confirmed that defined lines of responsibility and supervision were organised through the line management structure. Departmental staff meetings were held every four to six weeks. The strategic aims included developing the discharge pathway by completing functional needs assessments for all residents.

None of the heads of discipline were aware of any key performance indicators relating to the service provided in St. Catherine’s Ward. Operational risks included a shortage of medical and nursing staff. Allied health professionals confirmed that they regularly had to run a limited service due to not having personnel for maternity leave cover.
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
- Executive Clinical Director
- Area Director of Nursing
- Acting Assistant Director of Nursing
- Assistant Director of Nursing
- Senior Occupational Therapist
- Social Work Team Leader
- Acting Clinical Nurse Manager 2 X 2
- Administration Staff Officer

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.
9.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the identification of residents, which was last reviewed in October 2016. It outlined the roles and responsibilities in relation to the identification of residents. It did not include any of the other requirements of the Judgement Support Framework:

- The use of two appropriate resident identifiers prior to the administration of medications, initiation of medical investigations, or provision of other services.
- The required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.
- The process of identification used for residents with the same or a similar name.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for identifying residents in the approved centre.

Monitoring: There was no evidence that an annual audit had been undertaken to ensure that clinical files contained appropriate resident identifiers. Analysis had not been undertaken to identify opportunities for improving the resident identification process.

Evidence of Implementation: At least two person-specific resident identifiers were used, including name, hospital record number, and photographic ID. The identifiers were appropriate to the residents’ communication abilities. Both name and photograph were checked before the administration of medication, the undertaking of medical investigations, and the provision of health care services. Names were checked prior to the provision of therapeutic services and programmes.

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 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 October 2016. It included requirements of the Judgement Support Framework, with the exception of the process for monitoring residents’ food and water intake.

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

Monitoring: A systematic review of menu plans was 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. Resident dissatisfaction with the food was brought to the attention of the catering manager.

Evidence of Implementation: Food was delivered to the approved centre from the main hospital kitchen. Menus were approved by a dietitian/nutritionist to ensure nutritional adequacy. There was a two-week rolling menu, which provided residents with a variety of wholesome and nutritious food choices. Hot meals were served daily, and residents had regular access to hot and cold drinks. Fresh water dispensers were available.

A number of residents were on modified consistency diets, but the food was not presented in an attractive manner in terms of both texture and appearance. Weight charts were implemented, monitored on a monthly basis, and acted upon, where required. Residents, their representatives, family, and next of kin were educated about residents’ diets, where appropriate. Nutritional and dietary needs were documented in residents’ individual care plans.

The approved centre did not use an evidence-based nutrition assessment tool, and the needs of residents identified as having special nutritional requirements were not regularly reviewed. Residents on soft food diets did not have access to a dietitian or a speech and language therapist.
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 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 two written policies in relation to food safety. There was a St. Catherine’s policy, dated October 2016, and a St. Finbarr’s Hospital Catering Department ward kitchen procedural folder. The policies 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 food safety policies. Relevant staff interviewed were able to articulate the processes relating to food safety, as set out in the policies. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP).

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

Evidence of Implementation: The catering equipment was adequate, with appropriate facilities for the refrigeration, storage, preparation, cooking, and serving of food. Appropriate hand-washing facilities were in place for catering services. Hygiene was maintained to support food safety requirements, and catering areas and associated catering and food safety equipment were appropriately cleaned. Residents had access to a supply of suitable crockery and cutlery.

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 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, dated October 2016. It included requirements of the Judgement Support Framework, with the exception of a process for ensuring that clothing provided to residents by the approved centre took into consideration residents’ preferences, dignity, bodily integrity, and religious and cultural practices.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the processes in relation to residents’ clothing, as set out in the policy.

Monitoring: The approved centre did not have a supply of emergency clothing for residents. No residents wore nightclothes during the day because this practice was never prescribed.

Evidence of Implementation: Residents were supported to keep and wear their personal clothing, which could be stored in secure, locked wardrobes. Residents’ clothing was observed to be clean and appropriate to their needs. The approved centre did not maintain an emergency supply of clothing as there were few admissions. Funds were available for the purchase of emergency clothing if it was required. All residents had an adequate supply of individualised clothing.

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 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 dated October 2016. It included requirements of the Judgement Support Framework, with the exception of the process for communicating with the resident and their representatives regarding the residents’ entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.

Training and Education: Not all 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: Personal property logs were maintained and monitored. Analysis had not been completed to identify opportunities for improving the processes around residents’ personal property and possessions.

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 them or others, as indicated in their individual care plans (ICPs). When the approved centre assumed responsibility for residents’ personal property and possessions, these were secured. A combination safe was used for monies, and each resident had a locked wardrobe in their room for the securing of personal effects.

A property checklist was maintained for each resident and kept separately to their ICP. Where money belonging to a resident was handled by staff, a log of the staff issuing money was retained in the nursing station. The log was countersigned by one member of staff and where possible the resident or their representative.
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 Judgment Support Framework under the processes, training and education, monitoring, and evidence of implementation pillars.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

Processes: The approved centre did not have a written policy in relation to the provision of recreational activities.

Training and Education: There was no policy for staff to have received training on or to articulate.

Monitoring: A timetable was maintained of the occurrence of planned recreational activities, however details of resident uptake and attendance were not recorded. Analysis had been completed to identify opportunities for improving the processes in relation to recreational activities.

Evidence of Implementation: Residents had access to appropriate timetabled activities, including newspaper discussion, gardening, cookery, walking group, and trips out. Recreational activities were scheduled on weekdays and at weekends, and the approved centre had access to a people carrier to facilitate resident trips. Information on recreational activities was provided to residents in an accessible format.

Recreational activities were developed, maintained, and implemented with resident involvement through the care planning process. Residents offered their views on the range of activities available, and they were asked which activities they would like to participate in, on a daily basis.

Recreational activities were appropriately resourced, and opportunities were available for indoor and outdoor exercise and physical activity. There were two exercise bikes in the approved centre as well as an outdoor gym on the grounds. There were suitable indoor areas for recreation. Residents’ decisions on whether or not to participate in activities were respected.

Records of resident attendance at recreational activities were not maintained.

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, monitoring and evidence of implementation pillars.
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, dated October 2016. The policy included requirements of the Judgement Support Framework, with the exception of processes for the following:

- Respecting religious beliefs during the provision of services, care, and treatment.
- Respecting a resident’s religious beliefs and values within the routines of daily living, including resident choice regarding their involvement in religious practice.

Training and Education: Not all relevant staff had signed a log indicating that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for facilitating residents in the practice of their religion, as set out in the policy.

Monitoring: The policy’s implementation had not been reviewed to ensure that residents’ identified religious needs were met.

Evidence of Implementation: Residents were facilitated in the practice of their religion, insofar as was practicable. Mass was said on the ward regularly and in the grounds of St. Finbarr’s Hospital, and a Church of Ireland minister visited weekly. Residents could attend services outside of the approved centre, following a risk assessment.

The care and services provided within the approved centre were respectful of residents’ religious beliefs and values. Residents were facilitated in observing or abstaining from religious practice in line with their wishes. Particular religious requirements relating to the provision of services, care, and treatment were documented.

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 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 October 2016. The policy included requirements of the Judgement Support Framework, with the exception of the following:

- Details of the availability of appropriate locations for resident visits.
- The arrangements and appropriate facilities for children visiting a resident.
- The required visitor identification methods.

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

Monitoring: At the time of the inspection, there were no restrictions on residents’ rights to receive visitors. There was no documentary evidence that analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Visiting times, which were appropriate and reasonable, were publicly displayed in the approved centre. A separate visitors’ room had opened following completion of renovations in the approved centre, and residents could use this to meet visitors in private, unless indicated otherwise in their individual care plans. Appropriate steps were taken to ensure visitor safety and the safety of residents during visits.

Children were welcomed when accompanied and supervised to ensure their safety. Visiting areas were suitable for visiting children, and a supply of toys was available.

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 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 October 2016. It included all of the requirements of the Judgement Support Framework.

Training and Education: Not all 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 needs.

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: There was evidence that the resident communication policy and procedures were implemented throughout the approved centre. Unless otherwise risk-assessed, residents had access to external communications such as mail and telephone, including a cordless phone that could be used in private. Residents were also permitted to use their mobile phones without restriction. Residents did not have access to e-mail or the Internet.

At the time of the inspection, no residents were subject to restrictions on or monitoring of their communications.

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, monitoring, and evidence of implementation 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 be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had 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, including 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.
- The process for communicating the approved centre’s search policies and procedures to residents and staff.

Training and Education: Not all relevant staff had signed a document indicating that they had read and understood the policy. Relevant staff interviewed could articulate the procedures relating to searches, as outlined in the policy.

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the care of the dying, dated October 2016. It included requirements of the Judgement Support Framework, with the following exceptions:

- The protocols relating to advance directives, Do Not Attempt Resuscitation orders, and residents’ religious and cultural preferences at end of life.
- The process for ensuring that the approved centre was informed in the event of the death of a resident who had been transferred elsewhere.

Training and Education: Not all relevant staff had 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 policy.

As no deaths had occurred in the approved centre since the date of the last inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was compliant with this regulation.
Regulation 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). The policy, which was not dated, stipulated that residents should have access to their ICPs. It did not contain any other requirements of the Judgement Support Framework:

- The roles and responsibilities relating to individual care planning.
- The process for assessing residents at admission and on an ongoing basis.
- The required content of the set of documentation comprising the ICP.
- The implementation of ICP reviews and updates.
- The required resident involvement in individual care planning.
- The time frames for assessment planning, implementation, and evaluation of the ICP.

Training and Education: Not all clinical staff had signed a log indicating that they had read and understood the policy. Clinical staff interviewed were able to articulate the processes relating to individual care planning, as set out in the policy. Not all multi-disciplinary team (MDT) members had received training in individual care planning.

Monitoring: There was no evidence that ICPs were audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify opportunities to improve the individual care planning process.

Evidence of Implementation: The ICPs of 11 residents were inspected. Each was a composite set of documents, was stored in the clinical file, was identifiable and uninterrupted, and was kept separately from progress notes. The ICPs included an individual risk management plan. Residents were assessed at admission, however the assessments forms were not evidence-based. An initial care plan was completed by the admitting clinician within seven days. Only one of the 11 ICPs was developed by the MDT; 10 were developed by one member of the team and not in collaboration with the full MDT.

A key worker was identified to ensure continuity in the implementation of an ICP. The care plan template included sections on “needs identified” and “how to meet these needs”, but there was no section for goals. As a result appropriate goals were not clearly identified in the ICPs inspected.
The resources required to address residents’ goals were not specified in three ICPs. Two ICPs did not address the care and treatment required to meet identified goals. In ten of the ICPs examined, there was no preliminary discharge plan in place. The ICPs were reviewed by the senior house officer and not by the MDT.

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

a) ICPs did not contain appropriate goals.

b) The resources required to meet assessed needs were not specified in three ICPs.

c) The care and treatment required to meet identified goals were not specified in two ICPs.

d) ICPs were not developed by an MDT with full MDT input.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the provision of therapeutic services and programmes to residents, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of the following:

- Details of the facilities for the provision of therapeutic services and programmes.
- The process for the provision of therapeutic services and programmes by external providers in external locations.

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

Monitoring: There was no documentary evidence that the range of therapeutic services and programmes provided was monitored on an ongoing basis to ensure that residents’ assessed needs were met. Analysis had been completed to identify opportunities for improving the processes for therapeutic services and programmes.

Evidence of Implementation: A functional needs assessment by nursing, social work and occupational therapy was taking place. It was anticipated that from this needs assessment an appropriate range of therapeutic services and programmes could then be implemented. Four residents attended external rehabilitation programmes. There was an activities nurse who provided therapeutic programmes. The therapeutic services and programmes were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

A list of the therapeutic services and programmes provided by the approved centre was available to the residents. Adequate and appropriate resources and facilities were available to provide therapeutic services and programmes, and a dedicated room was available for individual and group therapies. A record was maintained of residents’ participation and engagement in therapeutic services or programmes and of outcomes achieved. 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, training and education, and monitoring 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 the approved centre did not admit children, 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 October 2016. It included requirements of the Judgement Support Framework, but it did not reference the following:

- The planning and management of the resident transfer process in a safe and timely manner.
- The criteria for transfer.
- The interagency involvement in the transfer process.
- The resident assessment requirements prior to transfer.
- The management of resident medications during transfer from the approved centre.
- The involvement of the resident/their representative in a transfer.
- The protection of resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- The management of resident property during a transfer.
- The process for emergency transfers.

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

Monitoring: The approved centre maintained a transfer log, but each record had not been reviewed to ensure that all relevant information was sent 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 who had recently been transferred to another facility were inspected. The decision to transfer both residents followed an assessment. Communication records with the receiving facility were documented, and the residents’ entire clinical file was sent to the receiving facility along with a referral letter, which included information about medication.

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, monitoring, and evidence of implementation 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 two different policy documents in relation to the provision of general health care to residents, both of which were dated October 2016: a general health statement and a medical emergency response policy. The documents included requirements of the Judgement Support Framework, with the following exceptions:

- The staff training requirements in relation to Basic Life Support.
- The management of emergency response equipment, including the resuscitation trolley and Automated External Defibrillator (AED).
- 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.
- Residents’ access to national screening programmes.

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

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

Evidence of Implementation: Staff had access to a resuscitation trolley and an AED, and these were checked weekly. Registered medical practitioners assessed residents’ physical health on admission and on an ongoing basis.

Residents received appropriate general health care as indicated in their individual care plans. Residents’ needs were assessed every six months and earlier if indicated. Records were maintained of residents’ completed general health checks and the associated results. Residents had access to age- and gender-appropriate national screening programs. Information on national screening programs was also provided.
Adequate arrangements were not in place for residents with swallowing difficulties as they did not have access to a speech and language therapist or to a dietitian for review.

The approved centre was not compliant with this regulation because adequate arrangements were not in place for residents to access general health services or to be referred to other health services, 19(a).
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. The policy included requirements of the Judgement Support Framework, with the following exceptions:

- The process for identifying residents’ preferred way of giving and receiving information.
- The methods for providing information to residents with specific communication needs.
- The interpreter and translations services available.
- The process for managing the provision of information to resident representatives, family, and next of kin, as appropriate.
- The advocacy arrangements.

Training and Education: Not all staff had 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 not audited on an ongoing basis to ensure it was appropriate and accurate. There was no evidence that analysis had been completed to identify opportunities for improving the processes around the provision of information.

Evidence of Implementation: The approved centre did not have a booklet containing relevant information required by residents and/or their representatives at admission, including the care and services provided, the housekeeping arrangements, complaints procedure, visiting times and arrangements, details of relevant advocacy and voluntary agencies, and residents’ rights. Details of the multi-disciplinary team were provided to residents verbally.
Residents did not routinely receive written and verbal information about their diagnosis. Information was available, but residents had to request it. Similarly, information relating to adverse effects of treatments was not routinely provided.

Medication information sheets were available in a format appropriate to residents’ needs. These documents contained information that included indications for use of medications, including possible side-effects. The information in the documents provided by or in the approved centre was evidence-based. Where necessary, residents had access to interpretation and translation services.

Information documents provided by the approved centre had not been appropriately reviewed and approved prior to their use.

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

a) Residents did not receive relevant information because there was no information booklet, 20(1)(b) and (d).

b) Residents did not routinely receive written and verbal information about their diagnosis, 20(1)(c).

c) Information on indications for the use of all medications administered to residents was not routinely provided to residents, 20(1)(e).
INSPECTION FINDINGS

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

- The roles and responsibilities for the provision of resident privacy and dignity.
- The process applied where resident privacy and dignity were not respected by staff.

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

Monitoring: There was no evidence that an annual review had been undertaken to ensure that the policy was being implemented and that the premises and facilities were conducive to resident privacy. Analysis had not 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 interact with residents in a friendly, helpful, and caring manner. 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. All observation panels on doors of bedrooms and treatment rooms were appropriately screened. Residents were facilitated in making and taking private phone calls.

The noticeboards in the nurses’ station displayed identifiable resident information and were in full view of the public. This was rectified during the inspection. There was no privacy screen around one of the beds in a shared bedroom, which compromised the resident’s privacy.

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

a) Identifiable resident information was displayed on a noticeboard in the nurses’ station, which could be viewed by the public.

b) The absence of a bed screen in a shared bedroom compromised the resident’s privacy.
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 its premises, which was dated October 2016. The policy included requirements of the Judgement Support Framework, but it did not reference the following:

- The premises maintenance programme.
- The cleaning programme.
- The utility controls and requirements.
- The provision of adequate and suitable furnishings.
- The identification of hazards and ligature points.

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

Monitoring: The approved centre had not completed hygiene or ligature audits since 2015. There was no documented analysis to identify opportunities to improve the ground floor of the premises.

Evidence of Implementation: The approved centre provided residents with access to personal space in terms of bedrooms. There was suitable and sufficient heating throughout the approved centre, and rooms were appropriately ventilated. Private and communal spaces were suitably sized and furnished to eliminate excessive noise. The lighting in communal rooms suited the needs of residents and staff.
Residents also had access to sufficient outdoor spaces and could walk the grounds of the hospital when they wanted.

Hazards such as large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised. Appropriate signage and sensory aids were not in place to support residents’ orientation needs because door signs had not been fitted on the upper level. Ligature points had not been minimised in the bedroom area downstairs.

The upper level of the approved centre was in an excellent state of repair because it had recently been refurbished. By contrast, there were problems on the lower level, including holes in walls, peeling floor covering, scratched walls, and peeling paint. The approved centre did not, however, have a programme of renewal of the fabric and decoration for this area.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment for the upper level of the approved centre. Maintenance issues were raised by the clinical nurse manager and passed on to the maintenance foreman.

A cleaning schedule incorporating a deep clean of each area at least once a week was in place, and current national infection guidelines were followed. The facility was clean, hygienic, and free from offensive odours. The approved centre had adequate toilet and bathroom facilities, including assisted needs facilities, with at least one assisted toilet per floor. Visitors could use the wheelchair accessible toilet facilities on the first floor but there was no signage to identify where they were.

Residents’ bedrooms were appropriately sized. Furnishings throughout the approved centre supported residents’ independence and comfort.

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

a)  The bedroom level was not maintained in good decorative condition, 22(1)(a).
b)  There was no programme of renewal for the fabric and decoration of the lower level, 22(1)(c).
c)  Ligature points had not been minimised in the bedroom area, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the ordering, storing, prescribing, and administration of medication, which was last reviewed in October 2016. It included requirements of the Judgement Support Framework, with the exception of processes for the following:

- Prescribing resident medication.
- Ordering resident medication.
- Administering controlled drugs, including checks and records required.
- Self-administering medication.
- Crushing medications.
- Managing medication at admission, transfer, and discharge.

Training and Education: Not all nursing and medical staff had signed a document 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. Not all nursing, medical, and pharmacy 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) had not been completed to determine compliance with the policies and procedures and with the relevant legislation and guidelines. There had been no analysis to identify opportunities for improving medication management.

Evidence of Implementation: An MPAR was maintained for each resident, and 21 of these were inspected. Two appropriate resident identifiers were used when medication was being administered. Names of medications were written in full, and generic names were recorded where applicable. The frequency of administration, the dosage, and the administration route for medications were recorded, as were the dates of initiation and discontinuation for each medication, where applicable. A record of any medications refused by residents was maintained. The Medical Council Registration Numbers of medical practitioners prescribing medication to residents were recorded on each MPAR.

The allergy section had not been completed in 19 of the 21 MPARs inspected.
Residents’ medication was reviewed every six months. Where there were alterations in the medication order, the medical practitioner rewrote the prescription. Medication, including scheduled controlled drugs, was appropriately administered by a registered nurse or registered medical practitioner. The expiration date of medication was checked prior to administration, and good hand-hygiene and cross-infection control techniques were implemented during the dispensing of medications. Where a resident’s medication was withheld, the justification was noted in the MPAR and documented in the respective clinical file. Where a resident refused medication, this was documented in the MPAR and clinical file and communicated to medical staff. Directions to crush medication were only accepted from the resident’s medical practitioner.

Medication arriving from the pharmacy was verified against the order and stored in the appropriate environment. Where medication required refrigeration, a log of fridge temperatures was maintained. The medication trolley was locked and secured. Medication dispensed to residents was secured in a locked medication room, either in a cupboard or the trolley. There were no scheduled controlled drugs in the approve centre at the time of the inspection. 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.

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, monitoring, and evidence of implementation pillars.
Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written documents in relation to health and safety: a safety statement dated October 2016 and an infection control and hygiene plan dated March 2016. Together, the documents included requirements of the Judgement Support Framework, with the exception of details of the following:

- The allocated safety representative roles.
- The fire management plan.
- Falls prevention initiatives.
- Vehicle controls.

Training and Education: Not all staff had signed the signature sheet indicating that they had read and understood the safety statement and hygiene plan. Not all staff interviewed were able to articulate the processes relating to health and safety, as set out in the safety statement and hygiene plan.

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to staffing, which was last reviewed in October 2016. It 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.
- The roles and responsibilities in relation to staffing processes.
- The roles and responsibilities in relation to staff training processes.

It did not include details of the following:

- The organisational structure of the approved centre.
- The process for reassigning staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility between staff members.
- Ongoing staff requirements and frequency of training required.
- The evaluation of training programmes.

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

Monitoring: There was no staffing plan for staff to review. Details of the number and skill mix of staff had not been assessed against the levels recorded in the approved centre’s registration. Analysis had not 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. A planned and actual staff rota was in place. Staff were recruited, selected, and vetted in line with the approved centre’s policy. Staff were qualified for their roles, and an appropriately qualified staff member was on duty and in charge at all times, as indicated by the rota. Where agency staff were used, there was a comprehensive contract between the approved centre and the staffing agency.

The number and skill mix of staff did not meet resident needs. A night-time inspection, conducted on the first day of the Mental Health Commission’s inspection, found that there was insufficient staff in that there were only two nurses on duty at night. Staff commenced the medication round upstairs at 9.30pm, after which residents went downstairs to their rooms. It was not possible for residents to retire early because there was insufficient staff to have both floors open at the same time. After residents retired the upstairs area was locked until 9.15am the following day.

Annual staff training plans were not in place for all staff. Staff orientation and induction training was completed. Not all health care professionals had received training in fire safety, Basic Life Support (BLS), Therapeutic Management of Aggression and Violence (TMAV), and the Mental Health Act (MHA) 2001. At least one staff member was trained in Children First. Not all staff were trained in accordance with the assessed needs of residents, and staff said they had difficulty getting time off to attend training.

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 trained. The MHA 2001, the associated regulation, Mental Health Commission rules and codes, and all other relevant Mental Health Commission documentation and guidance were made available to staff throughout the approved centre.

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

<table>
<thead>
<tr>
<th>Ward or Unit</th>
<th>Staff Grade</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Catherine’s Ward</td>
<td>CNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>HCA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Consultant Psychiatrist (on call)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Non-consultant hospital doctor (on call)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

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

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

a) The number and skill mix of staff was insufficient to meet residents’ needs, 26(2).

b) All staff did not have up-to-date mandatory training in BLS, fire safety, TMAV, and the MHA 2001, 26(4) and (5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the maintenance of records, which was last reviewed in June 2016. It covered requirements of the Judgement Support Framework, including policies and procedures relating to the following:

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

The policy did not reference record review requirements, the destruction of records, or the retention of reports relating to food safety, health and safety, and fire inspections.

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

Monitoring: Resident records were not audited to ensure their completeness, accuracy, and ease of retrieval. No analysis had been undertaken to identify opportunities for improving the processes relating to the maintenance of records.

Evidence of Implementation: A record was initiated for every resident, and residents’ current records were physically stored together in the nurses’ office. Records were reflective of the residents’ current status and the care and treatment being provided, and they were maintained using an appropriate, resident-specific identifier: a medical record number.
Not all residents’ records were secure or maintained in good order. Multiple boxes of old clinical files for archiving were stored in the staff toilet area, and some of these contained clinical entries and MPARs relating to current residents.

Clinical files were not always closed when health care records reached capacity, one file contained entries dating back to 2014, and one file had a torn outer cover. Records were not developed and maintained in a logical sequence so as to ensure completeness, accuracy, and ease of retrieval. Loose pages were observed in clinical files.

Resident records were accessible to authorised staff only, and only authorised staff could make entries in them. Residents had access to the records in line with the Data Protection Acts. Residents’ records contained factual, consistent, and accurate entries, which were written legibly and accompanied by a signature and the date and time, expressed using the 24-hour clock. Documentation relating to food safety, health and safety, and fire inspections was maintained.

Records were not retained or destroyed in accordance with legislative requirements and the approved centre’s policy and procedures.

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

a) Not all residents’ records were secure or maintained in good order, 27(1).

b) Records and reports were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval.

c) The records maintenance policy did not reference the destruction of records, 27(2).
### Regulation 28: Register of Residents

<table>
<thead>
<tr>
<th>NON-COMPLIANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Rating</td>
</tr>
<tr>
<td>Risk Rating</td>
</tr>
</tbody>
</table>

(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 did not have a documented register of residents.

The approved centre was not compliant with this regulation because it did not have a register of residents, 28(1).
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:

- Disseminating operating policies and procedures.
- Training on operating policies and procedures, including the requirements for training following the release of a new or updated policy and procedure.
- Making obsolete and retaining previous versions of policies and procedures.

In addition, the policy did not reference a standardised layout for operating policies and procedures.

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

Monitoring: There was 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 were developed with input from clinical and managerial staff and in consultation with all relevant stakeholders. Policies and procedures incorporated relevant legislation, evidence-based best practice, and clinical guidelines and were communicated to all relevant staff. Operating policies and procedures were appropriately approved before they were implemented.

All operating policies and procedures required by the regulations were reviewed within the required three-year time frame, and obsolete versions were removed from circulation. Operating policies and procedures were presented in a standardised format that included title, reference and version number, details of the document owner, date of implementation, and details of approvers and reviewers. Where generic policies were used, such as the HSE’s Your Service Your Say complaints procedure, there was a written statement adopting the policies in question.
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 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 did not have a written policy in relation to the facilitation of Mental Health Tribunals.

Training and Education: There was no policy for staff to have read and understood. Relevant staff interviewed were able to articulate the process for facilitating Mental Health Tribunals in the approved centre.

Monitoring: Analysis had not been completed to identify opportunities for improving the processes for facilitating Mental Health Tribunals.

Evidence of Implementation: To support the tribunals process, the approved centre provided private facilities and adequate resources. Staff assisted and supported residents to attend and participate in Mental Health Tribunals, where necessary. There had been one Mental Health Tribunal since the last inspection, and the patient did not require assistance.

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 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 October 2016. It included all the requirements of the Judgement Support Framework.

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

Monitoring: Audits of the complaints log had not been completed. Complaints data were 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. Ways in which residents and their representatives could lodge a complaint were detailed in the complaints policy and in notices on display in the approved centre. The approved centre’s management of complaints was well publicised and accessible, and copies of the HSE’s Your Service Your Say document were available.

All complaints were documented, investigated promptly, and handled with sensitivity. There were separate complaints logs for minor and serious complaints. Minor complaints were often raised by residents during community meetings, the minutes of which recorded the resolutions. Where complaints
could not be addressed by the nominated person, they were recorded and addressed by the senior executive officer.

The quality of service, care, and treatment of a resident was not adversely affected by reason of a complaint being made. Details of complaints, investigations, and outcomes were recorded and kept separately from the resident's individual care plan.

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 monitoring pillars.
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:
   - The identification and assessment of risks throughout the approved centre;
   - The precautions in place to control the risks identified;
   - The precautions in place to control the following specified risks:
     - resident absent without leave,
     - suicide and self harm,
     - assault,
     - accidental injury to residents or staff;
   - Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
   - Arrangements for responding to emergencies;
   - 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 policy in relation to risk management, which was last reviewed in October 2016. It addressed few of the requirements of the Judgement Support Framework, including the following:

- The process for rating identified risks.
- The record keeping requirement for risk management.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to emergencies.
- The roles and responsibilities in relation to the incident reporting process.

The policy did not address the following:

- The individual with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- The responsibilities of the multi-disciplinary team (MDT).
- The person responsible for the completion of six-monthly incident summary reports.
- A defined quality and safety oversight and review structure as part of the governance process.
- The processes of identification, assessment, treatment, reporting, and monitoring of risks, including:
  - Organisational risks.
  - Structural risks such as ligature points.
- Capacity risks relating to the number of residents in the approved centre.
- Health and safety risks to residents, staff, and visitors.
- Risks to the resident group during the provision of general care and services.
- Risks to individual residents during the delivery of individualised care.
- The methods for controlling risks such as resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register.
- The process for protecting children and vulnerable adults in the care of the approved centre.

**Training and Education:** Not all relevant staff had received training in the identification, assessment, and management of risk or in health and safety risk management. Clinical staff were trained in individual risk management. Management staff had not received training in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had acknowledged that they had read and understood the policy, and not all staff interviewed were able to articulate the risk management processes, as set out in the policy. All training was documented.

**Monitoring:** The risk register presented to the inspectors was blank, meaning that it could not be audited to determine compliance with the approved centre’s risk management policy. All incidents were documented and risk-rated. Analysis of incident reports had been completed to identify opportunities for improving 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.

The risk register did not record any risks, including clinical or corporate risks. Health and safety risk had not been identified, assessed, treated, reported, and monitored, as indicated by the stacking of boxes of files in the staff room up to door-height level.

Structural risks, including ligature points, were monitored and mitigated. A plan was in place to reduce risks to residents during renovations to the approved centre.

The approved centre completed resident risk assessments at admission to identify individual risk factors. Assessments were also completed prior to resident transfer and discharge and in conjunction with medication requirements or administration. The requirements for the protection of children and vulnerable adults were appropriate and implemented as necessary.

The MDT did not have input into the development, implementation, and review of individual risk management processes and residents and/or their representatives were not involved in risk management.

Incidents were recorded and risk-rated using a standardised form, and clinical incidents were reviewed by the MDT at their regular meetings. Incidents were reviewed for any trends or patterns occurring in the service using the National Incident Management System, and 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 not compliant with this regulation for the following reasons:

a) The risk management policy was not comprehensive, 32(1).

b) The risk management policy did not address the identification and assessment of risks throughout the approved centre, including organisational risks, structural risks, capacity risks, health and safety risks, and risks to the residents during the provision of general care and services and the delivery of individualised care, 32(2)(a).

c) The risk management policy did not include arrangements for the protection of children and vulnerable adults in the care of the approved centre, 31(2)(f).
**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 auspices of the State Claims Agency for public liability, employer’s liability, clinical indemnity, and property.

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

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was prominently displayed.

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

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

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

INSPECTION FINDINGS

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

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

INSPECTION FINDINGS

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

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

INSPECTION FINDINGS

As the approved centre did not use mechanical means of bodily restraint, 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

During the inspection, there was one involuntary patient in the approved centre for more than three months and in continued receipt of medication. The patient had consented to treatment, and the consent form included 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 in terms of the nature and purpose and effects of the medication(s).
- Supports provided to the patient in terms of the discussion and their decision-making process.

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.
Use of Physical Restraint

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

**INSPECTION FINDINGS**

**Processes:** The approved centre had a written policy in relation to the use of physical restraint, which was last reviewed in January 2017. The policy had been reviewed annually and it addressed 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, nor did it reference the provision of information to residents.

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

As there had been no episodes of physical restraint in the approved centre since the last inspection, the monitoring and evidence of implementation pillars for this regulation were not inspected against.

The approved centre was 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) There was no written record indicating that all staff 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 the approved centre did not admit children, this code of practice was not applicable.
Notification of Deaths and Incident Reporting

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

INSPECTION FINDINGS

Processes: The approved centre had a risk management policy in relation to incident reporting to the Mental Health Commission (MHC). The notification of deaths was addressed in the care of the dying policy, which outlined the roles and responsibility of staff in relation to the reporting of deaths and incidents.

The incident management policy did not identify a risk manager or specify the roles and responsibilities in relation to the following:

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

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

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

There had been no deaths in the approved centre since the last inspection.

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

a) The policy did not identify the risk manager or person with responsibility for risk management within the mental health service, 4.2.

b) The policy did not reference the roles and responsibilities in relation to completing death notification forms, submitting forms to the Mental Health Commission, and completing six-monthly incident summary reports, 4.3.

c) The approved centre was non-compliant with Regulation 32: Risk Management Procedures, 3.1.
INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to working with people with an intellectual disability. It reflected person-centred treatment planning and presumption of capacity, and it addressed the roles and responsibilities of staff and the process for ensuring appropriate and relevant communication and liaison with relevant external agencies. The policy did not address the following:

- The management of problem behaviours.
- The procedures for training staff in working with people with an intellectual disability.
- Least restrictive interventions.

Training and Education: There was documentary evidence that education and training was provided in support of the principals and guidance of this code of practice. Staff had received training in person-centred approaches, relevant human rights principles, and preventative and responsive approaches to problem behaviours.

Monitoring: The policy had been reviewed in January 2017, within the required three-year time frame.

Evidence of Implementation: Residents diagnosed with an intellectual disability had an individual care plan (ICP), which contained assessed needs and available resources but did not address the level of support and treatment required or consideration of the environment.

Residents 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 engagement in meaningful activities.

There was no documentary evidence that residents’ understanding of information had been documented. Assessments of functional capacity had not been completed. No key worker had been identified.

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

a) The relevant policy did not reference least restrictive practices, 5.3.

b) There was no process for managing problem behaviours, 5.3.

c) There were no policy or procedures for training staff in working with people with an intellectual disability, 6.2.
<table>
<thead>
<tr>
<th>d)</th>
<th>No key worker had been identified, 8.4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>e)</td>
<td>There was no evidence that the resident’s understanding of the information given was documented, 9.6.</td>
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<tr>
<td>f)</td>
<td>A capacity assessment using a functional approach had not been undertaken, 12.2 and 12.3.</td>
</tr>
</tbody>
</table>
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, which were dated June 2016.

Admission: The admission policy included processes for planned admission, with reference to pre-admission assessments, eligibility for admission, and referral letters. It detailed the roles and responsibilities of multi-disciplinary team (MDT) members in relation to post-admission assessment. It contained a procedure for involuntary admission. There was a separate policy on confidentiality, privacy, and consent. The policy did not include protocols for urgent referrals, self-presenting individuals, and timely communication with primary care or community mental health care teams.

Transfer: The transfer policy detailed how a transfer is arranged and outlined the roles and responsibilities of staff in relation to the transfer of residents. It included procedures for involuntary transfer and transfer abroad, and it addressed the safety of the resident and staff during a transfer. It did not include provisions for an emergency transfer.

Discharge: The discharge policy included procedures for the discharge of homeless people and older people. It referenced prescriptions and supply of medication on discharge and documented the roles and responsibilities of staff in relation to providing follow-up care, including when and how much follow-up contact residents should have.

The policy did not include procedures for discharging involuntary patients, managing discharge against medical advice or a protocol for discharging people with an intellectual disability. The follow-up procedures did not reference relapse prevention strategies, crisis management plans, or a process for following up and managing missed appointments.

Training and Education: Staff had signed a log to indicate that they had read and understood the policies on admission, transfer, and discharge.

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

The admission, transfer, and discharge processes were non-compliant because the approved centre did not comply with Regulation 32: Risk Management Procedures.

**Admission:** The clinical file of one resident was examined in relation to admission. It 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). An admission assessment was completed by the RMP, and assessments and examinations were documented in the clinical files. The resident was admitted to the unit most appropriate to his or her needs. There was no evidence in the clinical file that a family member/advocate/carer was involved in the admission process.

The approved centre’s admissions process was compliant under Regulation 7: Clothing and Regulation 8: Residents’ Personal Property and Possessions. It was not compliant under Regulation 15: Individual Care Plan, Regulation 20: Provision of Information to Residents and Regulation 27: Maintenance of Records.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents. The clinical files of two residents who had recently been transferred to another facility were inspected. The decision to transfer was made by the RMP following an assessment and it was agreed with the receiving facility.

There was no evidence in either clinical file that an attempt was made to respect the residents’ wishes and obtain consent or that there was contact with the residents’ family/carer/advocate. In one case, MDT involvement was not recorded. In one case, the clinical file did not contain a copy of the referral letter.

**Discharge:** As no residents had been discharged from the approved centre since the last inspection, the evidence of implementation pillar for this code of practice was not inspected against.

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

- a) The admission policy did not include a protocol for urgent referrals, 4.4.
- b) The admission policy did not include a protocol for individuals who self-present, 4.5.
- c) The admission policy did not include a protocol for timely communication with primary care and community mental health care teams, 4.9.
- d) The transfer policy did not include provisions for emergency transfer, 4.13.
- e) The discharge policy did not include a procedure for the discharge of involuntary patients, 4.2.
- f) The post-discharge follow-up procedures did not reference relapse prevention, crisis management, or a means of following up and managing missed appointments, 4.14.
- g) The discharge policy did not include procedures for managing discharge against medical advice, 4.15.
- h) The discharge policy did not include a protocol for discharging people with an intellectual disability, 4.16.
- i) There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies, 4.19.
j) The clinical file inspected in relation to admission did not contain evidence that family member/advocate/carer was involved in the admission process, 18.3.

k) The admission policy was non-compliant because the approved centre did not comply with Regulation 20: Provision of Information to Residents, 16.3(c).

l) The admission policy was non-compliant because the approved centre did not comply with Regulation 15: Individual Care Plan, 17.1.

m) The admission policy was non-compliant because the approved centre did not comply with Regulation 27: Maintenance of Records, 22.6

n) In the two clinical files examined in relation to transfer, it was not recorded that the residents’ consent to the transfer had been sought, 28.1 and 31.4.

o) In one of the transfers, a copy of the referral letter was not retained in the resident’s clinical file, 31.2.

p) There was no evidence of MDT involvement in one of the transfers, 29.1.

q) The approved centre was non-compliant with Regulation 32: Risk Management Procedures, 7.1.
## Appendix 1 – Corrective and Preventative Action Plan

### Regulation 15: Individual Care Plan

*Report reference: Page 31-32*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring¹ or New² area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>1. ICPs did not contain appropriate goals.</td>
<td>New</td>
<td>Corrective Action(s): 1. New ICPs have been developed to include appropriate goals 2. The ICP policy will be reviewed 3. Training will be provided in the care planning process. Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): 1. All staff will be informed of the new ICP which should be reviewed in consultation and collaboration with the resident. 2. All staff will sign a log indicating that they have read and understood the policy Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
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</tbody>
</table>

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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>
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<tbody>
<tr>
<td>2. The resources required to meet assessed needs were not specified in three ICPs.</td>
<td>New</td>
<td>Corrective Action(s): Resources identified in ICPs will be specified and addressed in all Care Plans. Post-Holder(s) responsible: Dr. Josip Dujmovic, Consultant Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
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<tr>
<td></td>
<td></td>
<td>Preventative Action(s): All staff will be informed of the new ICP procedure. And documentation. Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td>3. The care and treatment required to meet identified goals were not specified in two ICPs.</td>
<td>New</td>
<td>Corrective Action(s): 1. New ICPs have been developed to include appropriate goals, care and treatment 2. The ICP policy will be reviewed Post-Holder(s) responsible: Dr. Josip Dujmovic, Consultant Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): All staff will be informed of the new ICP procedure. And documentation. Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
</tr>
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<tr>
<td>4. ICPs were not developed by an MDT with full MDT input.</td>
<td>New</td>
<td>Corrective Action(s): Full MDT meetings are being held fortnightly and ICPs are reviewed and discussed. Post-Holder(s) responsible: 1. Dr. Josip Dujmovic, Consultant 2. James Creasey OT Manager 3. David Hughes S/W Manager 4. Dr. Edgar Lonergan, Psychology Manager 5. Martin Denny, ADON</td>
<td>Audit of the ICP.</td>
<td>This objective has been achieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): All staff will be informed of the new ICP procedure and documentation. Post-Holder(s) responsible: 1. Dr. Josip Dujmovic, Consultant 2. James Creasey OT Manager 3. David Hughes S/W Manager 4. Dr. Edgar Lonergan, Psychology Manager 5. Martin Denny, ADON</td>
<td>Audit of the ICP.</td>
<td>This is both achievable and realistic.</td>
</tr>
</tbody>
</table>
### Regulation 19: General Health
*Report reference: Page 37-38*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5. Adequate arrangements were not in place for residents to access general health services or to be referred to other health services.</strong></td>
<td>New</td>
<td>Corrective Action(s): Residents will be able to access/or be referred to general or other health services. Review Pathway for General Health Services is being developed to include Speech and Language Therapy and Dietary Provision.</td>
<td>Referral Pathways will be reviewed to ensure proper accessibility.</td>
<td>This is both achievable and realistic.</td>
</tr>
</tbody>
</table>

Post-Holder(s) responsible:
1. Dr. Josip Dujmovic, Consultant
2. Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)
3. General Practitioner
4. Kevin Morrison, Senior Executive Officer

Preventative Action(s):
1. All staff will be informed of the referral process.
2. All staff will sign a log indicating that they have read and understood the referral process and related policies.

Post-Holder(s) responsible:
Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)

Referral Pathways will be reviewed to ensure proper accessibility.

This is both achievable and realistic.

December 2017 and ongoing
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</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>6. Residents did not receive relevant information because there was no information booklet.</td>
<td>New</td>
<td>Corrective Action(s): An information Booklet has been developed and will be available to all residents Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the Provision of Information. Information Booklet will be available to all residents.</td>
<td>This objective has been achieved Completed: August 2017</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): 1. All staff will be informed of the Patient Booklet. 2. All staff will sign a log indicating that they have read and understood the policy Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the Provision of Information Information Booklet will be available to all residents</td>
<td>This is both achievable and realistic.</td>
<td>October 2017</td>
</tr>
<tr>
<td>7. Residents did not routinely receive written and verbal information about their diagnosis.</td>
<td>New</td>
<td>Corrective Action(s): Residents will receive written and verbal information on their diagnosis Post-Holder(s) responsible: 1. Dr. Josip Dujmovic, Consultant 2. Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the Provision of Information This information will be included in a patient diagnosis leaflet.</td>
<td>This is both achievable and realistic. September 2017</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s):</td>
<td>Audit of the Provision of Information</td>
<td>This is both achievable and realistic.</td>
<td>October 2017</td>
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</table>
|                          | 1. All staff will be informed of the Patient diagnosis leaflets.  
2. All staff will sign a log indicating that they have read and understood the policy  
Post-Holder(s) responsible:  
1. Dr. Josip Dujmovic, Consultant  
2. Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II) | This information will be included in a patient diagnosis leaflet. | | |
|                          | 8. Information on indications for the use of all medications administered to residents was not routinely provided to residents. | New  
Corrective Action(s): Information on indications for the use of all medications administered to residents will be routinely provided to residents.  
Post-Holder(s) responsible:  
1. Dr. Josip Dujmovic, Consultant  
2. Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II) | Audit of the Provision of Information  
This information will be included in patient medication leaflets. | This is both achievable and realistic | September 2017 |
|                          | Preventative Action(s):  
1. All staff will be informed of the Patient leaflets.  
2. All staff will sign a log indicating that they have read and understood the policy  
Post-Holder(s) responsible: 1. Dr. Josip Dujmovic, Consultant  
2. Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II) | Audit of the Provision of Information  
This information will be included in patient medication leaflets. | This is both achievable and realistic. | October 2017 |
## Regulation 21: Privacy

### Report reference: Page 41

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
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<td><strong>Taken from the inspection report</strong></td>
<td><em>Reoccurring or New area of non-compliance</em></td>
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<td></td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
<td>Provide the timeframe of the completion of the action(s)</td>
</tr>
<tr>
<td>9. Identifiable resident information was displayed on a notice board in the nurses’ station, which could be viewed by the public.</td>
<td>New</td>
<td>Corrective Action(s): Identifiable resident information will be removed from a notice board in the nurses’ station. Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Inspection</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): All staff will sign a log indicating that they have read and understood the policy Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>A record that staff have read and understood the policy will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
<td>October 2017</td>
</tr>
<tr>
<td>10. The absence of a bed screen in a shared bedroom compromised the resident’s privacy.</td>
<td>New</td>
<td>Corrective Action(s): Bed screens will be provided in the shared bedrooms. Spare bed screens will be available at all times. Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Audit of the Privacy Policy</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): Annual review of policy will take place Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>Annual review of Policy</td>
<td>This is both achievable and realistic.</td>
<td>October 2017</td>
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</table>
## Regulation 22: Premises

### Report reference: Page 42-43

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
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<th>Achievable / Realistic</th>
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<tr>
<td><strong>Regulation 22</strong></td>
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<tr>
<td><strong>Taken from the inspection report</strong></td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>11. The bedroom level was not maintained in good decorative condition.</td>
<td>Reoccurring since 2016 (in relation to the premises in general)</td>
<td>Corrective Action(s): Meeting held with Maintenance Department in August 2017 to develop a schedule of works for the bedroom level. Works will commence in Autumn 2017 and will be a rolling programme over 2017/18</td>
<td>The approved centre will be in good decorative condition</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): The approved centre will be assessed for decorative condition on a quarterly basis.</td>
<td>The approved centre will be in good decorative condition</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. There was no programme of renewal for the fabric and decoration of the lower level.</td>
<td>New</td>
<td>Corrective Action(s): Meeting held with Maintenance Department in August 2017 to develop a schedule of works for the bedroom level. Works will commence in Autumn 2017 and will be a rolling programme over 2017/18</td>
<td>The approved centre will be in good decorative condition</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer Maintenance Department</td>
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<tr>
<td>Area(s) of non-compliance</td>
<td>Specific</td>
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</tr>
<tr>
<td>13. Ligature points had not been minimised in the bedroom area.</td>
<td>Preventative Action(s): The approved centre will be assessed for decorative condition on a quarterly basis. Post-Holder(s) responsible: Michelle Curran/Dermot Houlihan (Clinical Nurse Manager II)</td>
<td>The approved centre will be in good decorative condition</td>
<td>This is both achievable and realistic.</td>
<td>January 2018</td>
</tr>
<tr>
<td></td>
<td>Corrective Action(s): Ligature review will be completed and any ligature points identified will be corrected. Post-Holder(s) responsible: MarieLouise Sheehy, Risk and Patient Safety Advisor Martin Denny (Assistant Director of Nursing), Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>Any ligature points identified following the last ligature audit will be removed and/or addressed.</td>
<td>This is both achievable and realistic.</td>
<td>Ligature points will be addressed and/or removed by 31.08.17.</td>
</tr>
<tr>
<td></td>
<td>Preventative action(s): An updated ligature audit will be conducted on the unit. Post-holder(s): Martin Denny (Assistant Director of Nursing), Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>An updated ligature audit will be available for inspection by 31.08.17.</td>
<td>This is both achievable and realistic.</td>
<td>A ligature audit will be completed by 31.08.17.</td>
</tr>
</tbody>
</table>
## Regulation 26: Staffing

*Report reference: Page 48-49*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
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<th>Achievable / Realistic</th>
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<tr>
<td>Taken from the inspection report</td>
<td>Reoccurring or New area of non-compliance</td>
<td>Provide corrective and preventative action(s) to address the area of non-compliance</td>
<td>Provide the method of monitoring the implementation of the action(s)</td>
<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>14. The number and skill mix of staff was insufficient to meet residents’ needs.</td>
<td>Reoccurring since 2016</td>
<td>Corrective action(s): A review of staffing and skill mix has taken place to scope suitable solutions. Post-holder(s): Ned Kelly (Area Director of Nursing), Kevin Morrison (Senior Executive officer), Martin Denny (Assistant Director of Nursing).</td>
<td>Staffing will be reviewed.</td>
<td>This is both achievable and realistic but will be dependent on available resources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative action(s): A review of staffing will be completed. Post-holder(s): Ned Kelly (Area Director of Nursing), Kevin Morrison (Senior Executive officer), Martin Denny (Assistant Director of Nursing).</td>
<td>Staffing will be reviewed.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td>15. All staff did not have up-to-date mandatory training in BLS, fire safety, PMAV, and the MHA 2001.</td>
<td>Reoccurring since 2016</td>
<td>Corrective action(s): All staff will receive mandatory training in Fire Safety, Basic Life Support, Professional Management of Aggression and Violence and the Mental Health Act as required. Post-holder(s): Martin Denny (Assistant Director of Nursing). Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>All staff will be able to verify that they have received the necessary training in Fire Safety, Basic Life Support, Professional Management of Aggression and Violence and the Mental Health Act as required.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<tr>
<td></td>
<td>Preventative action(s): All staff will receive mandatory training in Fire Safety, Basic Life Support, Professional Management of Aggression and Violence and the Mental Health Act as required. Post-holder(s): Martin Denny (Assistant Director of Nursing). Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>All staff will be able to verify that they received the necessary training in Fire Safety, Basic Life Support, Professional Management of Aggression and Violence and the Mental Health Act as required.</td>
<td>This is both achievable and realistic.</td>
<td>Ongoing 2017</td>
</tr>
</tbody>
</table>
## Regulation 27: Maintenance of Records

**Report reference: Page 50-51**

<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 details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td><strong>16. Not all residents’ records were secure or maintained in good order.</strong></td>
<td>Reoccurring since 2016 (in relation to maintained in good order)</td>
<td>Corrective Action(s): Administration staff have / will ensure that resident’s records are in good order. Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer</td>
<td>Audit of Records</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Administration staff will ensure that resident’s records are in good order. Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer</td>
<td>Audit of Records</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td><strong>17. Records and reports were not maintained in a manner so as to ensure completeness, accuracy, and ease of retrieval.</strong></td>
<td>New</td>
<td>Corrective Action(s): Administration staff have / will ensure that resident’s records are in good order. All deficits are being addressed. Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer</td>
<td>Audit of Records</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Administration staff will ensure that resident’s records are in good order. Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer</td>
<td>Audit of Records</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
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<tr>
<td>18. The records maintenance policy did not reference the destruction of records.</td>
<td>New</td>
<td>Corrective Action(s): Policy to be reviewed Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer</td>
<td>Audit of Policy</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s): Policy to be reviewed All staff will be informed of the updated policy. Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer</td>
<td>Audit of Policy</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
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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>
</tr>
<tr>
<td>19. Did not have a register of residents.</td>
<td>New</td>
<td>Corrective Action(s):</td>
<td>Register available for inspection</td>
<td>This objective has been achieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Register now in place</td>
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<tr>
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<td></td>
<td>Post-Holders responsible:</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative Action(s):</td>
<td>Register available for inspection</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Register now in place</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td>Post-Holders responsible:</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
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</tbody>
</table>

Report reference: Page 52
## Regulation 32: Risk Management Procedures (and Code of Practice: Notification of Deaths and Incident Reporting)

*Report reference: Page 58-59 and 73*

<table>
<thead>
<tr>
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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>
</tr>
</tbody>
</table>
| **20. The risk management policy did not meet all requirements of the regulation and code of practice.** | Reoccurring since 2016 for code of practice | Corrective Action(s): Policy to be reviewed  
Post-Holder(s) responsible:  
Dr. Josip Dujmovic, Consultant  
2. James Creasey OT Manager  
3. David Hughes S/W Manager  
4. Dr. Edgar Lonergan, Psychology Manager  
5. Martin Denny, ADON  
6. Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II). | The policy will have been reviewed. | This is both achievable and realistic. | The policy will be reviewed by 01.10.17. |
| Preventative action(s): The policy will have been reviewed within the specified time frame.  
Post-holder(s):  
Martin Denny, ADON  
Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II). | The policy will have been reviewed. | This is both achievable and realistic. | The policy will be reviewed by 01.10.17. |
## Code of Practice: The Use of Physical Restraint

**Report reference: Page 71**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<td><strong>Provide corrective and preventative action(s) to address the area of non-compliance</strong></td>
<td><strong>Provide the method of monitoring the implementation of the action(s)</strong></td>
<td><strong>Provide details of any barriers to the implementation of the action(s)</strong></td>
</tr>
<tr>
<td>21. The policy did not identify those authorised to initiate and implement physical restraint.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): Policy has been reviewed Post-Holder(s) responsible: Martin Denny, ADON</td>
<td>The policy has been reviewed.</td>
<td>This objective has been achieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative action(s): The policy will have been reviewed within the specified time frame. Post-holder(s): Martin Denny, ADON</td>
<td>The policy has been reviewed and will be audited.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td>22. There was no written record indicating that all staff had read and understood the policy.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): All staff will sign a log indicating that they have read and understood the policy Post-Holder(s) responsible: Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>A record that staff have read and understood the policy will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
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<td>Preventative action(s): The requirement for staff to record that they have read and understood the policy will be communicated in staff induction material. Post-holder(s): Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>Staff induction material will be amended to ensure that staff read and understand the policy and record same.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td>Provide details of any barriers to the implementation of the action(s)</td>
</tr>
<tr>
<td>23. The policy did not meet all requirements of the code of practice.</td>
<td>Reoccurring since 2016</td>
<td>Corrective Action(s): Policy will be reviewed Post-Holder(s) responsible: Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preventative action(s): The policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection. Post-holder(s): Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
<td>24. No key worker had been identified.</td>
<td>New</td>
<td>Corrective Action(s): Policy will be reviewed and Key workers will be identified. Post-Holder(s) responsible: Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
</tr>
<tr>
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<td>Preventative action(s): The policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection. Post-holder(s): Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
</tr>
<tr>
<td>25. There was no evidence that the resident’s understanding of the information given was documented.</td>
<td>Corrective Action(s): Policy will be reviewed and resident’s understanding will be documented. Post-Holder(s) responsible: Dr. Josip Dujmovic, Consultant Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
</tr>
<tr>
<td></td>
<td>Preventative action(s): The policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection. Post-holder(s): Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
</tr>
<tr>
<td>26. A capacity assessment using a functional approach had not been undertaken.</td>
<td>Corrective Action(s): Policy will be reviewed and a Capacity assessment will be completed. Post-Holder(s) responsible: Dr. Edgar Lonergan, Psychology Manager</td>
<td>A capacity assessment using a functional approach will be undertaken.</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.11.17.</td>
</tr>
<tr>
<td>Area(s) of non-compliance</td>
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<td></td>
<td>Preventative action(s): The policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection. Post-holder(s): Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II).</td>
<td>Policy on Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities will be available for inspection.</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
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<tr>
<td>Reoccurring or New area of non-compliance</td>
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<tr>
<td>27. The admission, transfer and discharge policies did not meet all requirements of the code of practice.</td>
<td>Corrective Action(s): Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
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<tr>
<td></td>
<td>Preventative Action(s): Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
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<tr>
<td>28. There was no documentary evidence that audits had been completed on the implementation of and adherence to the admission or discharge policies.</td>
<td>Corrective Action(s): Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
</tr>
<tr>
<td></td>
<td>Post-Holder(s) responsible: Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
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<tr>
<td></td>
<td>Preventative Action(s): Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>Audit of Code of Practice: Admission, Transfer and Discharge</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
</tr>
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</tr>
<tr>
<td>Post-Holder(s) responsible: Martin Denny, ADON Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
<td>Audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
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<tr>
<td>Corrective Action(s): All family will be involved in the admission process. Audit of Code of Practice: Admission, Transfer and Discharge</td>
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</tr>
<tr>
<td>Preventative Action(s): Audit of Code of Practice: Admission, Transfer and Discharge</td>
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<td></td>
</tr>
<tr>
<td>Post-Holder(s) responsible: Dr. Josip Dujmovic, Consultant Dermot Houlihan (Clinical Nurse Manager II), Michelle Curran (Clinical Nurse Manager II)</td>
<td>Audit of Code of Practice: Admission, Transfer and Discharge.</td>
<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
<td></td>
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<td>This is both achievable and realistic.</td>
<td>The policy will be reviewed by 01.10.17.</td>
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<td>31. In one of the transfers, a copy of the referral letter was not retained in the resident’s clinical file.</td>
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<td>32. There was no evidence of MDT involvement in one of the transfers.</td>
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<td>Where appropriate MDT members will be involved in Transfers.</td>
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