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

ID Number: AC0044

2018 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 Services – Cork & Kerry

Inspection Team:
Dr Ann Marie Murray MCRN363031, Lead Inspector
Dr Enda Dooley MCRN004155
Carol Brennan-Forsyth

Inspection Date:
13-16 March 2018

Inspection Type:
Unannounced Annual Inspection

Previous Inspection Date:
16 - 19 May 2017

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication:
6 September 2018

2018 COMPLIANCE RATINGS

REGULATIONS
RULES AND PART 4 OF THE MENTAL HEALTH
CODES OF PRACTICE

Compliant
Non-compliant
Not applicable
RATINGS SUMMARY 2016 – 2018

Compliance ratings across all 39 areas of inspection are summarised in the chart below.

Chart 1 – Comparison of overall compliance ratings 2016 – 2018

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 2016 – 2018
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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, achievable, realistic, and time-bound (SMART). The approved centre’s CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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

Inspector of Mental Health Services

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

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

In Brief

St. Catherine’s Ward in St. Finbarr’s Hospital was a 21-bed unit located over two floors with day accommodation predominantly on the upper floor and sleeping accommodation on the lower floor. It functioned as a continuing care and rehabilitation facility. Over the last three years, there had been a modest improvement in the level of compliance, although the risk ratings applied to areas of non-compliance had deteriorated. Following this inspection, risk management was deemed a critical risk. In 2018, 75% of non-compliances were considered high or critical risk. No compliances were rated as excellent.

Safety in the approved centre

The risk management policy was deficient in a number of areas. Staff training in risk management process was not adequate to safeguard resident needs. The number and skill-mix of staff was not adequate to address resident needs and not all staff had received training in various areas deemed essential under the relevant regulation. The register did not adequate record the required information. Medication management processes were adequate as were food safety processes.

Appropriate care and treatment of residents

The needs of residents identified as having special nutritional or dietary needs were not regularly reviewed. Individual care plans were not adequate and there was a failure to ensure full multi-disciplinary team involvement in the review process. Therapeutic programmes were not adequately resourced with a lack of adequate input from allied health professionals. Programme content was predominantly recreational rather than therapeutic. All residents had regular physical reviews documented but access to secondary care, particularly in the areas of dietetics and speech and language assessment, was inadequate. Resident clinical records were not in good order. Consent processes required under part 4 of the Act were inadequate and require immediate review to ensure compliance. As previously, there were multiple deficits in the processes relating to the code of practice on admission, transfer, and discharge.
Respect for residents’ privacy, dignity and autonomy
Residents were supported to keep and wear their own personal clothing. Residents had access to personal locked wardrobes and there was adequate provision to safeguard residents’ personal possessions. Bathrooms, showers and toilets all had locks on the inside of the doors with an override facility, if required. Single rooms did not have locks on the doors. Due to limited staff availability and the structure of the unit, residents did not have access to their bedrooms until 10.00pm. This was considered a restrictive practice not supporting or respecting the autonomy of the person. All personal or treatment rooms were appropriately screened. Resident personal data, in particular incident forms, was not appropriately stored to ensure confidentiality of the information.

Responsiveness to residents’ needs
Residents on modified diets were not routinely offered a choice of meals. Where residents were on modified consistency diets, the meals were not presented in an attractive fashion. As outlined previously, residents did not have access their bedrooms from morning until 10.00pm. They had access to refurbished communal areas, which provided adequate recreational space. The lower floor required significant refurbishment to meet the reasonable needs of residents. Visiting facilities were adequate. Residents were facilitated in making private contact with families or other external contacts. They were provided with an information booklet that outlined processes within the unit, and information on diagnosis and treatment effects was available.

Governance of the approved centre
The approved centre was part of the HSE Community Healthcare Organisation (CHO) area 4. It came under the direct management of the Cork Executive Management Team (EMT). There was a local management group for the approved centre but minutes provided indicated that this group did not meet on a regular basis. Minutes of the local management group did not reference risk management. The process for escalating local issues to the EMT was unclear and EMT minutes made only minimal reference to the approved centre. Review of the centre’s risk register was infrequent. There was not a clear understanding of governance issues relating to the approved centre by all heads of discipline. A clear strategic aim for the centre was not apparent. Processes for staff supervision and support were in place. Operational risks identified included lack of staffing, in particular lack of regular input from allied health professionals. The lack of dedicated rehabilitation team input to the approved centre was also identified. Staffing difficulties were highlighted by the on-going problems managing a unit that was located over two floors.
3.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had developed a horticulture project in the garden area that had been awarded a certificate of recognition from the Cork Food Policy Council.

2. The service had commenced a multi-disciplinary team assessment of needs of all residents.
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 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. There was a lift to transport the residents between floors. St. Catherine’s Ward operated as a continuing care facility and a rehabilitation unit. The upstairs day accommodation had been extensively renovated. The downstairs area was in need of maintenance and refurbishment.

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

<table>
<thead>
<tr>
<th>Resident Profile</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of registered beds</td>
<td>21</td>
</tr>
<tr>
<td>Total number of residents</td>
<td>21</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>1</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>2</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>20</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</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 (CHO4) area. There were two Executive Management (EMT) teams in place for CHO4. The Cork EMT and the Kerry EMT. The Cork EMT governed St. Catherine’s Ward.

There was a local management group for the approved centre and minutes were provided. These meetings did not occur on a regular basis. No minutes were provided after September 2017. The minutes provided did not reference risk management.

Staff in the approved centre reported there was a South Lee meeting but gave conflicting views at what level this management meeting was at. No minutes of these meetings were provided.
The minutes of the Cork EMT were provided. There was no reference to the St. Catherine’s local management team meeting or to a South Lee meeting. It was not clear how the local management group communicated with or escalated issues to the EMT. In the EMT minutes, there was evidence that items such as staffing, budget and national initiatives were being discussed, with clear actions identified. There was just one reference to St. Catherine’s unit since last June. The minutes documented that the risk register was last reviewed in June 2017 by the risk advisor.

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

- Clinical Director
- Area Director of Nursing
- Area Lead Social Work, Acting as Principal Social Worker
- Principal Psychologist
- Occupational Therapy Manager

Not all the heads of discipline had a clear understanding of lines of governance in relation to management meetings. Defined lines of responsibility were evident within each department. Each head of discipline met with their staff on a regular basis and there were clear processes for escalating issues of concern to heads of discipline. Not all heads of discipline had identified strategic aims for their departments. Not all departments had staff performance appraisals but all stated that this process was informally facilitated or addressed through supervision.

It was acknowledged by heads of disciplines that there was not a rehabilitation team in place for St. Catherine’s and that a business case had been put forward for a rehabilitation team. Not all heads of discipline had received training on clinical risk management. Staffing shortages and the approved centre being spread over two floors were acknowledged as the biggest operational risks by the heads of disciplines. Challenges relating to these risks included the locking of the bedroom area and the lack of dedicated allied health professionals to the unit, with an identified unmet need for Occupational Therapy. Quality improvement projects were ongoing for many of the disciplines but none of these related to the approved centre. The heads of discipline reported it was a challenge to engage in quality improvement when staffing resources were an issue.

Not all the heads of discipline were involved in drawing up and implementing Corrective and Preventative Action Plans (CAPAs) from the 2017 inspection. Those that were involved stated the main barriers of implementing CAPAs from last year’s inspection were due to on-going refurbishment and associated budgetary issues.
4.5 Use of restrictive practices

Environmental

The bedroom area downstairs was locked from 9:15 am until 10.00 pm. This meant residents could not access their bedrooms freely during this time. The rationale for locking of the bedroom area was not documented or regularly reviewed. A proposal had been made to recruit a “twilight” member of staff to allow access to the bedrooms from 18:00. This plan was in place since the 2017 inspection but had not yet been implemented. No date was provided to the inspection team for when this position would be in place.
5.0 Compliance

5.1 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 2017 and 2016 and the relevant risk rating when the service was non-compliant:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 5 Food and Nutrition</td>
<td>X Moderate</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 15 Individual Care Plan</td>
<td>X Low</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 16 Therapeutic Services &amp; Programmes</td>
<td>X Moderate</td>
<td>✓</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 19 General Health</td>
<td>X High</td>
<td>X High</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 22 Premises</td>
<td>X High</td>
<td>X Moderate</td>
<td>X High</td>
</tr>
<tr>
<td>Regulation 26 Staffing</td>
<td>X Moderate</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 27 Maintenance of Records</td>
<td>X High</td>
<td>X High</td>
<td>X Moderate</td>
</tr>
<tr>
<td>Regulation 28 Register of Residents</td>
<td>X Moderate</td>
<td>X Low</td>
<td>X Moderate</td>
</tr>
</tbody>
</table>

| Regulation 32 Risk Management Procedures                       | ✓ Moderate                  | X Critical                 |                           |
| Part 4 of The Mental Health Act 2001 Consent to Treatment       | ✓                           | ✓                          | X High                     |
| Code of Practice on the Use of Physical Restraint in Approved Centres | X Moderate | X Low | X Moderate |
| Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre | X Moderate | X Moderate | X High |

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

5.2 Areas of compliance rated “excellent” on this inspection

No areas of compliance were rated excellent on this inspection
### 5.3 Areas that were not applicable on this inspection

<table>
<thead>
<tr>
<th>Regulation/Rule/Code of Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17: Children’s Education</td>
<td>As the approved centre did not admit children, this regulation was not applicable.</td>
</tr>
<tr>
<td>Regulation 25: Use of Closed Circuit Television</td>
<td>As CCTV was not in use in the approved centre, this regulation was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Electro-Convulsive Therapy</td>
<td>As the approved centre did not provide an ECT service, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Seclusion</td>
<td>As the approved centre did not use seclusion, this rule was not applicable.</td>
</tr>
<tr>
<td>Rules Governing the Use of Mechanical Means of Bodily Restraint</td>
<td>As no resident had been mechanically restrained since the last inspection, this rule was not applicable.</td>
</tr>
<tr>
<td>Code of Practice Relating to Admission of Children Under the Mental Health Act 2001</td>
<td>As the approved centre did not admit children, this code of practice was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients</td>
<td>As the approved centre did not provide an ECT service, this code of practice was not applicable.</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.

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

Residents spoke positively about the staff. They praised the changes in the upstairs area. Some commented positively on the food. They suggested that the provision of grab rails in upstairs bathrooms could be helpful for those who are less mobile. They would like to move the therapy kitchen upstairs to facilitate use during the day. Some would like to have a TV in their bedrooms.
7.0 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:

- Acting Clinical Director
- Assistant Director of Nursing
- Area Principal Psychology Manager
- Area Director of Nursing
- Consultant Psychiatrist
- Acting Clinical Nurse Manager 2
- Acting Social Work Team Leader
- Risk Advisor
- Senior Executive Officer (representing Registered Proprietor)
- Occupational Therapy Manager

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.
8.0 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. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- The roles and responsibilities in relation to the identification of residents.
- The required use of an appropriate resident identifier prior to the provision of therapeutic services and programmes.
- The process for identifying residents with the same or a similar name.

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

Monitoring: An annual audit had not been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had not been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: Two resident identifiers appropriate to the resident group profile and individual residents’ needs were used. The identifiers, detailed in residents’ clinical files, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used in advance of the provision of therapeutic services and programmes.

The approved centre used the name, date of birth, photograph, and medical record number of each resident as identifiers. The identifiers used were person-specific, and were appropriate to the residents’ communication abilities. There was a large orange sticker alert system in place on clinical files, to assist staff in distinguishing between residents with the same or a similar name.

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 policy, and monitoring pillars.
INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to food and nutrition, which was last reviewed in October 2016. The policy included the requirements of the Judgement Support with the exception of the monitoring of residents’ food and water intake.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for food and nutrition, as set out in the policy.

Monitoring: A systematic review of menu plans had not been undertaken to ensure that residents were provided with wholesome and nutritious food in line with their needs. Documented analysis had not been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Hot meals were served daily. The approved centre menus were not approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs.

Residents on regular diets had at least two choices for meals but residents on special diets, such as vegan and modified diets, were not offered a menu choice at every meal. Food, including modified consistency diets, was presented in a bland, unattractive, and unappetising manner. Residents had access to safe and fresh drinking water through easily accessed water fountains and bottled water.

The approved centre did not use an evidence-based nutrition assessment tool for assessing residents with special dietary requirements. Instead, staff researched information on the internet in relation to what these residents should eat. The needs of residents identified as having special dietary requirements were not reviewed by a dietitian or speech and language therapist. Some residents were at risk of choking. Weight charts were implemented, monitored, and acted upon for residents, where appropriate.

The approved centre was non-compliant with this regulation for the following reasons:

a) Approved centre menus were not approved by a dietitian to ensure nutritional adequacy in accordance with residents’ needs, 5 (2).

b) The needs of residents identified as having special nutritional requirements were not reviewed by a dietitian, 5 (2).

c) Residents on special diets such as vegan and modified consistency diets, were not offered an element of choice at every meal, 5 (2).
Regulation 6: Food Safety

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

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

INSPECTION FINDINGS

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

- Food preparation, handling, storage, distribution, and disposal controls.
- The management of catering and food safety equipment.

Training and Education: All relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for food safety, as set out in the policy. All staff handling food had up-to-date training in the application of Hazard Analysis and Critical Control Point (HACCP). This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had not been completed periodically. Food temperatures were recorded in line with food safety recommendations. A food temperature log sheet was maintained and monitored. Documented analysis had not been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There was suitable and sufficient catering equipment in the approved centre. There were proper facilities for the refrigeration, storage, preparation, and serving of food. Hygiene was maintained to support food safety requirements and appropriate hand-washing areas were provided for catering services. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, and monitoring pillars.
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 residents’ clothing, which was last reviewed in October 2016. The policy included the requirements of the Judgement Support Framework with the exception of the responsibility of the approved centre to provide new clothing to residents, where necessary, with consideration of the residents’ preferences, dignity, bodily integrity, and religious and cultural practices.

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

Monitoring: The availability of an emergency supply of clothing for residents was not monitored on an ongoing basis. There was no record to indicate that any residents were prescribed to wear night clothing during the day since the last inspection.

Evidence of Implementation: Residents had a sufficient supply of individualised clothing. Residents were dressed in clean clothing, which was appropriate to their needs at the time of the inspection. Residents were provided with emergency personal clothing that was appropriate to the resident and considered the residents’ preferences, dignity, bodily integrity, and religious and cultural practices.

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 policy, 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 operational policy in relation to residents’ personal property and possessions, which was last reviewed in October 2016. The policy addressed requirements of the Judgement Support Framework, with the exception of the communications with residents and their representatives regarding residents’ entitlement to bring personal property and possessions into the approved centre at admission and on an ongoing basis.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored. Analysis was not completed to identify opportunities to improve the processes for residents’ personal property and possessions.

Evidence of Implementation: Secure facilities were provided for the safekeeping of residents’ monies, valuables, personal property, and possessions, as necessary. Residents’ monies were either forwarded to nursing administration, or safeguarded in a personal wallet in a locked safe. Residents had locked wardrobes for the securing of personal effects.

The approved centre compiled a detailed property checklist with residents on admission, listing their personal property and possessions. The property checklist was kept distinct from the resident’s individual care plan (ICP). The checklist was updated on an ongoing basis, in line with the approved centre’s policy.

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The access to and use of resident monies was overseen by one member of staff rather than two staff members, and 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 Judgement Support Framework under the processes, 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.

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
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</thead>
<tbody>
<tr>
<td><strong>Processes:</strong> The approved centre did not have a written policy in relation to the provision of recreational activities.</td>
</tr>
<tr>
<td><strong>Training and Education:</strong> There was no policy in place for staff to read and articulate.</td>
</tr>
<tr>
<td><strong>Monitoring:</strong> A record was maintained of the occurrence of planned recreational activities, including a log of resident attendance. Documented analysis had not been completed to identify opportunities for improving the processes relating to recreational activities.</td>
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<tr>
<td><strong>Evidence of Implementation:</strong> The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Information on recreational activities was in an accessible format. Recreational activities programmes were developed, implemented, and maintained for residents, with resident involvement. A recreational activities programme was provided to residents, which included the types and frequency of recreational activities available within the approved centre. Opportunities were provided for indoor and outdoor physical activities such as gardening, crafts, cookery groups, walking groups, outings to the cinema and outings for breakfast on the weekends. Communal areas were suitable for recreational activities. Attendance at recreational activities was documented within each resident’s clinical file and attendance records were maintained by the registered psychiatric nurse, or the activities co-ordinator.</td>
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</tbody>
</table>

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 10: Religion

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the facilitation of religious practice by residents, which was last reviewed in October 2016. The policy included the requirements of the Judgement Support Framework with the exception of respecting a resident’s religious beliefs and values within the routines of daily living, including resident choice regarding involvement in religious practice.

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

Monitoring: The implementation of the policy to support residents’ religious practices was not reviewed to ensure that it reflected the identified needs of residents.

Evidence of Implementation: Residents’ rights to practice religion were facilitated within the approved centre insofar as was practicable. Facilities were available to support their religious practices both within the hospital grounds, and in external religious buildings.

Residents, once risk assessed, could attend religious facilities in the community. They had access to multi-faith chaplains. Residents were facilitated to observe or abstain from religious practice in accordance with their own will and preferences.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, and monitoring pillars.
Regulation 11: Visits

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<tr>
<th>COMPLIANT</th>
<th>Quality Rating</th>
<th>Satisfactory</th>
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(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. The policy was last reviewed in October 2016. The policy included the requirements of the Judgement Support Framework, with the following exceptions:

- 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: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for visits, as set out in the policy.

Monitoring: Restrictions on residents’ rights to receive visitors were monitored and reviewed on an ongoing basis. Documented analysis had been completed to identify opportunities for improving visiting processes.

Evidence of Implementation: Appropriate and reasonable visiting times were publicly displayed. The times were also displayed in print format within the resident information booklet. A separate visitors’ room, including the quiet room, and visiting spaces were provided where residents could meet visitors in private, unless there was an identified risk to the resident or others or a health and safety risk.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children could visit if accompanied by an adult and supervised at all times and this was communicated to all relevant individuals publicly. The visiting room, overall visiting areas, and facilities available were suitable for visiting children.

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy in relation to resident communication. The policy was last reviewed in October 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities for resident communication processes.
- The assessment of resident communication needs.

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

Monitoring: Resident communication needs and restrictions on communication were not monitored on an ongoing basis. Documented analysis had not been completed to identify ways of improving communication processes.

Evidence of Implementation: Residents had access to communication methods such as e-mail, telephone, and their personal mobile phone. Residents had supervised Internet access, and a hands-free phone was available to facilitate private communication. There were no restrictions placed on any resident’s communications since the last inspection, and therefore their communications were not subject examined by senior staff.

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

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.
(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.
(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.
(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.
(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.
(6) The registered proprietor shall ensure that there is at least 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: All relevant staff had signed the signature log indicating that they had read and understood the policy. Relevant staff interviewed could articulate the procedures relating to searches, as set out 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

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(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 series of written operational policies in relation to care of the dying. The care of the dying policy was last reviewed in October 2016. The policies addressed requirements of the 
Judgement Support Framework, with the following exceptions:

- The process for ensuring that the approved centre is informed in the event of the death of a resident who has been transferred elsewhere (e.g. for general health care services).
- Advance directives in relation to end of life care, Do Not Attempt Resuscitation (DNAR) orders, and residents’ religious and cultural end of life preferences.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for end of life care, as set out in the policy.

As no resident had died 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 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 did not have a written policy in relation to the development, use, and review of individual care plans (ICPs).

**Training and Education:** There was no policy in place for staff to read and articulate. Multi-disciplinary team (MDT) members were not trained in individual care planning.

**Monitoring:** Residents’ ICPs were not audited on a quarterly basis to determine compliance with the regulation. Documented analysis had not been completed to identify ways of improving the individual care planning process.

**Evidence of Implementation:** Each resident had an Individual Care Plan (ICP). Ten ICPs were inspected. All ICPs were a composite set of documentation that included allocated spaces for treatment, care, and resources required but there was no space for allocated goals. A key worker was not identified in two ICPs inspected to ensure continuity in the implementation of a resident’s ICP.

Each resident had been assessed at admission by the admitting clinician and an ICP was completed by the admitting clinician to address immediate needs of the resident. None of the residents received an evidenced based comprehensive assessment within seven days of admission, which meant they were not assessed on medical, psychiatric, and psychosocial history, medication history and current medications, current physical health, risk, social, interpersonal, and physical environment-related issues, communication abilities, educational, occupational, and vocational history.

In all ten care plans inspected, the ICPs were not developed by the entire MDT; only nursing and medical staff members were involved. Evidence of family involvement in the ICP process was lacking in a number of the ICPs inspected. All ICPs inspected were drawn up with the resident’s involvement. All ten ICPs inspected did not identify appropriate goals for the resident and there was no section in the ICPs for current or future goals to be written into. All ICPs identified appropriate resources required to provide the care and treatment identified.

The ICP did not include an individual risk management plan in any of the ten ICPs inspected. Instead, it contained a checklist in relation to clinical risk assessment.

ICP did not include a preliminary discharge plan. The ICP was reviewed by nursing and medical staff, and not the entire MDT, in consultation with the resident every six months. The ICPs were updated following review, as indicated by the residents’ changing needs. This was documented.
All residents had access to their ICPs and were kept informed of any changes. None of the ten residents were offered a copy of their ICP, including any reviews, and no reason for this was documented in any of the ICPs inspected.

The approved centre was non-compliant with this regulation for the following reasons:

a) Ten ICPs did not specify or identify appropriate goals for the resident.
b) The ICPs were not developed or consistently reviewed by the full MDT. Only nursing and medical staff were involved.
**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 did not have a written policy in relation to the provision of therapeutic services and programmes.

**Training and Education:** There was no policy in place for staff to read, and articulate.

**Monitoring:** The range of services and programmes provided in the approved centre was not monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had not been completed to identify opportunities for improving the processes relating to therapeutic services and programmes.

**Evidence of Implementation:** The therapeutic services and programmes provided by the approved centre were not adequately resourced to appropriately meet the assessed needs of the residents, as documented in residents’ individual care plans. The services and programmes were not evidence-based and were not clearly directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Therapeutic staff were not involved in providing or supervising therapeutic programmes. Their input was on a referral basis only.

A list of all therapeutic services and programmes provided in the approved centre was available to residents. However, the programme content had a recreational emphasis rather than therapeutic. Residents had access to therapy gardening, movement, and music. A mindfulness session ran once a week. Occupational therapy, social work, and psychology had no input into the activities programmes. Residents had no access to a dietitian, or speech and language therapy.

Adequate resources and facilities were not available to provide therapeutic services and programmes. There were separate dedicated rooms containing facilities and space for individual and group therapies. The upstairs space was limited. There was a therapy kitchen downstairs, which required refurbishment, and residents were unable to access it during the day unless they were supervised. The lower downstairs level of the approved centre was locked for security purposes. The residents had access to the garden area when accompanied, and only when staff were available.

A record was maintained of participant, engagement, and outcomes achieved in therapeutic services or programmes within each resident’s clinical file.

**The approved centre was non-compliant with this regulation for the following reasons:**

- **a)** Therapeutic services and programmes were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, 16 (2).
- **b)** Residents did not have access to an appropriate range of therapeutic services and programmes, 16 (1).
c) There was little involvement from therapeutic staff in relation to therapeutic services programme design, delivery, and supervision, 16 (2).
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 and procedures in relation to the transfer of residents. The policy was last reviewed in June 2016. The policy included the requirements of the Judgement Support Framework with the following exceptions:

- The process for managing resident medications during transfer from the approved centre.
- The process for ensuring resident privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- The process for emergency transfers.

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

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

Evidence of Implementation: The clinical file of one resident who had been transferred from the approved centre to an external hospital was examined. Communication records with the receiving facility were documented, and their agreement to receive the resident in advance of the transfer was documented.

Verbal communication and liaison took place between the approved centre and the receiving facility in advance of the transfer taking place. This included the reasons for transfer, the resident’s care and treatment plan, including needs and risks, and the resident’s accompaniment requirements on transfer.

The resident was risk assessed prior to the transfer, and documented consent of the resident to the transfer was available. Written information was issued as part of the transfer, including a letter of referral, a list of current medications, but the resident transfer form was not documented. A copy of the resident transfer form was not retained in the resident’s clinical file.

A checklist was not completed by the approved centre to ensure comprehensive records were transferred to the receiving facility. Copies of all records relevant to the transfer process were retained in the resident’s clinical file.

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a series of written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The policy was last reviewed in October 2016. The policies and procedures addressed 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 resuscitation trolley and Automated External Defibrillator (AED).
- Resident access to a registered medical practitioner.
- 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.
- Access to national screening programmes available for residents through the approved centre.

Training and Education: All clinical staff had signed the signature log to indicate that they had read and understood the policies. All clinical staff interviewed were able to articulate the processes relating to the provision of general health services and the response to medical emergencies, as set out in the policies.

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

Evidence of Implementation: The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). The emergency equipment was checked weekly. Records were not available of any medical emergency within the approved centre and the care provided.

The general practitioner (GP) attended the approved centre on a daily basis where residents’ general health needs were addressed. Residents received appropriate general health care interventions in accordance with individual care plans. All residents had received a regular physical examination six-monthly. This was documented.

Residents on antipsychotic medication were assessed on glucose regulation including fasting glucose/Hba1c, blood lipids, and electrocardiogram (i.e. heart scan), within the appropriate timeframe.
Adequate arrangements were not in place for residents to access general health services and for their referral to other health services, as required. Residents had no access to speech and language therapy, or to a dietitian. Residents could access secondary care through GP referral. Residents had access to national screening programmes appropriate to age and gender. Information was provided to all residents regarding the national screening programmes available through the approved centre.

Residents did not have access to smoking-cessation programmes and supports. There were no programmes available within the approved centre. The nearest programme was located on the Western Road, which was arranged through the smoking cessation officer, but that location was impractical for residents of the approved centre.

The approved centre was non-compliant with this regulation because adequate arrangements were not in place for access by residents to other health services, specifically dietetics, and speech and language therapists, 19 (1).
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 written operational policy and procedures in relation to the provision of information to residents. The policy was last reviewed in October 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

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

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to the provision of information to residents, as set out in the policy.

Monitoring: The provision of information to residents was not monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had not been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Residents were provided with an in-patient information booklet on admission that included details of meal times, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details. Information on residents’ rights was not included. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team (MDT) on the notice board.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist’s view, the provision of such information might be prejudicial to the resident’s physical or mental health, well-being, or emotional condition. At the time of the inspection, there were no restrictions
on information regarding a resident’s diagnosis applied to any resident. Medication information sheets as well as verbal information were provided in a format appropriate to the resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side effects.

The information in the documents provided by or within the approved centre was evidence-based. The document information was sourced through the Acute Mental Health unit in Cork, and their information originated from the Royal College of Psychiatrists. Residents had access to interpretation and translation services when needed. The approved centre used an interpretation service by telephone for a Polish resident when required.

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to resident privacy, which was last reviewed in October 2016. The policy included the method for identifying and ensuring, where possible, the resident’s privacy and dignity expectations and preferences.

The policy did not include:

- The roles and responsibilities for the provision of resident privacy and dignity.
- The approved centre layout and furnishing requirements to support resident privacy and dignity.
- The approved centre’s process for addressing a situation where resident privacy and dignity is not respected by staff.

Training and Education: All staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed could articulate the processes for ensuring resident privacy and dignity, as set out in the policy.

Monitoring: A documented annual review had not been undertaken to ensure that the policy was being implemented and that the premises and facilities in the approved centre 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: The general demeanour of staff and the way in which staff addressed and communicated with residents was respectful. No ageist, racist, sexist, or other inappropriate staff comments or jokes were heard during the inspection time. Staff were discreet when discussing the resident’s condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity.

All bathrooms, showers, and toilets, had locks on the inside of the door. Locks had an override function. Single bedrooms, however, did not have locks on the inside of the door. Rooms were not overlooked by public areas. Observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation. The quality was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, monitoring, and evidence of implementation pillars.
Regulation 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 last reviewed in October 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The approved centre’s premises maintenance programme.
- The approved centre’s cleaning programme.
- The approved centre’s utility controls and requirements.
- The provision of adequate and suitable furnishings in the approved centre.
- The identification of hazards and ligature points in the premises.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes relating to the maintenance of the premises, as set out in the policy.

Monitoring: The approved centre had not completed a hygiene audit. The approved centre had completed a ligature audit, using a validated tool. Documented analysis had not been completed to identify opportunities for improving the premises.

Evidence of Implementation: The approved centre provided appropriately sized communal rooms. The twin bedrooms were small and there was insufficient space between bed ends. There was a sufficient number of toilets and showers for residents in the approved centre. There was at least one assisted toilet per floor. The premises were adequately lit, heated, and ventilated. Sufficient spaces were provided to residents to move about, including outdoor spaces.
Hazards were not minimised. A stairwell in the lower level of the approved centre which was a fire escape was blocked with equipment. Ligature points in the lower level bedrooms and bathrooms were not minimised.

There was a cleaning schedule implemented within the approved centre, and the approved centre was clean, hygienic, and free from offensive odours. Regular deep cleaning took place. The approved centre was not kept in a good state of repair externally and internally. There was not a documented programme of general maintenance, decorative maintenance, decontamination, and repair of assistive equipment. Records were not maintained. General maintenance was poor in the residents sleeping areas downstairs. There were holes in the walls of the bedrooms where ligatures had been removed and taped up. The walls in the corridor areas were chipped and scuffed.

Radiators were guarded upstairs in the day area but not downstairs in the bedrooms. Radiator temperatures were centrally controlled in the boiler room on the campus. There were two generators on the hospital campus, which supplied back up power. The approved centre did not have a designated cleaning room; instead, the sluice room was also used as a cleaning room. Not all furnishings supported resident independence and comfort. Many of the bedrooms did not have bedside lockers, and the downstairs sitting room had only two chairs for 21 residents to use. Furnishings upstairs were adequate and in good repair.

The Mental Health Commission was not informed in advance of the commencement of works. There were currently building works happening close to the residents’ garden and staff were unsure of what was being built. This work limited residents’ free use of the garden.

The approved centre was non-compliant with this regulation for the following reasons:

a) The bedrooms were not maintained in good decorative condition, 1 (a).
b) Ligature points had not been minimised in the bedrooms and bathrooms on the lower level, 22 (3).
c) There was no programme of general maintenance in the approved centre, 1 (c).
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 four written operational policies and procedures in relation to the ordering, storing, prescribing, and administration of medication. The policy on administration and storage of medical preparation was last reviewed in October 2016.

The policies addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities for the ordering, prescribing, storing, and administration of medication.
- The process for prescribing resident medication.
- The process for ordering resident medication.
- The process for the administration of resident medication, including routes of medication.
- The process for administering controlled drugs including checks and records required.
- The process for crushing medications.
- The process for medication management at admission, transfer, and discharge.
- The process for medication reconciliation.
- The process for reviewing resident medication.

Training and Education: All nursing and medical staff as well as pharmacy staff had signed the signature log to indicate that they had read and understood the policies. All nursing and medical staff, as well as pharmacy staff interviewed could articulate the processes relating to the ordering, prescribing, storing, and administering of medicines, as set out in the policies. Staff had access to comprehensive, up-to-date information on all aspects of medication management. Nursing and medical staff as well as 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 undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Incident reports were recorded for medication incidents, errors, and near misses. Analysis had not been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: Each resident had an MPAR. All MPARs inspected evidenced a record of appropriate medication management practices, including a record of three resident identifiers, records of all medications administered, and details of route, dosage, and frequency of medication. Residents’ allergy status was recorded in each MPAR inspected. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included on each MPAR. A record was kept when medication was refused by or withheld from the resident.

All entries in the MPAR were legible, and written in black indelible ink. Medicinal products were administered in accordance with the directions of the prescriber. The expiration date of the medication
was checked prior to administration and expired medications were not administered. Medication was reviewed and rewritten at least six-monthly or more frequently when there was a significant change in the resident’s care or condition, and this was documented.

All medicines were administered by a registered nurse or registered medical practitioner. The use of appropriate resident identifiers and good hand-hygiene techniques, in addition to cross-infection control techniques were observed during the administration of medication. Medication was stored in the appropriate environment, as advised by the pharmacist. Medication was supplied in personalised trays, which were stored in an open storage shelving area in a locked room and not in a locked storage unit.

Refrigerators for medication were used only for this purpose and a log was maintained of fridge temperatures. An inventory of medications was conducted on a monthly basis, checking the name and dose of medication, quantity of medication, and expiry date.

Medications that were no longer required, which were past their expiry date, or had been dispensed to a resident, were stored in a secure manner, segregated from other medication, and were returned to the pharmacy for disposal.

The approved centre was compliant with this regulation. The quality was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, monitoring, and evidence of implementation pillars.
Regulation 24: Health and Safety  

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.  
(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

Processes: The approved centre had a series of written operational policies and procedures in relation to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in October 2016. The policies included the requirements of the Judgement Support Framework with the following exceptions:

- Specific roles allocated to the registered proprietor in relation to the achievement of health and safety legislative requirements.
- Safety representative roles.
- First aid response requirements.
- Falls prevention initiatives.
- Vehicle controls.

Training and Education: Not all staff had signed the signature log to indicate that they had read and understood the policy. All staff interviewed were able to articulate the processes relating to health and safety, as set out in the policies.

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 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 and procedures in relation to its staffing requirements. The policy was last reviewed in October 2016. The policy and procedures addressed the requirements of the Judgement Support Framework, with the following exceptions:

- The staff rota details and the methods applied for their communication to staff.
- Staff performance and evaluation requirements.
- The use of agency staff.
- The process for reassignment of staff in response to changing resident needs or staff shortages.
- The process for transferring responsibility from one staff member to another.
- The required qualifications of training personnel.
- The evaluation of training programmes.

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

Monitoring: The implementation and effectiveness of the staff training plan was not reviewed on an annual basis. The numbers and skill mix of staff had been reviewed against the levels recorded in the approved centre’s registration. Documented analysis to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents had not been completed.

Evidence of Implementation: There was an organisational chart in place which showed the leadership and management structure and the lines of authority and accountability of the approved centre’s staff. Staff were recruited and selected in accordance with the approved centre’s policy and procedures for recruitment, selection, and appointment. Staff within the approved centre had the appropriate qualifications to do their jobs. A planned and actual staff rota, showing the staff on duty at any one time during the day and night, was maintained in the approved centre. An appropriately qualified staff member was on duty and in charge at all times.
The number and skill mix of staffing was inadequate to meet resident needs. There was an unmet need for an occupational therapist at the time of the inspection. There was not a written staffing plan available within the approved centre.

Annual staff training plans were not completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training was completed for all staff. Staff were not trained in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan.

Staff were trained in manual handling, and care for residents with an intellectual disability. Not all staff were trained in infection control and prevention, end of life care, resident rights, risk management, and treatment, and the protection of children and vulnerable adults, incident reporting, dementia care, or recovery-centred approaches to mental health care and treatment.

Not all staff were trained in the following:

- Fire safety: 67% of nursing staff were trained.
- Professional management of violence and aggression: 91% trained.
- The Mental Health Act 2001: 91% of staff were trained

In addition, 83% of staff were trained in children first. The occupational therapist had up-to-date training in all areas apart from the professional management of violence and aggression. The psychologist and social worker was up to date in all five areas of training required. A record was provided of the non-consultant hospital doctor training which did not document children first training. No training record was provided in relation to the consultant psychiatrist.

Opportunities were made available to staff by the approved centre for further education. 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</td>
<td>ACNM2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Occupational Therapist: On a referral basis
Social Worker: On a referral basis
Psychologist: On a referral basis

*Acting Clinical Nurse Manager (ACNM), Registered Psychiatric Nurse (RPN)*

The approved centre was non-compliant with this regulation for the following reasons:

a) Not all staff had up-to-date mandatory training in Basic Life Support, fire safety, PMAV, Children First, 26(4).

b) Not all staff had up-to-date mandatory training in the Mental Health Act 2001, 26(5).

c) The number and skill mix of staff was not adequate to meet resident needs, 26 (2).
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 and procedures in relation to the maintenance of records. The policy was last reviewed in October 2016. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities for the creation of, access to, retention of, and destruction of records.
- Record review requirements.
- The destruction of records.
- Retention of inspection reports relating to food safety, health and safety, and fire inspections.

Training and Education: All clinical staff and other relevant staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff and other relevant staff interviewed were able to articulate the processes relating to the creation of, access to, retention of, and destruction of records, as set out in the policies. Not all clinical staff were trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. Analysis had not been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: A record was initiated for every resident assessed or provided with care and service by the approved centre. Resident records were reflective of the residents’ current status and the care and treatment provided, and were maintained using an identifier that was unique to the resident. All resident records were physically stored together where possible. Residents’ access to their records was managed in accordance to the Data Protections Acts.

Not all clinical files were and in good order. Five clinical files were inspected. Information was difficult to retrieve in some files. There was an index at the front of the file; however, papers were not always filed in order. The files contained loose pages and pages were crumpled. Some files were very thick, which made them difficult to handle. There was information dating back to 2015-2016. Resident records were not developed or maintained in a logical sequence.
Records were not appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised use. Old incident forms with resident information were kept in the dry food store room upstairs in the approved centre. Kitchen staff had access to the room. The approved centre’s environmental health officer report was not available for inspection.

The approved centre was non-compliant with this regulation for the following reasons:

a) Not all clinical files were in good order, 27 (1).
b) The policy did not refer to the destruction of records, 27 (2).
c) Not all records were stored securely, 27 (1).
Regulation 28: Register of Residents

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

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

INSPECTION FINDINGS

The approved centre had a documented up-to-date register of residents admitted in both electronic and hard copy format. The register did not contain all of the required information specified in Schedule 1 to the Mental Health Act 2001 (Approved Centres) regulations 2006 because:

- Resident admission date was not recorded for five residents.
- Resident discharge date was not recorded for two residents.
- Resident diagnosis on discharge in relation to psychiatric diagnosis was not recorded on the register.

The approved centre was non-compliant with section 2 of this regulation because the register did not include all of the information specified in Schedule 1 to these regulations:

a) Resident admission date was not recorded for five residents.
b) Resident discharge date was not recorded for two residents.
c) Resident diagnosis on discharge in relation to psychiatric diagnosis was not recorded on the register.

Risk Rating: MODERATE

Quality Rating: Requires Improvement

NON-COMPLIANT
INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development and review of operating policies and procedures required by the regulations, which was last reviewed in October 2016. It addressed requirements of the Judgement Support Framework, with the following exceptions:

- The process for disseminating operating policies and procedures, either in electronic or hard copy.
- The process for training on operating policies and procedures, including the requirements for training following the release of a new or updated operating policy and procedure.
- The process for making obsolete and retaining previous versions of operating policies and procedures.
- The standardised operating policy and procedure layout used by the approved centre.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Not all relevant staff had been trained on approved operational policies and procedures. Not all relevant staff interviewed could articulate the processes for developing and reviewing operational policies, as set out in the policy.

Monitoring: An annual audit had not been undertaken to determine compliance with review time frames. Analysis had been completed to identify opportunities for improving the processes of developing and reviewing policies.

Evidence of Implementation: The approved centre’s operating policies and procedures were developed with input from clinical and managerial staff but were not developed in consultation with service users. Operating policies and procedures were communicated to all relevant staff. The operating policies and procedures required by the regulations were all reviewed within the required timeframes, but they did not incorporate relevant legislation, evidence-based best practice and clinical guidelines. Instead, many of the policies were one or two paged documents and had minimal reference to literature or other best practice guidelines.

The format of operating policies and procedures was not entirely standardised. Policies included the title of the policy, and procedure, the reference number and revision of the policy and procedure, policy approver details, the scope of the policy and procedure, the date of which the policy will be effective from, the scheduled review date, and the total number of pages. Policies did not include the document owner or the policy reviewer. Where generic policies were used, the approved centre had a written statement to this effect adopting the generic policy, which was reviewed every three years. Any generic policies used were appropriate to the approved centre and the resident group profile.

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 30: Mental Health Tribunals

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the facilitation of Mental Health Tribunals. The policy was last reviewed in September 2017. The policy and procedures included all of the requirements of the Judgement Support Framework.

Training and Education: Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed could articulate the processes for facilitating Mental Health Tribunals, as set out in the policy.

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

Evidence of Implementation: The approved centre provided private facilities and adequate resources to support the Mental Health Tribunals process. Only one patient required Mental Health Tribunals, and the tribunals took place in a different approved centre close to the approved centre. Staff accompanied and assisted this patient to attend their Mental Health Tribunals as required.

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in place in relation to the management of complaints. The policy was last reviewed in October 2016. In addition, the approved centre used the HSE’s Your Service, Your Say complaints policy and process. The policy and procedures addressed requirements of the Judgement Support Framework, including the process for managing complaints. This included the handling and investigation of complaints from any person regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

The policy did not detail the appeal process available where the complainant is dissatisfied with the outcome of the complaint investigation.

Training and Education: Relevant staff had not been trained on the complaints management process. All staff had signed the signature log to indicate that they had read and understood the policies. All staff interviewed were able to articulate the processes for making, handling, and investigating complaints, as set out in the policies.

Monitoring: Audits of the complaints log and related records had not been completed. Complaints data was not analysed for senior management to consider.

Evidence of Implementation: There were no formal complaints lodged in the approved centre since the last inspection. There was a nominated complaints officer responsible for dealing with all complaints who was available to the approved centre. The approved centre’s management of complaints processes, including how to contact the nominated person was well publicised and accessible to residents and their representatives. Residents were provided with the complaints policy and procedure at admission or soon thereafter. The complaints process information was provided within the resident information booklet.
Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected due to the complaint being made.

Minor complaints were documented in community meeting minutes and the complaints log. A method for addressing minor complaints within the approved centre was provided. Timeframes were provided by the approved centre which addressed the following: responding to the complainant following the initial receipt of the complaint, the investigation period for complaints, and the required resolution of complaints. The timeframes were in line with the HSE national policy. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes, training and education, and monitoring pillars.
(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

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

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

INSPECTION FINDINGS

Processes: The approved centre had two written policies in relation to risk management and incident management procedures. The risk management policy was last reviewed in October 2016. The notification of deaths and incident report writing policy was last reviewed in June 2016. The policies addressed requirements of the Judgement Support Framework, with the following exceptions:

- The person with overall responsibility for risk management.
- The responsibilities of the registered proprietor.
- 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 for managing risk.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm.
- The process of identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for maintaining and reviewing the risk register.
- The record keeping requirement for risk management.
- The process for risk-rating incidents.
- The process for investigating incidents.
- The process for learning from incidents.
- The process for responding to specific emergencies, including the following: the roles and responsibilities of key staff, the sequence of required actions, the process for communication, and the escalation of emergencies to management.
- The process for the protection of children and vulnerable adults within the care of the approved centre.
**Training and Education:** Relevant staff had not received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were not trained in individual risk management processes. Management were not trained in organisational risk management. Not all staff had been trained in incident reporting and documentation. Not all staff had signed the signature log to indicate that they had read and understood the policy. Not all staff interviewed were able to articulate the risk management processes, as set out in the policy. Not all training was documented.

**Monitoring:** The risk register was not reviewed at least quarterly to determine compliance with the approved centre’s risk management policy. Analysis of incident reports had been completed to identify opportunities for improving risk management processes.

**Evidence of Implementation:** Responsibilities were not clearly allocated at management level and throughout the approved centre to ensure their effective implementation. Staff expressed conflicting views on the management of risk and where responsibilities lay. The person with responsibility for risk was not identified and known by all staff. The risk management procedure did not actively reduce identified risks to the lowest practicable level of risk. Risk assessment forms had identified controls but many risks had not been identified or documented at a local level. Numerous risks were observed during the inspection time.

Clinical risks were not identified, assessed, treated, reported, monitored, and documented in the risk register. The ligature audit, which was completed, did not document if risks had been treated, what risks were outstanding, and controls in place.

Structural risks, including ligature points, were not removed or effectively mitigated. There were numerous ligatures in the bedroom floor, and there were no documented controls in place to mitigate the risks.

Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre. Corporate risks were not documented in the risk register but were evident in executive management team meetings. The approved centre did not implement a plan to reduce risks to residents while any works to the premises were ongoing. The builders arrived without any notice to nursing staff on the unit.

Individual risk assessments were completed on admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed on resident discharge.

Multi-disciplinary teams were not always involved in the development, implementation, and review of individual risk management processes. A clinical risk assessment tool was used to assess clinical risks every six months. However, this was not always done at the time of the multi-disciplinary team (MDT) or individual care plan review. It was done by the non-consultant hospital doctor or the registered practitioner nurse. A risk assessment was done but there was no documentation of a risk management plan. Residents and/or their representatives were not involved in individual risk management processes.

There was no emergency plan that specified responses by the approved centre staff to possible emergencies and evacuation procedures. Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT at their regular meeting. A record was not maintained of this review and recommended actions.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.
The approved centre was non-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 cover the identification and assessment of risks throughout the approved centre, 32 (2) (a).
c) The risk management policy did not cover the precautions in place to control identified risks, 32 2 (b).
d) The risk management policy did not cover the precautions in place to control for resident absent without leave, 32 (c), (1), suicide and self-harm, 32 (c), 2.
e) The risk management policy did not cover the arrangements for responding to emergencies, 32 (e).
f) The risk management policy did not cover the arrangements for the protection of children.
g) There was no multi-disciplinary management review group that identified and reviewed risks as described in their policy. The policy was not implemented, 32 (1).
### Regulation 33: Insurance

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

#### INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by 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.

<table>
<thead>
<tr>
<th>INSPECTION FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently.</td>
</tr>
</tbody>
</table>

The approved centre was compliant with this regulation.
None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 5.3 Areas of compliance that were not applicable on this inspection for details.
10.0 Inspection Findings – Mental Health Act 2001

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. The patient’s file was inspected against Part 4 of the Mental Health Act 2001: Consent to Treatment. The patient had agreed to receiving treatment.

The clinical file evidenced the following:
- There was a record of the patient’s consent that contained a written record of the name of specific medications prescribed.
- Details were provided of discussion with the patient, including:
  - The nature and purpose of the medications.
  - The effects of medication, including risks and benefits and views expressed by the patient.

The clinical file did not evidence the following:
- There was no record to indicate that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent.
• Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications was not documented, at the time consent was accepted.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment for the following reasons:

a) There was no documented evidence to indicate that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent, 56 (a).

b) Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications was not documented, at the time consent was accepted 56 (a).
11.0 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.
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: There was a written policy in relation to the use of physical restraint, which was last reviewed in January 2018. The policy was reviewed annually. The policy included the provision of information to the resident in relation to the use of physical restraint, and child protection processes. The policy did not address who can implement physical restraint.

There was a separate training-related policy, which did not specify the frequency of training, and did not identify areas addressed within the training programme, such as training in the prevention of management of violence, breakaway techniques, and training in alternatives to physical restraint.

Training and Education: Staff had signed a generic confirmation that they had read all policies. A record of attendance at training was maintained.

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 non-compliant with this code of practice for the following reasons:

   a) The policy did not identify who can implement physical restraint, 9.2 (d).
   b) The training-related policy did not identify areas addressed within the training programme such as training in the prevention of management of violence, breakaway techniques, and training in alternatives to physical restraint, 10.1 (b).
   c) The training-related policy did not specify the frequency of training, 10.1 (c).
INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in July 2016, included a procedure for involuntary admission and protocols for pre-admission assessments, eligibility for admission, referral letters, urgent referrals, and the roles and responsibilities of multi-disciplinary team (MDT) in relation to post-admission assessment.

The admission policy did not include:

- A procedure for self-presenting individuals.
- A protocol for timely communication with general practitioners/primary care and community mental health teams (CMHTs).
- Any reference to a policy on privacy, confidentiality, and consent.

Transfer: The transfer policy, which was last reviewed in June 2016, included the procedure for involuntary transfer, the roles and responsibilities of staff in relation to the transfer of residents, protocols covering the way in which transfer is arranged, and the safety of resident and staff during the transfer process. The transfer policy did not include the provisions for emergency transfer.

Discharge: The discharge policy, which was last reviewed in October 2016, included the procedure for the discharge of involuntary patients, medical prescriptions and the supply of medication on discharge, the protocol for discharging homeless persons. It also covered relapse prevention strategies and crisis management plans, roles and responsibilities of staff in providing follow-up care, and details of when and how much follow-up contact residents should have.

It did not include the following policy-related criteria for this code of practice:

- A way of following up and managing missed appointments.
- Procedures for managing discharge against medical advice.

Training and Education: All relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had not been completed on the implementation of and adherence to the admission and transfer policies. Monitoring of the discharge policy in relation to it being implemented did not apply because no resident had been discharged from the approved centre to another care location since the last inspection.

Evidence of Implementation: The admission, transfer, and discharge processes were non-compliant under Regulation 32: Risk Management Procedures, which is associated with this code of practice.
**Admission:** The approved centre’s admission process was compliant with the following regulations associated with this code of practice: Regulation 7: Clothing, Regulation 8: Residents’ Personal Property and Possessions, and Regulation 20: Provision of Information to Residents. It did not comply with the following: Regulation 15: Individual Care Plan and Regulation 27: Maintenance of Records.

The clinical file of one resident was inspected in relation to the admission process. The resident was assigned a key worker. The decision to admit was made by the registered medical practitioner/consultant psychiatrist. The admission assessment was comprehensive and included; presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, and any other relevant information, such as work situation, education, and dietary requirements. All assessments and examinations were documented within the resident’s clinical file.

**Transfer:** The approved centre complied with Regulation 18: Transfer of Residents.

The clinical file of one resident who had been transferred was inspected in relation to the admission process. The resident was transferred to receive specialised treatment in another facility and a registered medical practitioner made the decision to transfer the resident. The resident’s agreement/consent to being transferred was documented. The decision to transfer was agreed with the receiving facility and was documented in the resident’s clinical file. An assessment; including a risk assessment was completed in advance of the resident being transferred. Multi-disciplinary team members were involved in the transfer. The resident’s property was returned to him/her in line with the approved centre’s policy.

**Discharge:** No resident had been discharged from the approved centre to another care location since the last inspection.

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

- a) The admission, transfer, and discharge processes were non-compliant under Regulation 32: Risk Management Procedures, which is associated with this code of practice, 7.1.
- b) The admission policy did not include:
  - A procedure for self-presenting individuals, 4.5.
  - A protocol for timely communication with general practitioners/primary care and community mental health teams (CMHTs), 4.9.
  - Any reference to a policy on privacy, confidentiality, and consent, 4.18.
- c) The transfer policy did not include the provisions for emergency transfer, 4.13.
- d) The discharge policy did not include:
  - A way of following up and managing missed appointments, 4.14.
  - Procedures for managing discharge against medical advice, 4.15.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 5: Food and Nutrition

*Report reference: Page 19*

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 1. Approved centre menus were not approved by a Dietitian to ensure nutritional adequacy in accordance with residents’ needs. | Corrective Action(s): Liaison with St Finbarrs catering Department to ascertain dietician input to menus  
Post-Holder(s) responsible: CNM2 Michelle Curran/Noreen Buchan  
Preventative Action(s): None  
Post-Holder(s) responsible: | Audit of Regulation 5 Food and nutrition 1st September 2018 | Achievable | 13th September 2018 |
| 2. The needs of residents identified as having special nutritional requirements were not reviewed by a Dietitian. | Corrective Action(s): Dietician input required for St Catherines  
Post-Holder(s) responsible: ADON/ Kevin Morrison, Senior Executive Office  
Preventative Action(s): To place on Risk Register  
Post-Holder(s) responsible: Assistant Director of Nursing | Checking if community dietician input is possible. | Achievable | 13th September 2018 |
| 3. Residents on special diets such as vegan and modified consistency | Corrective Action(s): Meeting held with Kitchen staff and CNM2 and agreement that special | Review agreement in September 2018 | Achievable | 13th September 2018 |
| diets, were not offered an element of choice at every meal. | diets, including vegan, will become available in 6 weeks’ time. Post-Holder(s) responsible: CMN2 Michelle Curran/Noreen Buchan | Preventative Action(s): 3 monthly audit against JSF criteria of Regulation 5. Patient Satisfaction with food survey to be completed in 6 months Post-Holder(s) responsible: CMN2 Michelle Curran/Noreen Buchan | Audit of Regulation 5 Food and nutrition | Achievable | 13th December 2018 |
### Regulation 15: Individual Care Plan

**Report reference: Page 30-31**

<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>4. Ten ICPs did not specify or identify appropriate goals for the resident.</td>
<td>Corrective Action(s): 1. Heads of discipline to email staff to remind staff to complete the goals section of the ICP 2. New ICP template being developed by staff of St Catherine’s 3. Reference guide to be made available to staff to assist in writing goals</td>
<td>3 monthly Audit of Regulation 15 ICP Introduction of new ICP</td>
<td>Achievable</td>
<td>13th September 2018</td>
</tr>
</tbody>
</table>

*Reoccurring*

| | Preventative Action(s): 3 monthly audit against JSF criteria of Regulation 15 | 3 monthly Audit of Regulation 15 ICP | Achievable | 13th September 2018 |
| | Post-Holder(s) responsible: Heads of Discipline ADON, CNM2, Consultant, Nursing staff | | | |
| | | | | |
| 5. The ICPs were not developed or consistently reviewed by the full MDT. Only nursing and medical staff were involved. | Corrective Action(s): Permanent item on the Management team meeting, minutes of this meeting will be made available on MHC inspection | 3 monthly Audit of Regulation 15 ICP | | 13th September 2018 |

*Reoccurring*
<table>
<thead>
<tr>
<th>Post-Holder(s) responsible: Heads of Discipline</th>
<th>ADON, CNM2, Consultant, Nursing staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Action(s): New ICPs will be developed and implemented</td>
<td>3 monthly Audit of Regulation 15 ICP</td>
</tr>
<tr>
<td>Post-Holder(s) responsible: Consultant, ADON, CNM2, SW, OT, Psychologist</td>
<td></td>
</tr>
</tbody>
</table>
### Regulation 16: Therapeutic Services and Programmes

**Report reference:** Page 32-33

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Therapeutic services and programmes were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.</td>
<td><strong>New</strong> Corrective Action(s): Current therapeutic programme being reviewed and updated by nurse therapist Post-Holder(s) responsible: Nurse Therapist Preventative Action(s): 3/12 audit against JSF (MHC, 2018) Regulation 16 to improve compliance Post-Holder(s) responsible: Nurse Therapist</td>
<td>Audit of Regulation 16</td>
<td>Achievable</td>
<td>13th December 2018</td>
</tr>
<tr>
<td>7. Residents did not have access to an appropriate range of therapeutic services and programmes.</td>
<td><strong>New</strong> Corrective Action(s): This requirement to be discussed at next management team meeting. Post-Holder(s) responsible: St Catherine’s Management Team Preventative Action(s): This requirement to be discussed at next management team meeting. Post-Holder(s) responsible: St Catherine’s Management Team</td>
<td>Audit of Regulation 16</td>
<td>Achievable</td>
<td>1st September 2018</td>
</tr>
<tr>
<td>8. There was little involvement from therapeutic staff in relation to therapeutic services programme</td>
<td><strong>New</strong> Preventative Action(s): This requirement to be discussed at next management team meeting. Post-Holder(s) responsible: St Catherine’s Management Team</td>
<td>Audit of Regulation 16</td>
<td>Achievable</td>
<td>1st September 2018</td>
</tr>
<tr>
<td>Preventative Action(s): This requirement to be discussed at next management team meeting.</td>
<td>3/12 audit against JSF (MHC, 2018) Regulation 16 to improve compliance</td>
<td>Achievable</td>
<td>1st September 2018</td>
<td></td>
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<tr>
<td>Post-Holder(s) responsible: St Catherine’s Management Team</td>
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<tr>
<td>design, delivery, and supervision.</td>
<td></td>
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</tbody>
</table>
### Regulation 19: General Health

**Report reference: Page 35-36**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 9.                        | Adequate arrangements were not in place for access by residents to other health services, specifically dietetics, and speech and language therapists. | **Corrective Action(s):** SALT and Dietician referrals to be made under GMS scheme  
Post-Holder(s) responsible: Dr Ronan O’Sullivan GP | Review at next St Catherine’s Management Team  
Achievable | Immediate |
|                           | **Reoccurring**                                                          | **Preventative Action(s):** SALT and Dietician to be included on risk register  
Post-Holder(s) responsible : Assistant Director of Nursing                      | Place on Risk Register  
Achievable | Immediate |
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. The bedrooms were not maintained in good decorative condition.</td>
<td>Corrective Action(s): Plan for works implemented as per letter to the MHC on the 27th June 2018. New flooring, painting, new sink, enclosed radiator and lowering of ceiling in progress. Post-Holder(s) responsible: Kevin Morrison, Senior Executive Office, Pat Cronin, Maintenance department and estates</td>
<td>The approved centre will be in good decorative condition</td>
<td>Achievable</td>
<td>13th December 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): On-going maintenance plan to be developed for St Catherines 2/12 Walkthroughs by ADON to review Post-Holder(s) responsible: Kevin Morrison, Senior Executive Office, Pat Cronin, Maintenance department and estates, ADON Martin Denny</td>
<td>The approved centre will be in good decorative condition</td>
<td>Achievable</td>
<td>13th December 2018</td>
</tr>
<tr>
<td>11. Ligature points had not been minimised in the bedrooms and bathrooms on the lower level.</td>
<td>The previous audit in September 2017 highlighted that none of the risks identified were High or Medium-high Risk as none of the scores came to over 36. Any risks identified as medium risk have been reviewed and remedial action is being taken or the risk is being managed locally. This remedial action includes the works in bedrooms 5 and 6. Once this work is complete a repeat Ligature audit</td>
<td>All ligature points identified following the ligature audit will be removed and/or addressed</td>
<td>Achievable</td>
<td>13th December 2018</td>
</tr>
</tbody>
</table>
### Corrective Action

#### Preventative Action(s): Yearly ligature audit to be completed
- **Post-Holder(s) responsible:** ADON, Risk Advisor

An updated ligature audit will be available for inspection which will document the risks treated, risks outstanding and controls in place to manage risks.

| Achievable | 13th December 2018 |

12. There was no programme of general maintenance in the approved centre.

#### Corrective Action(s): On-going maintenance plan to be developed for St Catherines
- **Post-Holder(s) responsible:** Kevin Morrison, Senior Executive Office, Pat Cronin, Maintenance department and estates

The approved centre will be in good decorative condition

| Achievable | 13th December 2018 |

#### Preventative Action(s): 3/12 audit against JSF (MHC, 2018) Regulation 22 to improve compliance.
- **Post-Holder(s) responsible:** Nursing staff, estates, maintenance

3/12 audit against JSF (MHC, 2018) Regulation 22 to improve compliance.

| Achievable | 13th December 2018 |
### Regulation 26: Staffing

**Report reference: 45-46**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
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</thead>
</table>
| 13. Not all staff had up-to-date mandatory training in Basic Life Support, fire safety,  | Corrective Action(s):  
1. Email from all heads of discipline to remind staff to complete mandatory training  
2. Training logs to be held for all disciplines regarding mandatory training, these will be available for inspection by the MHC | 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. | Achievable              | 13th December 2018      |
<p>| PMAV, Children First.                                                                    | Post-Holder(s) responsible: |                                                                                                                                                                                                 |                        |                         |
| 14. Not all staff had up-to-date mandatory training in the Mental Health Act 2001.       | Preventative Action(s): 3/12 audit against JSF (MHC, 2018) Regulation 26 to improve compliance.                                                                                                               | 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. | Achievable              | 13th December 2018      |
|                                                                                         | Post-Holder(s) responsible: Heads of Discipline                                                                                                                                                        |                                                                                                                                                                                                 |                        |                         |
| 15. The number and skill mix of staff was not adequate to meet resident needs.           | Corrective Action(s): This requirement to be discussed at next management team meeting.                                                                                                                 |                                                                                                                                                                                                 | Achievable              | 1st September 2018      |
|                                                                                         | Post-Holder(s) responsible: St Catherine’s Management Team                                                                                                                                                |                                                                                                                                                                                                 |                        |                         |
|                                                                                         | Preventative Action(s): This requirement to be discussed at next management team meeting.                                                                                                                 |                                                                                                                                                                                                 | Achievable              | 1st September 2018      |</p>
<table>
<thead>
<tr>
<th>Post-Holders responsible: St Catherine’s Management Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Holders responsible:</td>
</tr>
</tbody>
</table>
## Regulation 27: Maintenance of Records

**Report reference: Page 47-48**

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 16. Not all clinical files were in good order. | **Corrective Action(s):**  
Email sent on 10th of July by CMN2 to Administrative manager to request support with the upkeep of files. Administrative support has been approved.  
Post-Holder(s) responsible: CNM2, Administrative Manager  
**Corrective Action(s):**  
Guidance on medical records management to be sought from acute hospital with regards to volumisation.  
Post-Holder(s) responsible: Administrative Manager  
**Corrective Action(s):**  
All staff emailed by heads of discipline to remind them that the upkeep of files was a shared responsibility  
Post-Holder(s) responsible: Heads of Disciplines | Audit of Maintenance of Records | Achievable | 13th September 2018 |
<p>| 17. The policy did not refer to the | <strong>Corrective Action(s):</strong> Added to the policy on 10th of July 2018 by CMN2 | Audit of Maintenance of Records | Completed | N/A |</p>
<table>
<thead>
<tr>
<th>18. Not all records were stored securely.</th>
<th>Post-Holder(s) responsible: Kevin Morrison, Senior Executive Officer</th>
<th>Preventative Action(s): 3/12 audit against JSF (MHC, 2018) Regulation 27 to improve compliance. Post-Holder(s) responsible: MDT staff, nursing staff</th>
<th>Audit of Maintenance of Records</th>
<th>Achievable</th>
<th>13th December 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Corrective Action(s): Secure trolley located in another ward, to be delivered to St Catherine’s as soon as it can be arranged. Email to be sent to remind all staff to lock trolley once it has been received. Post-Holder(s) responsible: ADON, CNM2</td>
<td></td>
<td>Audit of Maintenance of Records</td>
<td>Achievable</td>
<td>13th September 2018</td>
</tr>
<tr>
<td></td>
<td>Preventative Action(s): 3/12 audit against JSF (MHC, 2018) Regulation 27 to improve compliance Post-Holder(s) responsible: MDT staff, nursing staff</td>
<td></td>
<td>Audit of Maintenance of Records</td>
<td>Achievable</td>
<td>13th December 2018</td>
</tr>
</tbody>
</table>
### Regulation 28: Register of Residents

**Report reference:** Page 49

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
<th>Achievable / Realistic</th>
<th>Time-bound</th>
</tr>
</thead>
</table>
| 19. The register did not include all of the information specified in Schedule 1 to these Regulations:  
  - Resident admission date was not recorded for five residents.  
  - Resident discharge date was not recorded for two residents.  
  - Resident diagnosis on discharge in relation to psychiatric diagnosis was not recorded on the register. | Corrective Action(s):  
  1. Register has been updated as set out in the CAPA  
  2. Email sent to all staff to ensure register is kept up to date and fully completed.  
  Post-Holder(s) responsible: Heads of Discipline | The register of residents will contain the correct information  
  3/12 audit against JSF (MHC, 2018) Regulation 28 to improve compliance. | Completed                                      | N/A                           | 13th September 2018 |

Preventative Action(s): 3/12 audit against JSF (MHC, 2018) Regulation 28 to improve compliance.  
Post-Holder(s) responsible: MDT staff, nursing staff  
The register of residents will contain the correct information  
3/12 audit against JSF (MHC, 2018) Regulation 28 to improve compliance.  
Achievable                                          | 13th December 2018 |
**Regulation 32: Risk Management**

*Report reference: Page 55-57*

<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>20. The risk management policy was not comprehensive.</td>
<td>Corrective Action(s): 1. Risk Management Policy has been reviewed 2. Resident without leave policy in place 3. Guidelines for Self Harm in place 4. Emergency and Evacuation Policy in Place 5. Risk Advisor commenced training on identification, assessment and management of risk for staff on 23rd July 2018 6. All Mandated staff have completed Children’s First Training</td>
<td>All policies and training records will be made available to the MHC</td>
<td>Achievable</td>
<td>13th September 2018</td>
</tr>
<tr>
<td>21. The risk management policy did not cover the identification and assessment of risks throughout the approved centre.</td>
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<tr>
<td>22. The risk management policy did not cover the precautions in place to control identified risks.</td>
<td>Preventative Action(s): 3/12 audit against JSF (MHC, 2018) Regulation 32 to improve compliance.</td>
<td>3/12 audit against JSF (MHC, 2018) Regulation 32 to improve compliance.</td>
<td>Achievable</td>
<td>13th September 2018</td>
</tr>
<tr>
<td>23. The risk management policy did not cover the precautions in place to control for: resident absent without leave, suicide and self-harm.</td>
<td></td>
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<tr>
<td>24. The risk management policy did not cover the arrangements for responding to emergencies.</td>
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<tr>
<td>25. The risk management policy did not cover the arrangements for</td>
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</tbody>
</table>
26. There was no multi-disciplinary management review group that identified and reviewed risks as described in their policy. The policy was not implemented.

| New | Corrective Action(s): Incident Review group set up to meet quarterly first meeting 10th September 2018 – Audit Tool Developed and attached |
|     | Post-Holder(s) responsible: Consultant, ADON, CNM2, SW, OT, Psychologist, Senior Executive Officer |
|     | Records will be available to the MHC |
|     | Achievable |
|     | September 2018 |

<p>| New | Preventative Action(s): Incident Review Group to meet quarterly to identify and review incidents |
|     | Post-Holder(s) responsible: Consultant, ADON, CNM2, SW, OT, Psychologist, Senior Executive Officer |
|     | Records will be available to the MHC |
|     | Achievable |
|     | September 2018 |</p>
<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
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<th>Achievable / Realistic</th>
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</tr>
</thead>
</table>
| 27. There was no documented evidence to indicate that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent | Corrective Action(s): Confirmation a capacity assessment was undertaken for this patient and appropriate consent procedures followed based on the outcome of same.  
Post-Holder(s) responsible: Consultant | Evidence of any Consent to treatments will be available on inspection to the MHC                                                                                                                                 | Completed               | N/A        |
|                                                                                           | Preventative Action(s):  
1. Mental Health Act Administrator will alert Consultant in advance of Consent to treatment  
2. Consent to treatment will be dealt with by Consultant with an appropriate capacity assessments taking place.  
Post-Holder(s) responsible: Consultant and Mental Health Act Administrator | Evidence of any Consent to treatments will be available on inspection to the MHC                                                                                                                                 |                       |            |
| 28. Confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the | Corrective Action(s): Confirmation a capacity assessment was undertaken for this patient and appropriate consent procedures followed based on the outcome of same.  
Consultant | | Completed              | N/A        |
<table>
<thead>
<tr>
<th>medications was not documented, at the time consent was accepted</th>
<th>Post-Holder(s) responsible: Consultant and Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Action(s): The clinical director and the now treating consultant have confirmed that this patient is now a voluntary patient on the unit and has undergone appropriate capacity assessments at the time of being made voluntary.</td>
<td></td>
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<tr>
<td>Post-Holder(s) responsible: Consultant and Clinical Director</td>
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</table>
## Code of Practice: The Use of Physical Restraint

### Report reference: Page 65

<table>
<thead>
<tr>
<th>Area(s) of non-compliance</th>
<th>Specific</th>
<th>Measureable</th>
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<th>Time-bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. The policy did not identify who can implement physical restraint.</td>
<td>Corrective Action(s): Policy Revised July 2018 Post-Holder(s) responsible: ADON</td>
<td>Yearly audit against the Code of Practice to monitor and improve compliance</td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td>30. The training-related policy did not identify areas addressed within the training programme such as training in the prevention of management of violence, breakaway techniques, and training in alternatives to physical restraint.</td>
<td>Preventative Action(s): Yearly audit against the Code of Practice to monitor and improve compliance Post-Holder(s) responsible: ADON</td>
<td></td>
<td>Achievable</td>
<td>13th September 2018</td>
</tr>
<tr>
<td>31. The training-related policy did not specify the frequency of training.</td>
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*Reoccurring (#29)*
### Code of Practice: Admission, Transfer and Discharge

**Report reference: 66-67**

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<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>32. The admission policy did not include:</td>
<td>Corrective Action(s):</td>
<td>6/12 Audit of admissions against the criteria set out in the Code of Practice</td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>1. Procedure for self-presenting individuals added to the policy on 10th of July 2018 by CNM</td>
<td></td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>2. Section on confidentiality added by ADON on 12th July by ADON</td>
<td></td>
<td>Achievable</td>
<td>13th December 2018</td>
</tr>
<tr>
<td></td>
<td>3. Protocol for timely communication with GP’s and primary care to be agreed by the management team and added to the policy.</td>
<td></td>
<td>Achievable</td>
<td>13th December 2018</td>
</tr>
<tr>
<td></td>
<td>4. Consent to treatment policy to be developed by the management team.</td>
<td></td>
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<tr>
<td></td>
<td>Reoccurring</td>
<td>Post-Holder(s) responsible: Management team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. The transfer policy did not include the</td>
<td>Corrective Action(s):</td>
<td>6/12 Audit of transfers to another facility against the criteria set out in the Code of Practice</td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Added to the policy on 10th of July 2018 by CNM2</td>
<td></td>
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<tr>
<td></td>
<td>Reoccurring</td>
<td>Post-Holder(s) responsible: CNM2</td>
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</table>

Provisions for emergency transfer.

Preventative Action(s): 6/12 Audit of transfers to another facility against the criteria set out in the Code of Practice
Post-Holder(s) responsible: CNM2

Achievable 13th December 2018

34. The discharge policy did not include:
   - A way of following up and managing missed appointments.
   - Procedures for managing discharge against medical advice.

Reoccurring Corrective Action(s): Added to the policy on 10th of July 2018 by CNM2
Post-Holder(s) responsible: CNM2

Completed N/A

Preventative Action(s): 6/12 Audit of discharges against the criteria set out in the Code of Practice
Post-Holder(s) responsible: CNM2

Achievable 13th December 2018