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

ID Number: AC0044

2019 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
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date: 17 May 2019

Conditions Attached: Yes

Registered Proprietor: HSE

Registered Proprietor Nominee:
Mr Kevin Morrison, General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
Mary Connellan, Lead Inspector
Karen McCrohan
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Inspection Date: 18 – 21 June 2019

Previous Inspection Date: 13 -16 March 2018

Inspection Type: Unannounced Annual Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Date of Publication: Monday 06 January 2020

2019 COMPLIANCE RATINGS

REGULATIONS

3

18

10

Compliant
Non-compliant
Not applicable

RULES AND PART 4 OF THE MENTAL HEALTH

1

4

3

CODES OF PRACTICE
RATINGS SUMMARY 2017 – 2019

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

Chart 1 – Comparison of overall compliance ratings 2017 – 2019

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 2017 – 2019
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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Dr Susan Finnerty

In brief

The approved centre St. Catherine’s Ward was located on the grounds of St. Finbarr’s Hospital in Cork city. It was the only mental health in-patient facility located on the grounds, alongside continuing care services for the elderly. The buildings dated back to the mid 1800’s and in recent years a significant refurbishment of St. Catherine’s had been completed. Steps had been taken to address the ongoing situation whereby residents could not access the bedroom area from early morning until approximately 10pm each evening. The inspection team was informed that this would be remedied no later than three months from the date of the inspection. The residents, who were either continuing care or had an enduring mental health needs for which a specialist rehabilitation team would be appropriate, were all under the care of a general adult team. This was identified as a challenge by a number of staff.

There has been no improvement in the rate of compliance with rules, regulations and codes of practice from 2017 to 2019, remaining poor at 62% for the past three years. There was continuing non-compliance over three years with Regulation 15: Individual Care Plan; Regulation 19: General Health; Regulation 22: Premises; Regulation; 26: Staffing; Regulation 27: Maintenance of Records. Two compliances with regulations were rated as excellent.

Conditions to registration

There were three conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of this condition. However, it remained non-compliant with Regulation 15 Individual Care Plan which was rated as high risk.

Condition 2: To ensure adherence to Regulation 26(4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of this condition and, although non-compliant with Regulation 26, there was significant improvement in mandatory training of staff.
Condition 3: To ensure adherence to Regulation 26: Staffing, the approved centre shall ensure that residents of the approved centre have access to a suitably qualified speech and language therapist, and dietitian, in accordance with their assessed needs as documented in their individual care plan, by no later than 31 August 2019.

Finding on this inspection: At the time of inspection, the residents in the approved centre had access to a speech and language therapist. There was no access for residents to a dietician.

Safety in the approved centre

- Food safety audits had been completed periodically. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food and kitchen areas were clean.
- Hazards, including large open spaces, steps and stairs and slippery floors were minimised.
- The majority of mental health professionals were up-to-date with the required mandatory training in Basic Life Support, Fire Safety, Children First, the Management of Violence and Aggression and Mental Health Act training.
- There was an emergency plan that specified responses by the approved centre staff to possible emergencies. This emergency plan incorporated evacuation procedures.

However:

- The individual care plan did not include a risk management plan in five of the ten care plans reviewed.
- Ligature points in all the bedrooms had not been minimised.
- There were a small number of deficits in the medication prescription and administration records (MPAR), including one MPAR which did not identify the allergy status of the resident.
- All medications were not stored in a locked press in the locked pharmacy room.

Appropriate care and treatment of residents

- There were a significant number of deficits in the 10 individual care plans (ICPs) inspected. Eight ICPs reviewed did not specify appropriate goals for the residents. Four ICPs were not a composite set of documentation. One ICP did not specify the treatment and care required. Seven ICPs had not been regularly reviewed and updated by the resident’s multi-disciplinary team, in consultation with each resident. For seven residents it was not evidenced that they had been offered a copy of their ICP.
- The therapeutic services and programmes provided by the approved centre were appropriate and were evidence-based. A group facilitated by psychology staff had commenced since the last inspection. A group facilitated by social work and nursing staff had also been convened and was held weekly. A number of residents attended therapeutic programmes outside of the approved centre. Adequate resources and facilities were available to provide therapeutic services and programmes and a therapy kitchen located in the bedrooms area of the approved centre had been refurbished.
- Residents on antipsychotic medication were assessed on glucose regulation including fasting glucose/Hba1c, blood lipids, and electrocardiogram within the appropriate timeframe.
- Speech and Language assessments had been completed for residents, where required, since the last inspection.

However:
• For residents with special dietary requirements, an evidence-based nutrition assessment tool had not been used. Nutritional and dietary needs had not all been assessed, where necessary, and had not all been addressed in residents’ individual care plans. The needs of residents identified as having special dietary requirements had not been reviewed by a dietitian.

• Two of five clinical files inspected indicated that the resident had not received a physical examination within the previous six-month timeframe. Nursing staff had recorded family and personal history, Body Mass Index, weight, waist circumference, blood pressure and smoking status. The nutritional status had not been documented in any of the five clinical files inspected. All evidenced a medication review. One of five had not had an assessment of dental health.

Respect for residents’ privacy, dignity and autonomy

• All bathrooms, showers, and toilets, had locks on the inside of the door. Where residents shared a room, bed screening ensured that their privacy was not compromised. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

• The premises were adequately lit, heated, and ventilated. Sufficient spaces were provided for residents to move about, including outdoor spaces.

• There was a cleaning schedule implemented within the approved centre, and the approved centre was clean, hygienic, and free from offensive odours.

• There was a designated sluice room, cleaning room and laundry room.

However:

• Single bedrooms, did not have locks on the inside of the door.

• The residents could not use their bedrooms, located downstairs, from early morning until approximately 10pm at night. If a resident preferred to sleep during this time they did so in an armchair. This was not respectful of residents’ privacy and dignity.

• The approved centre was not kept in a good state of repair throughout internally. Some of the bedrooms were in a poor state and there were holes on some of the walls in the day area.

• The clinical files were not all maintained in good order as there were loose pages in a number of files reviewed. This had the potential to compromise patient confidentiality.

Responsiveness to residents’ needs

• Residents were provided with a variety of at least two choices for meals. Food, including modified consistency diets, were presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition.

• The approved centre provided access to recreational activities on weekdays and during the weekend. Recreational activities provided included arts and crafts, TV and DVDs, books and newspapers. Active recreational activities included a walking group and a social outing group. There was access to exercise equipment and an outdoor garden. Group activities included a current affairs discussion group, a brain gymnastics group and bingo.

Governance of the approved centre
• St. Catherine’s Ward was under the governance and management of the Cork and Kerry Community Health Care Organisation (formerly CHO 4). There were two executive management teams, one for each county. The approved centre was under management of the Cork Mental Health Area Management Team who were responsible and accountable for the strategic and operational direction of the service. A Quality and Patient Safety Committee, had recently commenced a quarterly meeting.

• There was an overarching Cork and Kerry Policy Standardisation and Review Group (PSRG). Work was ongoing to standardise applicable policies across the services. There was evidence of input from clinical and managerial staff from within the approved centres, including St. Catherine’s ward. A number of policies were in the process of being updated.

• There was an organisational chart and structure with defined lines of responsibility. Heads of discipline had identified strategic aims for their departments and there was clear evidence that changes had occurred since the previous inspection that impacted positively on the approved centre. Not all departments used a formal appraisal mechanism but it was reported that this was managed informally through supervision.

• All heads of discipline had received training on risk management and National Incident Management (NIMs) training. Concerns identified through the Mental Health Commission report from 2018 had in part been addressed. A therapeutic services committee had been established and therapeutic groups had commenced in the approved centre with positive outcomes.

• The multidisciplinary team now met monthly in the approved centre.

• There was evidence from within the approved centre of ongoing audit pertaining mainly to criteria set out in the Judgement Support Framework but as the local business meetings had not taken place, the learning from the audits had not always been disseminated.

However:

• Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management.

• 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 not been completed to identify opportunities for improving risk management processes.

• Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT which only took place monthly. The person with responsibility for risk management reviewed incidents for trends or patterns occurring in the service. Information provided was anonymous at resident level.

• The approved centre’s local heads of discipline management meeting had not taken place since November 2018, as there were no minutes of meeting subsequent to this. Management staff gave different accounts of how often this meeting took place varying from monthly to quarterly. There was poor attendances at these meetings in 2018.

• At the South Lee Management Meeting, which encompassed a number of mental health services including St. Catherine’s ward, there was no reference in the minutes to St. Catherine’s ward for the previous three month period.

• While the Non Consultant Hospital Doctors (NCHDs) were available to the approved centre, they did not see the residents on a regular basis.
The following quality initiatives were identified on this inspection:

1. A weekly psychology led therapeutic group had commenced in the approved centre.

2. A social work therapeutic group co-facilitated by the activity nurse had commenced.

3. A new template for the individual care plan had been introduced.

4. A multi-disciplinary therapeutic committee had been formed.
3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre St. Catherine’s Ward was located on the grounds of St. Finbarr’s Hospital, Douglas Road in Cork city. It was the only mental health in-patient facility located on the grounds alongside continuing care services for the elderly. The buildings dated back to the mid 1800’s and in recent years a significant refurbishment of St. Catherine’s had been completed. Situated on two floors, the upper floor which comprised day activities, a dining room and a sitting room had been completely upgraded. Works were ongoing in the lower ground floor which comprised all the bedrooms, a night sitting room and an activity therapy kitchen.

At the time of the inspection, all the residents had resided in the approved centre since the previous inspection. Occasionally, a small number had been admitted to another approved centre in Cork for short periods, returning to St. Catherine’s as their main place of residence. The residents were under the care of the general adult sector team for the catchment area that the approved centre was located in. The resident profile was described by staff as a mix between continuing care and rehabilitation although neither of these specialities were available to the residents. The age ranged from residents in the midspan of life to those in later life.

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>18</td>
</tr>
<tr>
<td>Number of detained patients</td>
<td>0</td>
</tr>
<tr>
<td>Number of wards of court</td>
<td>0</td>
</tr>
<tr>
<td>Number of children</td>
<td>0</td>
</tr>
<tr>
<td>Number of residents in the approved centre for more than 6 months</td>
<td>18</td>
</tr>
<tr>
<td>Number of patients on Section 26 leave for more than 2 weeks</td>
<td>0</td>
</tr>
</tbody>
</table>

3.2 Governance

St. Catherine’s Ward was located on the grounds of St. Finbarr’s Hospital and was under the governance and management of the Cork and Kerry Community Health Care Organisation (formerly CHO 4). There were two executive management teams, one for each county. The approved centre was under the governance and management of the Cork Mental Health Area Management Team who were responsible and accountable for the strategic and operational direction of the service. Minutes of these meetings evidenced a broad and active agenda. More recently, Quality and Patient Safety, which had been an agenda item, commenced a quarterly meeting of its own.
The approved centre’s local heads of discipline management meeting appeared not to have taken place since November 2018. Management staff gave different accounts of how often this meeting took place varying from monthly to quarterly. There was some evidence to indicate a meeting had taken place in May 2019 but this was not confirmed and there were no minutes to support this. There was poor attendances at the meetings in 2018. Senior Management stated that issues concerning the approved centre were discussed at the South Lee Management Meeting which encompassed a number of mental health services including St. Catherine’s ward. Minutes of these meetings that were reviewed included issues such as individual care planning which were applicable to the approved centre. There was no reference in the minutes to St. Catherine’s ward for the previous three month period.

There was an overarching Cork and Kerry Policy Standardisation and Review Group (PSRG). Work was ongoing to standardise applicable policies across the services. There was evidence of input from clinical and managerial staff from within the approved centres to include St. Catherine’s ward. A number of policies were in the process of being updated. There was evidence from within the approved centre of ongoing audit pertaining mainly to criteria set out in the Judgement Support Framework. As the local business meetings had not taken place, the learning from the audits had not always been disseminated.

The Mental Health Commission compiled information received from each of the heads of discipline operating in St. Catherine’s ward prior to the inspection. The inspection team also met with or discussed governance matters with the following:

- The Clinical Director
- The Area Director of Nursing
- Area Administrator
- Occupational Therapy Manager
- Principal Clinical Psychologist
- Senior Clinical Psychologist
- Principal Social Worker
- Area Lead for Mental Health Engagement
- Risk Advisor

Despite the fragmented business meetings for the approved centre, there was an organisational chart and structure with defined lines of responsibility. Heads of discipline had identified strategic aims for their departments and there was clear evidence that changes had occurred since the previous inspection that impacted positively on the approved centre. Not all departments used a formal appraisal mechanism but it was reported that this was managed informally through supervision.

All heads of discipline had received training on risk management and National Incident Management (NIMs) training. Concerns identified through the Mental Health Commission report from 2018 had in part been addressed. A therapeutic services committee had been established and therapeutic groups had commenced in the approved centre with positive outcomes. Refurbishment of the premises was ongoing. Steps had been taken to address the ongoing situation whereby residents could not access the bedroom area from early morning until approximately 10pm each evening. The inspection team was informed that this would be remedied no later than three months from the date of the inspection.
Access to the multi-disciplinary team (MDT) on a more regular basis was discussed. The MDT now met monthly in the approved centre. Previously this had been fortnightly. While the Non Consultant Hospital Doctors (NCHDs) were available to the approved centre, they were not based there and did not see the residents on a regular basis. The residents who were either continuing care or had an enduring mental health needs for which a specialist rehabilitation team would be appropriate, were all under the care of a general adult team. This was identified as a challenge by a number of staff.

### 3.3 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.
4.0 Compliance

4.1 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 2018 and 2017 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>✓</td>
<td>X</td>
<td>High</td>
</tr>
<tr>
<td>Regulation 15: Individual Care Plan</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 19: General Health</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 21: Privacy</td>
<td>X</td>
<td>Moderate</td>
<td>✓</td>
</tr>
<tr>
<td>Regulation 22: Premises</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 26: Staffing</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 27: Maintenance of Records</td>
<td>X</td>
<td>High</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 32: Risk Management Procedures</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
<tr>
<td>Regulation 34: Certificate of Registration</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre</td>
<td>X</td>
<td>Moderate</td>
<td>X</td>
</tr>
</tbody>
</table>

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

4.2 Areas of compliance rated “excellent” on this inspection

The following area was rated excellent on this inspection:

<table>
<thead>
<tr>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 4: Identification of Residents</td>
</tr>
<tr>
<td>Regulation 31: Complaints Procedures</td>
</tr>
</tbody>
</table>

4.3 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>Regulation 30: Mental Health Tribunals</td>
<td>As no Mental Health Tribunals had been held in the approved centre since the last inspection, 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>Part 4 of the Mental Health Act 2001: Consent to Treatment</td>
<td>As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.</td>
</tr>
<tr>
<td>Code of Practice on the Use of Physical Restraint in Approved Centres</td>
<td>As no resident in the approved centre had been physically restrained since the last inspection, this code of practice 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>
5.0 Service-user Experience

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

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

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.

The inspection team met with three residents formally. All residents were complimentary about staff in particular the nursing and activity staff. Residents praised the food and indicated that they felt there was enough to do during the day. One resident did not feel that they should continue to be residing in the facility although they did indicate that they were happy with their care and treatment.

One resident questionnaire was completed which stated the resident understood their care plan and was ‘sometimes’ involved in setting goals. It indicated that they knew who their individual keyworker was. The questionnaire indicated that there was enough activities during the day and that the respondent was happy with how staff talked to them. They also felt that their privacy and dignity was respected and that they had space for privacy. The resident noted that they ‘always’ felt safe in the approved centre but that they did ‘not know how to make a complaint’.

Feedback from the IAN was positive. The feedback from the residents to the IAN was that the nurses were excellent, the food was good and that the residents liked being in the approved centre.
6.0 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:

- Executive Clinical Director
- Clinical Director
- Acting /Assistant Director of Nursing
- Consultant Psychiatrist
- General Manager
- Area Administrator
- Area Lead for Mental Health Engagement
- Occupational Therapy Manager
- Acting / Clinical Nurse Manager
- Senior Clinical Psychologist x 2
- Principal Social Worker

Apologies were received on behalf of the head of service.

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. As applicable these have been included in the relevant section of the report.

7.0 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 January 2019. The policy 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 were able to articulate the processes for identifying residents, as set out in the policy.

Monitoring: An annual audit had been undertaken to ensure that there were appropriate resident identifiers on clinical files. Documented analysis had been completed to identify opportunities for improving the resident identification process.

Evidence of Implementation: A minimum of two resident identifiers, appropriate to the resident group profile and individual residents’ needs, were used. Photograph identification was also used with resident consent. Identifiers were person-specific and appropriate to the residents’ communication abilities. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other healthcare, therapeutic services, and programmes. A system for identifying residents with the same or similar name was in place.

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

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

INSPECTION FINDINGS

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

Training and Education: Not all 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 been completed to identify opportunities for improving the processes for food and nutrition.

Evidence of Implementation: Approved centre menus had been approved by a dietitian in the main kitchen of the hospital to ensure nutritional adequacy but not in accordance with the specific needs of the residents in the approved centre. Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. Food including modified consistency diets were presented in a manner that was attractive and appealing in terms of texture, flavour, and appearance in order to maintain appetite and nutrition. Hot and cold drinks were offered to residents regularly. A source of safe, fresh drinking water was available and hot meals were provided on a daily basis.

For residents with special dietary requirements, an evidence-based nutrition assessment tool had not been used. Where appropriate, weight charts were implemented, monitored and acted upon. Staff reported nutritional and dietary needs had not all been assessed by a dietitian where necessary, and had not all been addressed in residents’ individual care plans.

Speech and Language assessments had been completed for residents, where required, since the last inspection. Intake and output charts had been maintained for residents, where appropriate.

The approved centre was non-compliant with this regulation because the needs of residents identified as having special nutritional requirements had not been reviewed by a dietitian and, therefore, an account of special dietary requirements was not considered appropriately, 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 addressed 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: Not all 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 safety, as set out in the policy. All staff handling food had up-to-date training in food safety commensurate with their role. This training was documented, and evidence of certification was available.

Monitoring: Food safety audits had 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 been completed to identify opportunities to improve food safety processes.

Evidence of Implementation: There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Food was prepared in the main kitchen of St. Finbarr’s campus and was transported to the approved centre. Food was prepared in a manner that reduced the risk of contamination, spoilage, and infection.

There was suitable and sufficient catering equipment in the approved centre. Hygiene was maintained to support food safety requirements. 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 training and education 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 insert date here October 2016. The policy addressed 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. No residents were wearing nightclothes at the time of inspection.

Evidence of Implementation: Residents were supported to keep and use personal clothing. Residents’ clothing was clean and appropriate to their needs. Emergency clothing was available to residents in the approved centre. Residents changed out of nightclothes during the day and all residents had an adequate supply of individualised clothing.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes 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 communications with the resident and their representatives regarding the resident’s 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 interviewed were able to articulate the processes for residents’ personal property and possessions, as set out in the policy.

Monitoring: Personal property logs were monitored in the approved centre. Documented analysis had been completed to identify opportunities for improving the processes relating to residents’ personal property and possessions.

Evidence of Implementation: Residents’ personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of monies, valuables, and personal effects.

On admission, the approved centre compiled a detailed property checklist. These were filed separately from the resident’s individual care plan and were available to residents. Residents were supported to manage their own property, unless it posed a danger to the resident or others, as indicated in their individual care plan. The access to and use of resident monies was not always overseen by two members of staff and the resident or their representative. The practice was only one staff signature.

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 evidence of implementation pillars.
Regulation 9: Recreational Activities

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

INSPECTION FINDINGS

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

Training and Education: There was no policy for staff to read, understand, or articulate. Relevant staff interviewed were able to articulate the processes for recreational activities.

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

Evidence of Implementation: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Notices outlining a two weekly schedule of activities were displayed. A daily timetable was also displayed. Recreational activities provided included arts and crafts, TV and DVDs, books and newspapers. Active recreational activities included a walking group and a social outing group. There was access to exercise equipment and an outdoor garden. Group activities included a current affairs discussion group, a brain gymnastics group and bingo.

The recreational activity programme had been developed, implemented and maintained for residents with resident involvement. Individual risk assessments had been completed in relation to the selection of appropriate activities. Resident decisions on whether to participate or not were respected and documented, as appropriate. The recreational activities were appropriately resourced and there were opportunities for indoor and outdoor exercise and physical activity. Documented records of attendance had been retained in group records and within the residents’ clinical files.

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 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 addressed 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 their 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 reviewed to ensure that it reflected the identified needs of residents. This was documented.

Evidence of Implementation: Residents were facilitated to practice their religion insofar as was practicable. Mass was celebrated in the church on the grounds of St. Finbarr’s hospital. Residents had access to multi-faith chaplains.

The care and services provided in the approved centre were respectful of the residents’ religious beliefs and values. Specific religious requirements relating to the provision of services, care, and treatment had been clearly documented. Residents were facilitated to observe or abstain from religious practice in accordance with their wishes.

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 11: Visits

COMPLIANT

Quality Rating Satisfactory
(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 and procedures in relation to visits. The policy was last reviewed in October 2019. The policy and procedures addressed 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 method.

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. Visiting times were appropriate and very flexible. A separate visiting room and visiting areas were provided where residents could meet visitors in private. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Children visiting had been accompanied by an adult to ensure their safety and visiting areas were suitable for 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 and procedures in relation to resident communication. The policy was last reviewed in October 2016. The policy and procedures 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 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 mail, e-mail, internet, and telephone unless otherwise risk assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or others.

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in October 2016. The policy and procedures 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 is accommodated.
- The consent requirements of a resident regarding searches and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

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 searching processes, as set out in the policy.

As no search had been conducted in the approved centre since the last inspection the monitoring and evidence of implementation pillars were not applicable.

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

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.
(2) The registered proprietor shall ensure that when a resident is dying:
   (a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;
   (b) in so far as practicable, his or her religious and cultural practices are respected;
   (c) the resident’s death is handled with dignity and propriety, and;
   (d) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.
(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:
   (a) in so far as practicable, his or her religious and cultural practices are respected;
   (b) the resident’s death is handled with dignity and propriety, and;
   (c) in so far as is practicable, the needs of the resident’s family, next-of-kin and friends are accommodated.
(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.
(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

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

- Advance care directives in relation to end of life care, Do Not Attempt Resuscitation orders (DNARs), and residents’ religious and cultural end of life preferences.
- 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).

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.

Monitoring: There had been no deaths in the approved centre since the last inspection and therefore the monitoring section was not applicable.

Evidence of Implementation: End of life care provided was appropriate to the resident’s physical, emotional, social, psychological and spiritual needs. As applicable, this had been documented in residents’ respective individual care plans. Religious and cultural practices were respected. The privacy and dignity of residents were protected, e.g., provision of a single room within the approved centre during the provision of end of life care. Representatives, family, next of kin and friends were involved and accommodated during end of life care. Pain management was prioritised and managed during end of life care. All relevant documentation was evidenced in the clinical files.

The approved centre was compliant with this regulation.
Regulation 15: Individual Care Plan

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in July 2018. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The required content in the set of documentation making up the individual care plan.
- The timeframes for assessment planning, implementation and evaluation of the individual care plan.

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

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

Evidence of Implementation: Ten ICPs were reviewed as part of the inspection. Not all of the ICPs were a composite set of documents. Four were interrupted with various other documents filed amongst the ICP sheets. A new template had been developed and all ICPs examined included an allocated space for goals, treatment, care and resources, as well as space for review. There had been no new admissions since the previous inspection.

Evidence-based assessments were used where possible and the ICP was discussed, agreed, and where practicable, drawn up with the participation of the resident and their representative or family as appropriate. For eight of ten ICPs inspected, the ICP did not identify the residents’ assessed needs or appropriate goals. For one ICP the care and treatment required including responsibilities for implementing care and treatment was not specified. All the ICP identified the resources required to ensure continuity in the implementation of the residents’ ICP and a key worker system was used in the approved centre. The ICP did not include a risk management plan for five of the ten reviewed. For seven of the residents, the ICPs had not been reviewed by the MDT in consultation with the resident at least six-monthly.

ICPs were updated following reviews as indicated by the residents’ changing needs, condition, circumstances and goals. The resident had access to the ICP and was informed of any changes. For seven residents it was not evidenced that they had been offered a copy of their ICP and therefore it was not known if the resident declined or refused a copy of their ICP.
The approved centre was non-compliant with this regulation for the following reasons:

a) Four ICPs were not a composite set of documentation.

b) Eight ICPs reviewed did not specify appropriate goals for the residents.

c) One ICP did not specify the treatment and care required.

d) Seven ICPs had not been regularly reviewed and updated by the resident’s multi-disciplinary team, so far as practicable in consultation with each resident.
Regulation 16: Therapeutic Services and Programmes

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

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

INSPECTION FINDINGS

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

- The planning and provision of therapeutic services and programmes within the approved centre.
- Assessing residents as to the appropriateness of services and programmes (including risk).
- The resource requirements of the therapeutic services and programmes.
- The review and evaluation of therapeutic services and programmes.
- The facilities for the provision of therapeutic services and programmes.

Training and Education: Not all clinical staff had signed the signature log to indicate that they had read and understood the policy. All clinical staff interviewed were able to articulate the processes relating to therapeutic activities and programmes.

Monitoring: The range of services and programmes provided in the approved centre was monitored on an ongoing basis to ensure that the assessed needs of residents were met. Documented analysis had 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 appropriate and met the assessed needs of the residents as documented in their individual care plans. The therapeutic services and programmes provided by the approved centre were evidence based. A group facilitated by psychology had commenced since the last inspection. A group facilitated by social work and nursing staff had also been convened and was held weekly. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning. A list of therapeutic services and programmes provided in the approved centre was available to residents.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre did not always arrange for the service to be provided as the provision of a dietetic service for residents with an identified need had not been provided.

A number of residents attended therapeutic programmes outside of the approved centre. Adequate resources and facilities were available to provide therapeutic services and programmes which took place in two separate dedicated rooms. A therapy kitchen located in the bedrooms area of the approved centre had been refurbished. A record was maintained of participation and engagement in therapeutic services in the residents’ individual care plans.
The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the *Judgement Support Framework* under the processes, training and education and evidence of implementation pillars.
Regulation 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 July 2018. The policy addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities of the multi-disciplinary team and the resident’s key worker.
- The interagency involvement in the transfer process.
- The resident assessment requirements prior to transfer from the approved centre, including the individual risk to be assessed.
- The process for managing residents’ medications during transfer from the approved centre.
- The resident and/or their representative’s involvement in, and consent to, the transfer process.
- The process for ensuring privacy and confidentiality during the transfer process, specifically in relation to the transfer of personal information.
- The process for managing residents’ property.

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 maintained. Each transfer record had not been systematically reviewed to ensure all relevant information was provided to the receiving facility. Documented analysis had 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 to another facility was inspected. The clinical file did accompany the resident; however, the progress notes in the clinical file did not contain any entry regarding the resident’s transfer. A copy of the referral letter to the other facility had been retained in the clinical file. It did include a list of current medications. There was no evidence of documented consent of the resident to the transfer and no evidence of an assessment of the resident, including risk assessment having taken place. There was no evidence that a transfer form had been completed or that a checklist had been completed to ensure comprehensive resident records had been transferred to the receiving facility.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre did not meet all criteria of the Judgement Support Framework under the processes 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 written operational policies and procedures in relation to the provision of general health services and the response to medical emergencies. The general health policy was last reviewed in July 2018. The medical emergencies 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).

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’ uptake of national screening programmes was recorded and monitored, where applicable. A systematic review had not been undertaken to ensure that six-monthly general health assessments of residents occurred. Analysis had been completed to identify opportunities 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 available of any medical emergency within the approved centre and the care provided.

Residents received appropriate general health care interventions; however, these were not always documented in their respective individual care plans. Two of five resident files inspected indicated that they had not received a physical examination within the previous six-month timeframe. Nursing staff had recorded family and personal history, Body Mass Index, weight, waist circumference, blood pressure and smoking status. The nutritional status had not been documented in any of the five resident files inspected. All evidenced a medication review. One of five had not had an assessment of dental health.

Residents on antipsychotic medication were assessed on glucose regulation including fasting glucose/Hba1c, blood lipids, and electrocardiogram 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 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 had access to smoking-cessation programmes and supports.

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

a) One resident had not received an assessment of their dental health, 19(1)(a).

b) Not all residents’ general health needs had been assessed at least every six months, 19 (1)(b).

c) Nutritional status had not been documented, 19 (1)(b).
(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: 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 the provision of information to residents, as set out in the policy.

Monitoring: The provision of information to residents was monitored on an ongoing basis to ensure it was appropriate and accurate, particularly where information changed. Documented analysis had been completed to identify opportunities for improving the processes relating to the provision of information to residents.

Evidence of Implementation: Required information was provided to residents and their representatives at admission; this included an information booklet that detailed the care and services provided. This booklet was available in the required formats to support resident needs and was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies and resident rights. Residents were provided with details of their multi-disciplinary teams. Residents were provided with written and verbal information on diagnosis, unless, in the treating psychiatrists’ view the provision of such information might be prejudicial to the residents’ well-being. Information was provided to residents on the likely adverse effects of treatment including risks and other potential side-effects. Medication information sheets as well as verbal information were provided in a format appropriate to residents’ needs. The information provided within the approved centre was
evidence based and was appropriately reviewed. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation. The quality assessment was satisfactory and not rated excellent because the approved centre met all criteria of the *Judgement Support Framework* under the processes and training and education 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 addressed requirements of the Judgement Support Framework, with the following exceptions:

- The roles and responsibilities for the provision of resident privacy and dignity.
- The approved centre’s 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: Not 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 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 been completed to identify opportunities for improving the processes relating to residents’ privacy and dignity.

Evidence of Implementation: Residents were called by their preferred name. The general demeanour of staff and the way in which staff addressed and communicated with residents was respectful. 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. Where residents shared a room, bed screening ensured that their privacy was not compromised. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

The residents could not use their bedroom or spend time in the bedroom area located downstairs from early morning until approximately 10pm at night. If a resident preferred to sleep during this time they did so in an armchair. This was not respectful of residents’ privacy and dignity. The inspection team were informed that plans to recruit staff to facilitate the opening of the bedroom area from early evening had progressed. It was estimated that staff would be in post no later than three months from the inspection date.

The approved centre was non-compliant with this regulation because the bedroom area was locked from early morning until 10 pm approximately and, therefore, the resident’s privacy and dignity was not appropriately respected at all times.
Regulation 22: Premises

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

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

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

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

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

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and

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 been completed to identify opportunities for improving the premises.

Evidence of Implementation: Residents had access to personal space and the approved centre provided appropriately sized communal
rooms. The night sitting room downstairs was considered small but sufficient for the numbers who chose to use it. 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 for residents to move about, including outdoor spaces.

Hazards, including large open spaces, steps and stairs and slippery floors were minimised. Ligature points in all the bedrooms had not been
minimised. Two of these bedrooms were due for refurbishment.
There was a cleaning schedule implemented within the approved centre, and the approved centre was clean, hygienic, and free from offensive odours. The approved centre was not kept in a good state of repair throughout internally. Some of bedrooms were in a poor state and there were holes on some of the walls in the day area. There was a documented programme of general maintenance, decorative maintenance, decontamination, and repair of assistive equipment and records were maintained. Back-up power was available to the approved centre.

There was a designated sluice room, cleaning room and laundry room. There was an appropriately sized lift. The approved centre has a dedicated examination room and all the resident bedrooms were appropriately sized to address their needs. Suitable furnishings had been provided to support resident independence and comfort. As required appropriate assisted devices and equipment had been provided.

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

a) Not all bedrooms were kept in good decorative condition, 22 (1)(a).

b) The physical structure had not been maintained with due regard to the safety and well-being of residents as ligature points had not been minimised, 22(3).
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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


INSPECTION FINDINGS

Processes: The approved centre had written policies in relation to the ordering, storing, prescribing, and administration of medication. The policies were last reviewed in October 2016. Collectively 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 had signed the signature log to indicate that they had read and understood the policies. All nursing and medical 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. All nursing and medical 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 been undertaken to determine compliance with the policies and procedures and the applicable legislation and guidelines. Analysis had been completed to identify opportunities for improving medication management processes.

Evidence of Implementation: The MPARs for ten of the residents were inspected. A record of allergies or sensitivities to any medications, including if the resident had no allergies, had not been recorded for one resident. The generic names of medications and preparations were written in full with dedicated spaces for routine medications, once-off medications, and “as required” (PRN) medications. The frequency of administration, the dosage, and the administration route for medications were recorded.

Not all medications administered to residents were recorded. There were gaps in the administration records pertaining to two residents. It was not known, therefore, if the residents had received or refused the prescribed medication or if this medication had been withheld. When it was documented that a resident refused the medication in the MPAR there was not always corresponding documentation in the clinical file. There was a clear record of the date of initiation for each medication. The Medical Council
Registration Number (MCRN) of the medical practitioner prescribing medication to the residents had been included in all the MPARs inspected.

All entries in the MPARs were legible and written in black ink. Medication had been reviewed at least six-monthly. Schedule 2 controlled drugs were checked by two staff members.

Medication was stored in an appropriate environment and where medication required refrigeration, a log of the temperature of the fridge had been taken. Medication storage areas were free from damp and mould, clean, and free from litter. Food or drink was not stored in areas used for medication storage. The medication cabinets were not locked but were stored in a locked pharmacy room. This practice was rectified by staff at the time of the inspection. Schedule 2 drugs were locked in a separate cupboard from other medicinal products.

A system of stock rotation was implemented and an inventory of medications was conducted on a monthly basis. Medication that was no longer required was returned to the pharmacy for disposal.

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

a) One MPAR did not identify the allergy status of the resident, 23 (1).

b) Two MPARs evidenced gaps in the record of medications administered to the resident, 23 (1).

c) All medications were not stored in a locked press in the locked pharmacy room, 23(1).
Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

Processes: The approved centre had 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 Safety Statement had last been reviewed in November 2017. The HSE Corporate Safety Statement 2014 with General Information for Infection Control was also evident. 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 requirements of the Judgement Support Framework, including the following:

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

The policy and procedures did not include processes for the following:

- 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 had not been completed to identify opportunities to improve staffing processes and respond to the changing needs and circumstances of residents. There was evidence that the service did respond to the changing needs and circumstances of the residents.

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 a dietitian at the time of the inspection. While an occupational therapist was available, this was a limited resource. A written staffing plan not available. There were not sufficient staff to allow the bedroom areas be opened with supervision during the day and early evening. The inspection team was informed that a recruitment campaign for a twilight evening shift had been progressed and it was expected that staff would be in place within three months from the date of the inspection. Agency staff were used and there was a comprehensive contract between the approved centre and the registered staffing agency used.

Annual staff training plans had been completed for all staff to identify required training and skills development in line with the assessed needs of the resident group profile. Orientation and induction training was completed for all staff.

Staff were trained in manual handling, and most staff had completed the required mandatory training as set out in the table below. Other training that staff had included care for residents with an intellectual disability, end of life care, risk management, incident reporting, and protection of children and vulnerable adults. Opportunities were made available to staff for further education. In service training had been completed by appropriately trained individuals mainly in an education facility off-site.

<table>
<thead>
<tr>
<th>Profession</th>
<th>Basic Life Support</th>
<th>Fire Safety</th>
<th>Management Of Violence and Aggression</th>
<th>Mental Health Act 2001</th>
<th>Children First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing (14)</td>
<td>12</td>
<td>86%</td>
<td>11</td>
<td>79%</td>
<td>12</td>
</tr>
<tr>
<td>Medical (3)</td>
<td>3</td>
<td>100%</td>
<td>3</td>
<td>100%</td>
<td>3</td>
</tr>
<tr>
<td>Occupational Therapist (1)</td>
<td>1</td>
<td>100%</td>
<td>1</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Social Worker (1)</td>
<td>1</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist (2)</td>
<td>2</td>
<td>100%</td>
<td>1</td>
<td>50%</td>
<td>2</td>
</tr>
</tbody>
</table>

The following is a table of clinical staff assigned to the approved centre.
The approved centre was non-compliant with this regulation for the following reasons:

a) The numbers of staff and skill mix was not appropriate to the assessed needs of residents, most specifically the lack of a dietitian, 26(2).

b) The numbers of staff was not appropriate to the assessed needs of residents and to facilitate the bedroom area being accessible to the residents as appropriate, 26(2).

c) Not all healthcare professionals were up-to-date with the required mandatory training in Basic Life Support, Fire Safety, Children First and the Management of Violence and Aggression, 26(4).

d) One staff member had not completed Mental Health Act training, 26(5).
Regulation 27: Maintenance of Records

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

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

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


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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the maintenance of records. The policy was last reviewed in October 2016. The policy and procedures addressed requirements of the Judgement Support Framework, including the following:

- The required resident record creation and content.
- Those authorised to access and make entries in residents’ records.
- Record retention periods.

The policy did not include:

- 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. All clinical staff had been trained in best-practice record keeping.

Monitoring: Resident records were audited to ensure their completeness, accuracy, and ease of retrieval. This was documented. Analysis had been completed to identify opportunities to improve the processes relating to the maintenance of records.

Evidence of Implementation: Records were secure, and were constructed, maintained and used in accordance with national guidelines and legislative requirements. A record was initiated for every resident but not all resident records were reflective of the residents’ current status and care and treatment being provided. There was no entry in the record of a resident who had been transferred to another facility regarding the transfer. Resident records were maintained using an identifier that was unique to the resident. Records were not all developed and maintained in a logical sequence. It was difficult to locate records in some clinical files and in some various documents were amalgamated in the Individual Care
Plan section. The clinical files were not maintained in good order and there were loose pages in ten clinical files reviewed.

Resident records were accessible to authorised staff only, and only these staff made entries into the resident records. Staff had access to the data and information necessary to carry out their responsibilities. Residents’ access to their records was managed in accordance with the Data Protection Acts.

Entries were factual, consistent and did not contain jargon. Each entry included the date and noted the time using the 24-hour clock. All entries made by a student nurse or other clinical training staff were signed by a registered nurse or supervisor. Not all errors has been appropriately corrected. Two appropriate resident identifiers were recorded on all documentation. Records were appropriately secured throughout the approved centre from loss or destruction, tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre. Records were destroyed in accordance with legislative requirements and the policy and procedure of the approved centre.

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

- a) The registered proprietor did not ensure that the clinical files were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, 27(1).
- b) The clinical files were not all maintained in good order as there were loose pages in a number of files reviewed, 27(1).
- c) The approved centre’s policy did not include a process for the destruction of records, 27(2).
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 an electronic register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.
Regulation 29: Operating Policies and Procedures

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

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 the 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. 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. 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.

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. 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 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 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 policies and procedures addressed all of the requirements of the Judgement Support Framework, including the process for managing complaints, including the raising, 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.

Training and Education: Relevant staff had 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 been completed. Audits were documented and the findings acted upon. Complaints data was analysed. Details of the analysis had been considered by senior management. Required actions had been identified and implemented to ensure continuous improvement of the complaints management process.

Evidence of Implementation: There was a nominated individual with responsibility for dealing with complaints, who was available to the approved centre. A consistent and standardised approach was implemented for the management of all complaints. The approved centre’s management of complaints processes was well publicised and accessible to residents and their representatives. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being lodged.

All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The community meeting had also been used as forum for minor complaints. All complaints were documented and dealt with by the local nominated complaints officer. Details of complaints and of
subsequent investigations and outcomes were fully recorded and kept distinct from residents’ individual care plans.

The approved centre was compliant with this regulation. The quality assessment was rated excellent because the approved centre met all criteria of the *Judgement Support Framework*. 
Regulation 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;
(b) The precautions in place to control the risks identified;
(c) The precautions in place to control the following specified risks:
   (i) resident absent without leave,
   (ii) suicide and self harm,
   (iii) assault,
   (iv) accidental injury to residents or staff;
(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
(e) Arrangements for responding to emergencies;
(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to risk management and incident management procedures, which was last reviewed in July 2018. The policy addressed requirements of the Judgement Support Framework, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to emergencies.

The policy did not address the following:

- The responsibilities of the multi-disciplinary team for risk management and the implementation of the risk management policy.
- Capacity risks relating to the numbers in the approved centre.
- The process for learning from incidents.
- The process for communication specific to emergencies.
- The process for protecting vulnerable adults in the care of the approved centre.

Training and Education: Not all relevant staff had received training in the identification, assessment, and management of risk and in health and safety risk management. Clinical staff were trained in individual risk management processes. Management were trained in organisational risk management. All staff had been trained in incident reporting and documentation. 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 risk management processes, as set out in the policy. 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 not been completed to identify opportunities for improving risk management processes.

**Evidence of Implementation:** Responsibilities for risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. Clinical risks were documented in the risk register as appropriate. The risk management procedures did not actively reduce identified risks to the lowest practicable level. The business meetings for the approved centre had not taken place for over six-months and this was the forum where the risk register and all incidents in the approved centre were to be reviewed.

Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation. Health and safety risks were documented within the risk register as appropriate. Ligature points were not all removed but were mitigated using individual risk assessment. Individual risk assessment had not been documented for a resident transfer. The multi-disciplinary team (MDT) was involved in the development, implementation and review of individual risk management processes. Residents and their representatives were involved in the individual risk management processes. The requirements for the protection of vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format. All clinical incidents were reviewed by the MDT which only took place monthly. The person with responsibility for risk management reviewed incidents for trends or patterns occurring in the service. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan that specified responses by the approved centre staff to possible emergencies. This emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because the risk register for the approved centre had not been reviewed for over six months and, therefore, the risk management policy had not been fully implemented throughout the approved centre, 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

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

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

### INSPECTION FINDINGS

The approved centre did not have an up-to-date certificate of registration displayed with three conditions to registration attached.

The approved centre was non-compliant with this regulation because the certificate of registration was not up-to-date.
None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
Part 4 of the Mental Health Act 2001: Consent to Treatment, was not applicable to this approved centre. Please see Section 4.3 Areas of compliance that were not applicable on this inspection for details.
10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.
Admission, Transfer and Discharge

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in July 2018, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in July 2018, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in July 2018, included the policy-related criteria for this code of practice except procedure for discharge of involuntary patients.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, and discharge policies as applicable.

Evidence of Implementation:

Admission: No new residents had been admitted to the approved centre since the last inspection.

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

Discharge: The clinical file of a resident who had been discharged was inspected. The clinical file included a discharge plan which documented the estimated date of discharge, communication with the relevant general practitioner or primary care team. It did not include a follow-up plan or reference to early warning signs of relapse and risks. A discharge meeting, attended by the resident, key worker and relevant members of the MDT was held. A comprehensive discharge assessment was documented and a preliminary summary was sent as appropriate. A comprehensive discharge summary was issued within 14 days.

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

a) The discharge policy did not include procedures for discharge of involuntary patients, 4.2
b) The discharge plan did not include a follow-up plan or reference to early warning signs of relapse and risk, 34.2.
## Appendix 1: Corrective and Preventative Action Plan

### Regulation 15: Individual Care Plan

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Four ICPs were not a composite set of documentation.</th>
<th>Speciﬁc</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
<td>ICP working group to address same</td>
<td>Recent audit 23/10/2019 identified significant improvement in respect of ICP completion</td>
<td>CNM2 to monitor the maintenance of improvements in respect to ICP completion</td>
<td>07/11/2019</td>
<td>Clinical Director and Assistant DON</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
<td>CNM2 to monitor ICP quality and to work with the MDT to ensure that ICPs are a composite set of documents</td>
<td>MDT audit of ICP</td>
<td>Achievable</td>
<td>31/12/2019</td>
<td>Clinical Director and Assistant DON and CNM2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID</th>
<th>Eight ICPs reviewed did not specify appropriate goals for the residents. One ICP did not specify the treatment and care required.</th>
<th>Speciﬁc</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
<td>CNM2 in collaboration with the MDT will audit current ICP and identify areas for improvements including assessing the presence and quality of capture goals</td>
<td>All ICP to be audited and key finding reported back to MDT</td>
<td>Achievable</td>
<td>31/01/2020</td>
<td>MDT</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
<td>ICP progress to be reported back to the</td>
<td>St Catherine’s Local Management team</td>
<td>Realistic commencing Jan 2020</td>
<td>31/01/2020</td>
<td>Assistant DON</td>
</tr>
<tr>
<td>Reason ID : 10000480</td>
<td>Seven ICPs had not been regularly reviewed and updated by the resident's multidisciplinary team, so far as practicable in consultation with each resident.</td>
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</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Each current resident to have an MDT review of their ICP. In every instance possible this will be with each resident. ICP notes reflect consultation and collaboration. Achievable and realistic 21/02/2020 Clinical Director and Assistant DON</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>St Catherine's Local Management team to promote a culture of MDT Collaboration in regards to ICP completion. MDT team to complete ICP with residents as the expectation not the exception St Catherine's Local Management team agenda and minutes reflect same. Achievable 31/01/2020 MDT</td>
<td></td>
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<tr>
<td>Reason ID : 10000463</td>
<td>Nutritional status had not been documented, 19 (1)(b).</td>
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<tr>
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<td>--------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Integrate Nutritional Status as a key action point on the orange General Health 6 monthly assessment document to be completed by medical staff. The General Health assessment documents are audited 6 monthly. Achievable and realistic.</td>
<td>28/02/2020</td>
<td>Clinical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Processes for monitoring and recording Nutritional Status are outlined at the St Catherine's local management team meeting. Minutes of local management team meeting reflect discussion. Achievable and realistic</td>
<td>31/12/2019</td>
<td>Clinical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000464</th>
<th>Not all residents' general health needs had been assessed at least every six months, 19 (1)(b).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>St Catherine's to adopt the orange General Health assessment document that has been adopted at other Mental Health Service centres in Cork Kerry Community Healthcare. Dates of health checks will be recorded in a log and the log will be discussed at the Multidisciplinary Team Meeting. Achievable and realistic - This log has been implemented on the ward and is now in use</td>
</tr>
</tbody>
</table>
filed in the Physical Health Folder which is kept in the nursing office. The log will be discussed at MDT meetings and pre planning for same will identify when a physical health including dental appointments are due.

Preventative Action

Each service user has a 6 monthly General Health Assessment recorded on the orange General Health assessment form. During the Multidisciplinary discussion and pre planning for same will identify when a physical health check needs arises and Dental is included in this in addition to all other physicals. The ward diary will also reflect the next due date for dental appointments as with all other physicals.

The log will be discussed at the MDT and the ward diary will also reflect upcoming due dates for physicals and dental appointments

Achievable and realistic - the log has been implemented on the ward and is now in use. The log has been attached

01/11/2019

Clinical Director and Assistant Director of Nursing
<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service users to be encouraged to access annual dental health assessments. Dental health to put on the agenda for the St Catherine’s local management team meeting. Dates of health checks will be recorded in a log and filed in the Physical Health Folder which is kept in the nursing office. The log will be discussed at MDT meetings and pre planning for same will identify when a physical health including dental appointments are due.</td>
<td>The log will be discussed at MDT meetings.</td>
<td>Achievable and realistic - This log has been implemented on the ward and is now in use</td>
<td>31/12/2019</td>
<td>Clinical Director and Assistant Director of Nursing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff to discuss dental health and dental health education with service users. During the Multidisciplinary discussion and pre planning for same will identify when a physical health check needs arises and</td>
<td>Log and Ward Diary</td>
<td>achievable and realistic</td>
<td>01/11/2019</td>
<td>ADON and Clinical Director</td>
</tr>
</tbody>
</table>
Dental is included in this in addition to all other physicals. The ward diary will also reflect the next due date for dental appointments as with all other physicals. Service users will be offered appointments when due. If the offer of appointment is declined it will be noted on the log and discussed at MDT. The service user will continue to be offered appointments and encouraged and supported to attend same.
**Regulation 21: Privacy**

**Reason ID : 10000481**

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews for HCA staff members to facilitate the team's ability to support residents to access their bedrooms have been completed</td>
<td>Introducing HCA staff to the centre to support the team in coordinating access for residents to their rooms</td>
<td>Achievable and realistic</td>
<td>03/02/2020</td>
<td>ADON</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventative Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of HCA staff to support the team</td>
<td>Support from the HCA</td>
<td>Achievable</td>
<td>03/02/2020</td>
<td>ADON</td>
<td></td>
</tr>
</tbody>
</table>

The bedroom area was locked from early morning until 10 pm approximately and, therefore, the resident's privacy and dignity was not appropriately respected at all times.
### Regulation 22: Premises

<table>
<thead>
<tr>
<th>Reason ID : 10000468</th>
<th>Not all bedrooms were kept in good decorative condition, 22 (1)(a).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td>Minor Capital works underway to enhance the aesthetic of the bedrooms and make them a more modernised space. The works scheduled for 2019 are the ceiling reductions in bedrooms 2 and 3 including necessary anti-ligature works. Works to the small sitting room downstairs have been completed as indicated at Inspection. Minor decorating works to maintain the environment planned to be completed with contractors on site</td>
<td>Completion of works will be visible at St Catherine’s Unit</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Routine maintenance plan to be formalised</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000469</th>
<th>The physical structure had not been maintained with due regard to the safety and well-being of residents as ligature points had not been minimised, 22(3).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td><strong>Measurable</strong></td>
</tr>
</tbody>
</table>

AC044 St. Catherine’s Ward, St. Finbarr’s Hospital

Approved Centre Inspection Report 2019

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| Corrective Action | Ligature audit is currently underway. A maintenance and corrective plan is being developed. | Ligature audit completed. Timeframe Dec 2019. Maintenance plan approved and timeline for completion of works provided to St Catherine’s Local Management Team. Timeframe March 2020. | Achievable and realistic | 28/03/2020 | Area Admin and ADON |
| Preventative Action | Following completion of works anti-ligature follow up audit date to be set to assess the standard of completion of any anti-ligature works. | Audit and follow up to assess the standard of completion. | Achievable and realistic | 01/06/2020 | MDT |
### Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

<table>
<thead>
<tr>
<th>Reason ID: 10000470</th>
<th>Two MPARs evidenced gaps in the record of medications administered to the resident, 23 (1). One MPAR did not identify the allergy status of the resident, 23 (1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Clinical Director to issue email to medical staff to qualify the requirement of keeping with the Standards of MPARs including identifying the allergy status of residents as required of the file format. All Medical staff are issued an email by the Clinical Director. Medical Staff were informed that meds will not be administered if Allergy section not complete and also that an Incident form will be completed in this circumstance. Achievable and realistic 30/11/2019 Clinical Director</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>File audit results to be reviewed by the St Catherine’s Local Management Team. File audit results to be reviewed. Quarterly from January 2020. Achievable and realistic 31/01/2020 Clinical Director</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID: 10000472</th>
<th>All medications were not stored in a locked press in the locked pharmacy room, 23(1).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Assistant DON to circulate a directive to all staff regarding correct storage of medication processes. Swipe access placed on door to the pharmacy room to monitor access of the room. All staff receive email. ADON confirms that all medication is in a locked press. Achievable and realistic 30/11/2019 Assistant DON and CNM3</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Monthly medication audits completed.</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------</td>
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</tbody>
</table>

### Regulation 26: Staffing

**Reason ID:** 10000473

The numbers of staff and skill mix was not appropriate to the assessed needs of residents, most specifically the lack of a dietitian, 26(2).

<table>
<thead>
<tr>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An emergency Speech and Language Therapy dysphagia service is available to St Catherine’s. The first part of the Nutrition and Hydration Policy has been implemented on site and all modified diets have been mapped over to the IDDSI descriptors in the last few weeks this was overseen by a speech and language therapist and dietician on site. Catering continues to liaise with each ward on menu choices for the residents and this is working well throughout the site, we will continue with this approach. A Nutrition and Hydration steering committee is being set up at the moment.</td>
<td>SLT service is accessed in emergency situations. Diets are mapped to the IDDSI descriptors. Menu choices are reflective of the preferences of the residents of St Catherine’s.</td>
<td>achievable</td>
<td>31/01/2020</td>
<td>MDT to track the roll out of the initiatives</td>
</tr>
</tbody>
</table>
for the implementation of the HSE Nutrition and Hydration policy on site and there will be a dietician and speech and language therapist on that committee.

| Preventative Action       | An emergency Speech and Language Therapy dysphagia service is available to St Catherine's. The first part of the Nutrition and Hydration Policy has been implemented on site and all modified diets have been mapped over to the IDDSI descriptors in the last few weeks this was overseen by a speech and language therapist and dietician on site. Catering continues to liaise with each ward on menu choices for the residents and this is working well throughout the site, we will continue with this approach. A | Staff Nurse representation on the Nutrition and Hydration steering committee Catering will liaise with the ward in regard to menu choices An emergency Speech and Language Therapy dysphagia service is available to St Catherine's. | achievable | 31/01/2020 | MDT |
Nutrition and Hydration steering committee is being set up at the moment for the implementation of the HSE Nutrition and Hydration policy on site and there will be a dietician and speech and language therapist on that committee. A staff nurse on the unit has been nominated to represent the Unit on the steering group.

<table>
<thead>
<tr>
<th>Reason ID : 10000476</th>
<th>The numbers of staff was not appropriate to the assessed needs of residents and to facilitate the bedroom area being accessible to the residents as appropriate, 26(2).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Specific</strong></td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td>Recruitment campaign and interviews for HCA to enhance the team and facilitate the accessibility of the bedroom area complete.</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>2.5 additional WTE joining the MDT at St Catherine's</td>
</tr>
</tbody>
</table>

**Regulation 27: Maintenance of Records**

<table>
<thead>
<tr>
<th>Reason ID : 10000482</th>
<th>The registered proprietor did not ensure that clinical files were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, 27(1). The</th>
</tr>
</thead>
</table>
Clinical files were not all maintained in good order as there were loose pages in a number of files reviewed, 27(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT to write to staff outlining their responsibility in regards to record keeping. Timeframe</td>
<td>MDT to write to staff outlining their responsibility in regards to record keeping. Timeframe</td>
<td>All staff will be issued an email clearly outlining requirements</td>
<td>Achievable realistic</td>
<td>01/04/2020</td>
<td>MDT</td>
</tr>
<tr>
<td>Preventative Action</td>
<td>Quarterly file audit findings to be brought to the attention of the St Catherine’s Local Management team meetings</td>
<td>St Catherine’s Local Management Team meeting minutes reflect same and corrective actions are outlined in the minutes also</td>
<td>Achievable and realistic</td>
<td>31/03/2020</td>
<td>Assistant DON</td>
</tr>
</tbody>
</table>

Reason ID : 10000484

The approved centre’s policy did not include a process for the destruction of records, 27(2).
| Corrective Action | ADON to bring proposed enhancement to policy to include destruction of client records to the St Catherine’s Local Management team for discussion and sign off. | Policy to be updated and the contents of same are circulated to staff | achievable | 29/02/2020 | Assistant DON |
| Preventative Action | review and update policy | Policy will be updated | achievable and realistic | 28/02/2020 | Assistant DON |
### Regulation 32: Risk Management Procedures

**Reason ID: 10000467**

The risk register for the approved centre had not been reviewed for over six months and, therefore, the risk management policy had not been fully implemented throughout the approved centre, 32(1).

<table>
<thead>
<tr>
<th>Corrective Action</th>
<th>Specific</th>
<th>Measurable</th>
<th>Achievable/Realistic</th>
<th>Time-bound</th>
<th>Post-Holder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action</td>
<td>A charter for how risk is reviewed at the approved centre to be formalised. Quality and Patient Safety Advisor to support this process. Local Management Team to have Risk as a standing item on the agenda, with allocated time bi-monthly to review the register, or more frequently as required.</td>
<td>Charter completed and circulated to Local management team</td>
<td>Achievable and realistic</td>
<td>02/03/2020</td>
<td>Clinical Director and ADON</td>
</tr>
</tbody>
</table>

| Preventative Action                    | Charter up and running, staff familiar with process, local management team actively monitoring of same via having risk as a standing agenda item | Local management team to monitor same | Achievable and realistic | 02/03/2020   | Clinical Director and ADON |
### Regulation 34: Certificate of Registration

<table>
<thead>
<tr>
<th>Reason ID : 10000460</th>
<th>The certificate of registration was not up-to-date.</th>
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<tbody>
<tr>
<td></td>
<td>Specific</td>
</tr>
<tr>
<td><strong>Corrective Action</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The current Certificate of Registration is displayed on the Unit</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ADON to oversee the posting of the most current certificate on the Unit is always on display</td>
</tr>
</tbody>
</table>
## Code of Practice on Admission, Transfer and Discharge to and from an approved centre

<table>
<thead>
<tr>
<th>Reason ID : 10000461</th>
<th>The discharge policy did not include procedures for discharge of involuntary patients, 4.2.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>The current policy to be enhanced to outline the procedures for discharge of involuntary patients.</td>
</tr>
<tr>
<td></td>
<td>Policy is updated to include discharge for involuntary patients procedures. Achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td>28/03/2020</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>Policy will be updated and staff to familiarise themselves with same.</td>
</tr>
<tr>
<td></td>
<td>Policy will be updated. Achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td>28/03/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason ID : 10000462</th>
<th>The discharge plan did not include a follow-up plan or reference to early warning signs of relapse and risk, 34.2.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corrective Action</strong></td>
<td>A discharge plan that is in place at AMHU will be introduced at St Catherine's.</td>
</tr>
<tr>
<td></td>
<td>The plan will include risk assessment, relapse warning signs, a follow up plan and a patient notification form. The plan will be circulated at the November St Catherine's Local Management Team meeting.</td>
</tr>
<tr>
<td></td>
<td>30/11/2019</td>
</tr>
<tr>
<td><strong>Preventative Action</strong></td>
<td>As residents are discharged moving forwards the new form will be the standard discharge document required for completion.</td>
</tr>
<tr>
<td></td>
<td>All discharged residents from December 19 onwards will have a completed discharge plan. Achievable and realistic.</td>
</tr>
<tr>
<td></td>
<td>28/12/2019</td>
</tr>
</tbody>
</table>
Appendix 2: Background 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.