ST CATHERINE'S WARD, ST FINBARR'S HOSPITAL

mhc
coimisiún meabhair - shláinte
mental health commission

Annual Inspection
Report 2021

Promoting Quality Safety and Human Rights in Mental Health

ST CATHERINE'S WARD, ST FINBARR'S HOSPITAL

St. Catherine's Ward, St. Finbarr's Hospital
Douglas Road, Cork

Date of Publication:
Wednesday 25 August 2021

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2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care / Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
Yes

Most Recent Registration Date:
17 May 2019

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Hugh Scully, Acting General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
Fergal Duffy, Lead Inspector
Noeleen Byrne
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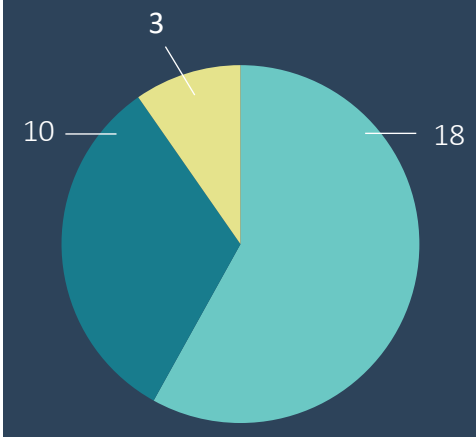
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
13 – 16 April 2021

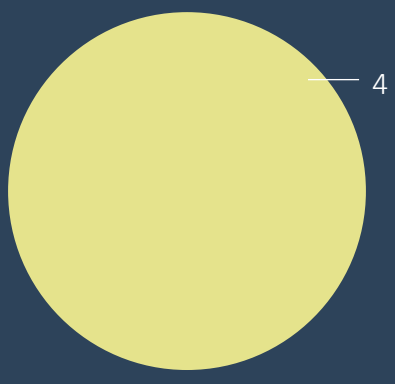
Previous Inspection date:
18 – 21 February 2020

Inspection Type:
Announced Annual Inspection

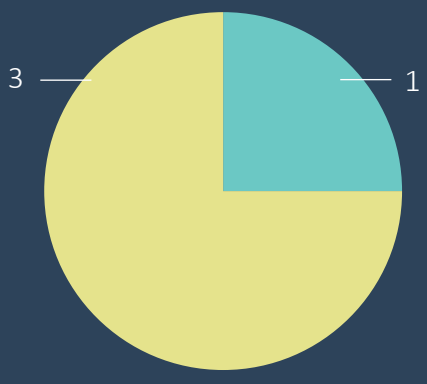
2021 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



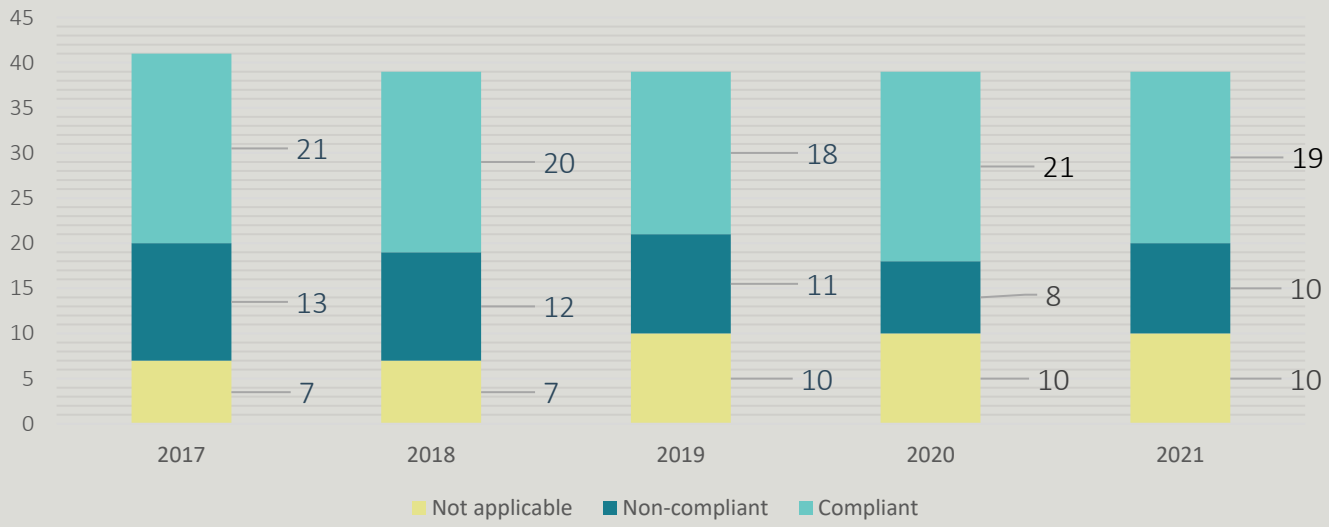
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2017 – 2021

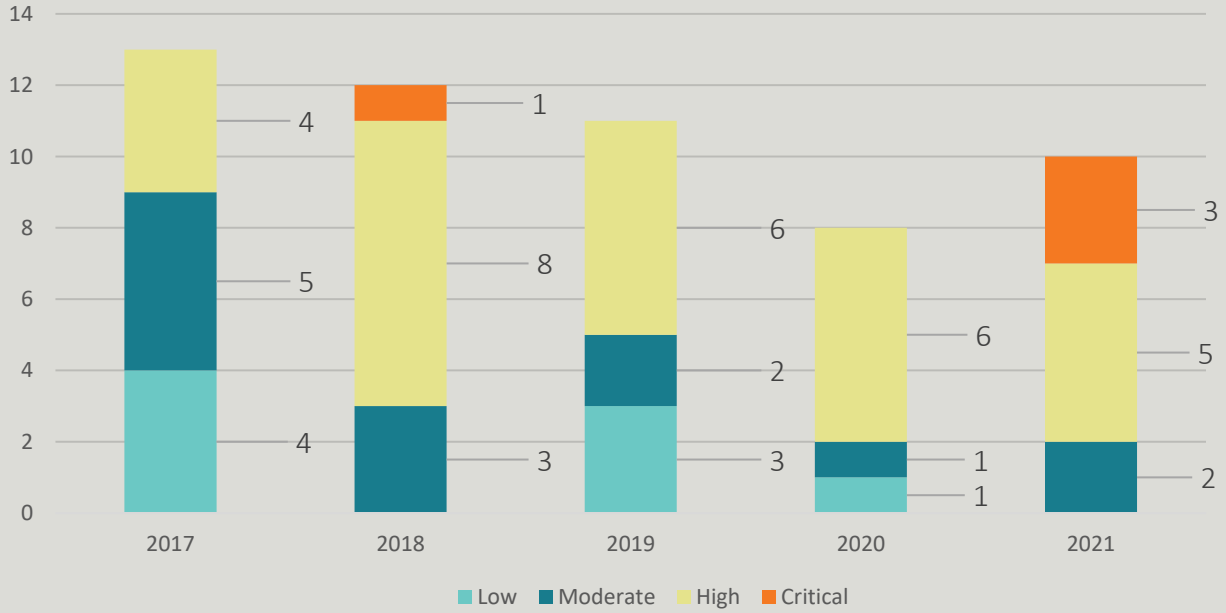
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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 – 2021



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with Regulations, Rules and Codes of Practice.

In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

St. Catherine's Ward was located on the grounds of St. Finbarr's Hospital, Cork City, and had 21 beds. It provided continuing care and psychiatry of later life services. Six General Adult teams and both Psychiatry of Later Life clinical teams from the South Lee area had admitting rights to St Catherine's Ward. Once admitted, responsibility for the residents' care was undertaken by a dedicated consultant psychiatrist. The needs of the residents included continuing care and rehabilitation; however, the approved centre did not deliver the rehabilitation care required.

St. Catherine's Ward consisted of two floors. The upper floor was comprised of rooms for day activities, a dining room, and a sitting room. The ground floor comprised of all the bedrooms, a night sitting room, and an activity therapy kitchen. A phased building refurbishment programme of the ground floor was ongoing.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	62%	63%	62%	72%	66%
Regulations Rated Excellent	1	0	2	3	N/A

The average rate of compliance across all approved centres in 2020 was 87%.

Conditions to registration

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

Conditions	Findings
Condition 1: *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.*	All staff were trained in the Mental Health Act 2001. Other areas of mandatory training were not assessed as it was not possible for approved centre staff to undergo training during COVID-19 restrictions
The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 26 at the time of inspection.	
Condition 2: *To ensure adherence to Regulation 26: Staffing, the approved centre shall ensure that residents of the approved centre have access 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.*	Residents had access to a speech and language therapist. Although referral had been made to a dietitian, no assessments had taken place.
The approved centre was in breach of Condition 2 and the approved centre was non-compliant with Regulation 26 at the time of inspection.	

Escalation and enforcement actions since last inspection

Enforcement Actions	Date applied	Provisions	Outcome
Regulatory compliance meeting	*26/03/2021*	*To provide plans to address areas of non-compliance found during the 2020 inspection*	*Plans were received at the regulatory compliance meeting. Further information has been requested*

Safety in the approved centre

We found that the approved centre did not operate safe practices in a number of areas, which increased the risk of harm to service users.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces were minimised in the approved centre.

- Medication was ordered, prescribed, and stored in a secure and safe manner.

However:

- Some residents were assessed as requiring a high level of support for the majority of their activities of daily living. The nursing resources were insufficient to provide safe care to the resident cohort.
- There was no indication that evidence-based nursing needs assessments had been conducted, despite increasing needs of an ageing resident cohort.
- Proper facilities for the storage of food was not maintained to support food safety requirements.
- Falls risks were not adequately identified, assessed, or monitored.
- Ligature anchor points were not minimised.
- Two medication prescription and administration records did not document that the resident had received medication, thus increasing the risk of a medication error.

Appropriate care and treatment of residents

We found that the approved centre did not provide adequate therapeutic activities and programmes or physical health monitoring appropriate to needs of residents.

- A speech and language therapist had been sourced privately to conduct assessments of residents in St. Catherine's Ward.

However:

- The six-monthly health assessment was not adequate as an assessment of residents' physical health.
- There was insufficient access to occupational therapy staff. Occupational therapy assessments of residents had been conducted, but the assessments stated that interventions would not be provided until such time as an occupational therapy post was sanctioned for St. Catherine's Ward.
- Residents' individual care plans were not of an adequate standard.
- The approved centre social worker position was not filled.
- There were no seating assessments in the clinical files of those using a wheelchair or found to be seated on a pressure-relieving cushion. A number of residents were observed using inappropriate chairs.
- Eleven referrals were made to the dietitian; however, assessments had not been completed by the time of inspection.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre did not provide accommodation in a way that met the needs of residents.

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However:

- Personal spaces did not always uphold the dignity and privacy of residents, and there was inadequate communal space downstairs. Residents did not have access to their bedrooms until after night time medications were dispensed. Some residents were resting or sleeping in unsuitable chairs during the day because they could not access their bedrooms.
- There were two single bedrooms, neither of which were en suite. There was a separate room identified as an isolation bedroom for suspected or confirmed COVID-19 cases, which had a toilet in an adjacent room but no shower. The other bedrooms were shared spaces, with six two-bed rooms and one four-bed rooms, none of which were en suite.
- One bedroom did not have curtains fitted.
- Three bedrooms were not in a state of good repair.
- Residents did not have sufficient space to sit downstairs.
- Residents expressed dissatisfaction at having to go to bed when it was bright outside during the summer months. Residents also said they would prefer their own bedroom. Residents who had to share bedrooms said they would like to choose who they shared with. A lack of access to TV after 9.15pm was highlighted, with some expressing a wish for a TV in their bedroom.

Responsiveness to residents' needs

We found that residents received information and could avail of a complaints procedure.

- While some recreational activities in the community were on hold due to COVID-19 restrictions, residents had access to gardening, cooking, walking, bingo, and social outings. Recreational activities were provided on weekdays and weekends.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.

Governance of the approved centre

We found that governance structures were in place, but that risks were not always adequately identified, assessed, or managed.

- The approved centre was part of the HSE's Community Healthcare Organisation 4 (CHO 4) and was governed under the Cork/Kerry Mental Health Services. A monthly Local Management Team provided clinical and management oversight for St. Catherine's Ward, addressing issues such as clinical audit, regulatory compliance, staff training, health and safety, and local risk management.
- There was an overarching Cork and Kerry Policy Standardisation and Review Group (PSRG) to standardise applicable policies across the services. There was evidence of input from clinical and managerial staff from St. Catherine's Ward. A number of policies were in the process of being updated.
- There was an ongoing audit pertaining mainly to criteria set out in the Mental Health Commission - Judgement Support Framework. The learning from the audits was disseminated, discussed, and analysed at the local management meeting.
- Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify and trends or patterns occurring in the service.
- Training records for all staff providing services to St. Catherine's indicated all staff had completed mandatory training in the Mental Health Act 2001. Support for continuing education and professional development programmes was available to staff of St. Catherine's Ward.
- Regular community meetings, in which residents were provided an opportunity to raise issues of concern with staff, were documented.

However:

- Clinical and health and safety risks were not always adequately identified, assessed, or managed, including falls risk factors. Additionally, regular psychiatric and medication reviews were not evident and ligature risks were not effectively minimised.
- The insufficient number and skill mix of staff was not included on the updated Risk Register.

COVID-19 response

- A plan had been implemented to prevent and/or contain a COVID-19 outbreak in St. Catherine's Ward, informed by the Health Protection and Surveillance Centre (HPSC) guidelines for residential care facilities.
- Professional and personal visits had been curtailed, as were social outings for residents. Appropriate signage had been erected and hygiene measures were implemented.
- At the time of inspection, staff and residents of the approved centre had been vaccinated and control measures were eased in line with HPSC guidance.

- Online events entitled “using technology to make social connections” were organised during World Mental Health Week (October 12 to 17th 2020). Online activities such as yoga, movies, bingo, and a live concert were accessible to residents of St. Catherine’s Ward. As part of development of this initiative residents of St. Catherine’s were taught to use technology to develop and maintain social connections.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Appointment of Registered Nurse Tutor (Mental Health) for Cork/Kerry region, to improve rollout of mandatory training and provide specialist post-registration mental health training for nurses.

2. A study project entitled “An examination of Community Residence amalgamation on residents-Moving House during COVID” had been undertaken by the service and involved team members from St. Catherine’s Ward.

3. Online events entitled “using technology to make social connections” were organised during World Mental Health Week (October 12 to 17th 2020). Online activities such as yoga, movies, bingo, and a live concert were accessible to residents of St. Catherine’s Ward. As part of the development of this initiative residents of St. Catherine’s were taught to use technology to develop and maintain social connections.

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. St. Catherine's Ward consisted of an upper floor: comprised of rooms for day activities, a dining room and a sitting room; and a ground floor comprised of all the bedrooms, a night sitting room and an activity therapy kitchen. A phased building refurbishment programme, paused due to COVID-19 related restrictions, was ongoing on the ground floor. There were two single bedrooms, neither of which were en suite. There was a separate room identified as an isolation bedroom for suspected or confirmed COVID-19 cases, which had a toilet in an adjacent room but no shower. The other bedrooms were shared spaces, with six two bed bedrooms and one four bed bedroom, none of which were en suite.

All six General Adult teams and both Psychiatry of Later Life clinical teams from South Lee had admitting rights to St Catherine's. However, once admitted to St Catherine's Ward, responsibility for the residents' care was undertaken by a dedicated consultant psychiatrist. The needs of the residents included continuing care and rehabilitation, however the approved centre did not deliver the rehabilitation care required.

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

Resident Profile	
Number of registered beds	**21**
Total number of residents	**17**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	17
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of the HSE's Community Healthcare Organisation 4 (CHO 4) and was governed under the Cork/Kerry Mental Health Services. A monthly Local Management Team Meeting provided clinical and management oversight for St. Catherine's Ward, addressing issues such as clinical audit, regulatory compliance, staff training, health and safety and local risk management. The Cork Mental Health Area Management Team (AMT) provided executive governance for St. Catherine's Ward and encompassed strategic service planning and the quality and patient safety forum. There was an organisational chart to identify the leadership and management structure and lines of authority and accountability in the approved centre. There was service user representation at the AMT 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 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 Mental Health Commission - Judgement Support Framework. The learning from the audits was disseminated, discussed and analysed at the local management meeting.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre. The approved centre had access to the service's Risk & Patient Safety Advisor. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify and trends or patterns occurring in the service. Clinical and health and safety risks were not always adequately identified, assessed or managed. An evening inspection was conducted as part of the annual inspection based on issues arising during the inspection. Falls risk factors were not adequately analysed or managed. Regular psychiatric and medication reviews were not evident, in line with increasing needs of an ageing resident cohort. Ligature points were not effectively minimised. Furnishings were not specific to residents based on an assessment of need. Personal spaces did not always uphold the dignity and privacy of residents and there was inadequate communal space downstairs. Residents did not have access to their bedrooms until after night time medications were dispensed. Some residents were resting or sleeping in unsuitable chairs during the day because they could not access their bedrooms. There was excellent provision of general practitioner services. A speech and language therapist had been sourced privately to conduct assessments of residents in St. Catherine's Ward.

To inform the inspection process regarding clinical governance issues, heads of discipline forwarded questionnaires outlining processes for discipline specific governance, issues of risk or specific concern for that discipline. Completed governance questionnaires were received from psychology, social work, occupational therapy and medical disciplines. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. There was effective formal and informal clinical supervision arrangements for clinical staff. In addition to the various governance forums outlined, other systems were in place to support quality improvement.

At the time of inspection, the numbers and skill mix of staff was insufficient to meet residents' needs. There was insufficient nursing staff to provide safe care for residents. There was no indication evidence based nursing needs assessments had been conducted, despite increasing needs of an ageing resident cohort. There was no evidence of the shortage of nursing staff on the updated Risk Register. There was insufficient access to occupational therapy staff. Occupational therapy assessments of residents had been conducted but the assessments stated that interventions would not be provided until such time as an occupational therapy post was sanctioned for St. Catherine's. A rationale for an Occupational Therapist post for St. Catherine's Ward was prepared by the clinical director and occupational therapy manager and sent forward for approval in March 2021. Referrals to a dietitian had been made, but no assessments had been conducted. There was limited social work input into St. Catherine's Ward. Service managers had arrangements in place to provide cross cover on a needs basis. There was a plan in place to recruit a rehabilitation and recovery consultant and the residents of St. Catherine's Ward will come under the remit of that consultant. The CHO Risk Register included risks to service provision due to lack of access to a full therapeutic milieu due to staffing shortages.

Training records for all staff providing services to St. Catherine's indicated all staff had completed mandatory training in the Mental Health Act 2001. Support for continuing education and professional development programmes was available to staff of St. Catherine's Ward.

Residents were involved in the development and review of their individual care plans. Regular community meetings were documented which outlined a process where residents were provided with an opportunity to bring issues of concern to the attention of staff.

A plan had been implemented to prevent and/or contain a COVID-19 outbreak in St. Catherine's Ward, informed by the Health Protection and Surveillance Centre (HPSC) guidelines for residential care facilities. Professional and personal visits had been curtailed, as were social outings for residents, appropriate signage erected and hygiene measures had been implemented. At the time of inspection staff and residents of the approved centre had been vaccinated and control measures relaxed in line with HPSC guidance.

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 (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2017 and 2021 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 06: Food Safety	✓		✓		✓		✗	Moderate	✗	Moderate
Regulation 15: Individual Care Plan	✗	Moderate	✗	High	✗	High	✓		✗	High
Regulation 16: Therapeutic Services	✓		✗	High	✓		✓		✗	Critical
Regulation 19: General Health	✗	High	✗	High	✗	High	✓		✗	High
Regulation 21: Privacy	✗	Moderate	✓		✗	High	✗	High	✗	Critical
Regulation 22: Premises	✗	Moderate	✗	High	✗	Moderate	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✗	Low	✗	High	✗	High
Regulation 26: Staffing	✗	High	✗	Moderate	✗	Moderate	✗	High	✗	Critical
Regulation 27: Maintenance of Records	✗	High	✗	High	✗	High	✓		✗	Moderate
Regulation 32: Risk Management Procedures	✗	Moderate	✗	Critical	✗	High	✓		✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

Part 4 of the Mental Health Act 2001: Consent to Treatment	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.
Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team for face to face, socially distanced interviews during the inspection.
- 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 feedback from residents was complimentary of the staff in the approved centre. Residents said they were "well looked after" and "the nurses take great care of me". Residents were also complimentary of the food and some reported improvements in recreational activities available to them.

Some issues were also highlighted, most importantly was lack of access to bedrooms during the day. Residents also expressed dissatisfaction at being obligated to go to bed when it was bright outside during the summer months. Another issue was shared accommodation, residents said they would prefer their own bedroom. Residents who have to share bedrooms, said they would like to choose who they share with. A lack of access to TV after 9.15pm was highlighted, with some expressing a wish for a TV in their bedroom.

5.2 Advocacy

The approved centre did have an advocacy service.

The inspectors did receive a report from the IAN representative and a telephone interview was conducted.

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:

- Interim Head of Service
- Registered Proprietor
- Executive Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Occupational Therapy Manager
- Principle Clinical Psychologist
- Clinical Nurse Manager II
- Clinical Nurse Manager II

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. Management gave a commitment that additional staff would be rostered and that the bedroom area would be open to residents at all times. The outcomes of referrals made by dietitian would be followed up on in a timely manner.

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

COMPLIANT

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

There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(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

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 and a source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

NON-COMPLIANT

Risk Rating **MODERATE**

(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 CommWardies Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

There was suitable and sufficient catering equipment in the approved centre. Proper facilities for the storage of food was not maintained to support food safety requirements, as personal protective equipment, hand sanitiser and incontinence wear were stored with dry food products in a storage room. Hygiene was maintained to support food safety requirements and residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that proper facilities for the storage of food was maintained to support food safety requirements, 6(4).

Regulation 7: Clothing

COMPLIANT

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

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of night clothes during daytime hours unless otherwise specified in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

(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

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in October 2019. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP or in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile. While some activities in the community were on hold due to COVID-19 restrictions, residents had access to gardening, cooking, walking, bingo, and social outings. Recreational activities were provided on weekdays and weekends.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

(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

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in October 2019. All visits were pre-planned and residents could receive two visits per week. Visiting times were appropriate and reasonable. A separate visitors' room provided residents with a private space to meet visitors, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting room was suitable for children. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

(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

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in October 2019. Residents had access to mail, the internet, and their own phones unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

(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

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in October 2019 and included all requirements related to:

- 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.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

No searches had been conducted in the approved centre since the previous inspection and compliance for this regulation was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

(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

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in October 2019. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care and resources required. However, the ICP template did not include allocated space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

Three ICPs did not identify appropriate goals for the resident. One ICP did not appropriately identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Two ICPs did not identify the resources required to provide the care and treatment identified. The ICP was reviewed by the multi-disciplinary team six-monthly, in consultation with the resident. Two ICPs were not suitably updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals: the two ICPs indicated changed needs between the six-monthly reviews, though these were not updated in the ICPs.

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

a) **Three individual care plans (ICP) did not contain all appropriate goals.**
b) **One individual care plan did not specify the treatment and care required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment in accordance with best practice.**
c) **Two individual care plans did not identify all necessary resources.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating CRITICAL

(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

The therapeutic services and programmes provided by the approved centre were not appropriate and did not meet the assessed needs of the residents, as documented in their individual care plans. At the time of inspection, the approved centre social worker position was not filled. There was a social worker covering some specific needs for two residents and any further social work needs were referred to the social work manager for screening. There was no Occupational Therapist (OT) in the approved centre. An OT from the community covered for one day a week and worked on referrals only. An Activity of Daily Living (ADL) assessment for all residents took place in April 2021 and highlighted several recommendations and needs of the service users on the back of a Corrective and Preventative Action Plan. The OT assessment stated that these interventions could not be provided until a full time post was in place. At the time of inspection, residents were not in receipt of appropriate OT interventions. There were no seating assessments in the clinical files of those using a wheelchair or found to be seated on a pressure-relieving cushion. A number of residents were observed using inappropriate chairs.

The therapeutic services and programmes provided by the approved centre were not suitably directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Psychology services were available to St Catherine's Ward for a half day per week. The approved centre's stress group was run with co-facilitation of a psychology trainee from October 2020 to April 2021. Prior to these months the psychologist completed one-to-one work with appropriate individuals. There were two therapy nurses that ran open groups, such as gardening, cooking, relaxation and deep breathing, an exercise group, and a health and wellness group co-facilitated with social work. The psychology and nurse therapy group ran on a 12-week programme and were evaluated regularly by the service users.

The approved centre was non-compliant with this regulation because it did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, as:

a) **Following an occupational therapy assessment for all residents, there was no programme or service provided towards restoration or maintenance of physical and psychosocial functioning in conjunction with the identified needs, 16(2).**
b) **Individuals were observed using inappropriate chairs or wheelchairs for long hours and did not have appropriate assessments in place, 16(2).**

Regulation 18: Transfer of Residents

COMPLIANT

(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

The approved centre had an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in July 2018. Full and complete written information regarding the resident was transferred when they moved from approved centre to another facility. This information was sent in advance to a named individual. The information sent included a letter of referral, containing a list of current medications, and a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(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

The approved centre had a general health policy and procedures, which included emergency procedures. The policy was last reviewed in October 2019. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED), both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided. Residents did not receive appropriate general health care interventions in line with individual care plans. At the time of inspection, dietitian assessments had not been completed for eleven residents referred for dietetic services. General health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Three clinical files were examined during the inspection process in relation to provision of general health services. The six-monthly health assessment documented a physical examination, blood pressure, smoking status, dental health and a medication review. However, one general health assessment did not document the residents family or personal history, while two assessments did not document the residents' body-mass index, weight, or waist circumference. Two general health assessments did not include a nutritional status.

For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram. However, one annual assessment did not document the resident's prolactin levels.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing e.g. lab results. Residents could access national screening programmes according to age and gender, including bowel screening and retina check. A medication review was documented.

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

a) **The registered proprietor did not ensure that adequate arrangements were in place for access by residents to general health services and for their referral to other health services as required. Eleven referrals were made to the dietitian; however, assessments had not been completed by the time of inspection. 19(1) a.**
b) **The six-monthly general health assessments were not adequately completed. In one case the residents' personal/familial history was not completed, and two residents' examination did not document nutritional status, diet, and physical activity. Two residents' waist circumference were not measured and documented, 19(1)(b).**
c) **For a resident on antipsychotic medication, their prolactin level was not tested and completed, 19(1)(b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

(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

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in October 2019. The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information is 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 residents' rights.

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating CRITICAL

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

INSPECTION FINDINGS

Residents were called by their preferred name and the general demeanour of staff and the way in which they dressed and communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs and sought the resident's permission before entering their room, as appropriate.

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy. Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

All residents were required to be awake and dressed at 09.00 every morning and go upstairs for breakfast. The bedroom area was then locked for the day and residents were not permitted to freely access their rooms or to lie down. Were a resident needed an item from their room, they had to seek permission from staff, who then accompanied the resident to unlock the bedroom door and allow resident access to their room. The lack of access to bedrooms during the day resulted in residents sleeping in chairs when tired.

Medication was provided to residents at 21.30 and all residents had no option apart from to go to the bedroom area. All non-bedroom areas were then locked for the night, preventing access to them by residents, who were unable to decide their own bedtimes. This has been a recurring issue witnessed by inspectors over a number of previous inspections and was caused by ongoing staffing capacity issues in the approved centre. On the first day of the inspection the inspection team returned at 20.45 and observed a television room occupied by seven residents, two of whom were asleep, with one slumped over in a chair. Two other residents were observed to be asleep in chairs in another room of the approved centre. The lack of resident access to their bedrooms infringed on their right to privacy and dignity.

The approved centre was non-compliant with this regulation because the bedroom area was locked from early morning until approximately 21.30 and the day area was locked from 21.30 until morning; a restrictive practice that was not conducive to resident privacy and dignity.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(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 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

There were three communal rooms for residents to sit in during the day and these rooms were appropriately sized and furnished. Residents did not have access to personal space at all times and in the evening some residents were sleeping in the chairs in the television room. The lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs. There was suitable and sufficient heating within the approved centre and it was well ventilated.

Sufficient spaces were not provided for residents to move about. It was observed that the television rooms would likely be cramped should all the residents want to watch television. After 21:30, the only television room available to residents was downstairs and there were only three chairs in the room. There was a garden at the back of the approved centre that was a sufficient size.

Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. However, ligature points had not been minimised to the lowest practicable level. Several ligature points were observed within bedrooms and bathrooms. Downstairs in the approved centre was not kept in a good state of repair internally. Bedrooms one, four, and seven were not in a good state of repair compared to others. Inspectors observed cracked plaster, a hole in a wall, and a missing locker handle. Two refurbished shower rooms had stains on the floors, likely caused by damp.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, for which records were maintained. This had improved on previous

inspection findings, particularly regarding general maintenance and cleaning. The approved centre was very clean, hygienic, and free from offensive odours.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address the resident needs. The approved centre provided assisted devices and equipment to address resident needs. The approved centre did not provide suitable furnishings to support resident independence and comfort, as bedroom ten, which was being used as an isolation bedroom at the time of inspection, did not have curtains fitted. Current national infection control guidelines were followed.

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

a) **The physical structure of the approved centre was not maintained with due regard to the safety and well-being of residents as ligature points had not been minimised, 22(3).**
b) **The approved centre did not have adequate furnishings suitable for residents' needs, as one bedroom did not have curtains fitted, 22(2).**
c) **Three bedrooms were not in a state of good repair, 21(1)(a).**
d) **Residents did not have sufficient space to sit downstairs, 22(3).**

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

NON-COMPLIANT

Risk Rating HIGH

(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.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

INSPECTION FINDINGS

The approved centre had multiple written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policies were last reviewed in October 2019 and included the process for storing resident medication.

However, the policies did not include:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for the administration of resident medication, including routes of medication.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; and a clear record of the date of discontinuation for each medication. However, not all MPARs contained a record of all medications administered to the resident, as two MPARs had no record that some medications were administered. The MPARs recorded the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition: this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

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

a) Two Medication, Prescription and Administration Records did not record all medications administered to the resident, 23(1).

b) The registered proprietor did not ensure that the approved centre had written operational policies on the process of ordering, prescribing and administration resident medication, 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

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in October 2019.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating CRITICAL

(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

The approved centre had a written operational policy and procedures in relation to staffing. The policy was last reviewed in October 2019 and included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staff were not sufficient to meet resident needs. Some residents were assessed as requiring a high level of support for the majority of their activities of daily living. The nursing resources were insufficient to provide safe care to the resident cohort. There was no occupational therapist on the multi-disciplinary team. An occupational therapist, who worked on a community team provided cover one day per week. This resource was insufficient to meet assessed needs. There was limited access to a social worker, on a case by case basis. Referrals were made to a dietitian, but no assessments had been conducted.

An appropriately qualified staff member was on duty and in charge at all times. This was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

The approved centre had one multi-disciplinary team. This included psychiatry, nursing and psychology staff.

Due to COVID-19 pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.

Staff Training Table		
Profession	Mental Health Act 2001	
Nursing	12	100%
Medical	2	100%
Occupational Therapist	1	100%
Social Worker	1	100%
Psychologist	1	100%

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

a) **The registered proprietor did not ensure that the numbers of staff and the skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre: There was insufficient nursing staff to provide safe care, 26(2).**
b) **The registered proprietor did not ensure that the numbers of staff and the skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre: There was insufficient occupational therapy input to address identified needs, 26 (2).**
c) **The registered proprietor did not ensure that the numbers of staff and the skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre: Referrals were made to a dietitian, but no assessments had been conducted, 26 (2).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating **MODERATE**

(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.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

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

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in October 2019. The policy included:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Record retention periods.
- The destruction of records.

Residents' records were secure and up-to-date. However, not all resident records were observed to be in good order, as loose pages were noted in clinical files. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was non-compliant with this regulation because it did not ensure that records were kept in good order as loose pages were noted in clinical files, 27(1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up-to-date. It 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

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures requiring a three-yearly review were reviewed appropriately.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(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

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in October 2019 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon thereafter. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented. No formal complaints had been made in the approved centre since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

(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

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in June 2018. The risk management policy addressed all requirements of the regulation with the exception of the following:

- The responsibilities of the registered proprietor.
- Capacity risks relating to the number of residents in the approved centre.

Responsibilities 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.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Clinical risks were not identified, assessed, treated, reported, monitored, and documented in the Risk Register as appropriate. The insufficient nursing staff numbers had not been identified as an operational risk. The shortage of nursing staff required to provide safe care was not on the Risk Register. The physical needs of residents had changed and the nursing staff required to meet those needs was not sufficient. Regarding the access to a social worker, no existing or additional risk controls were identified by the approved centre. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

Structural risks, including ligature points, were not removed or effectively mitigated. Ligature risks were not reduced to the lowest practicable level. The approved centre had reduced risks in some bedrooms that were renovated. However, other bedrooms contained significant ligature risks.

Individual risk assessments were completed in conjunction with medication requirements or administration and prior to and during resident transfer and discharge. Risk assessments were also completed during admission, to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Health and safety risks were identified, assessed, treated, reported, monitored and documented within the Risk Register as appropriate. Existing control measures did not adequately address falls risks in the approved centre.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

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

a) **The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre as health and safety risks were not identified, assessed and monitored: falls risks were not adequately identified, assessed or monitored, 32(1).**
b) **The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre as clinical risks were not effectively assessed or mitigated: there was no existing or additional control measures identified for access to a social worker, 32(1).**

Regulation 33: Insurance

COMPLIANT

The registered proprietor of an approved centre shall ensure that the Ward 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

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with two conditions to registration attached. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 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.

Admission, Transfer and Discharge

COMPLIANT

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 October 2019, 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 2020, included all of the policy-related criteria for this code of practice.

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.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the resident's family member was involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged was examined. The discharge plan included the estimated date of discharge, a follow-up plan, and documented communication with the relevant general practitioner, primary care team, or community mental health team (CMHT). The discharge meeting was attended by the resident, their key worker, relevant members of the multi-disciplinary team (MDT), and their family, carer, or advocate.

The discharge assessment addressed the resident's psychiatric and psychological needs, a current mental state examination, and a comprehensive risk assessment and risk management plan. The discharge was coordinated by a key worker.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 6: Food Safety					
Reason ID : 10001997		**The registered proprietor did not ensure that proper facilities for the storage of food was maintained to support food safety requirements, 6(4)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Nurse management have reviewed the space available adjacent to the Kitchen and Dinning area. An area has been identified within the Dining room which will not impact on the HACCP guidelines for the kitchen yet allow residents store additional personal food items. A patient designated storage unit has been requested from the maintenance department. Nurse management have logged the request for same.	Order Request has been logged through mainteance.	This is Achievable and Realistic	30/08/2021	Nurse Management.
Preventative Action	Nurse management have reviewed the space available adjacent to the Kitchen and Dinning area. An area has been identified within the Dining room which will not impact on the HACCP guidelines for the kitchen yet allow residents store additional personal food items. A patient designated storage unit has been requested from the maintenance department. Nurse management have logged the request for same. Maintenance department have reviewed and measured to have unit constructed for the Dinning area.	Order has been received and actioned.	The unit will fulfill the patients needs for food storage in an appropriate and safe manner	30/08/2021	Local Nurse Management and Maintenance

Regulation 15: Individual Care Plan					
Reason ID : 10001998		**Three individual care plans (ICP) did not contain all appropriate goals.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Patients ICP's reviewed with 5 specific patient files reviewed by MDT on a weekly basis.	Nursing team select 5 files weekly for discussion at MDT and ensure fair rotation of files reviewed.	Achievable & Realistic	30/04/2021	Unit MDT
Preventative Action	ICP's and correct completion of ICP's is an integral component of the care and resident care planning requirement. Accurate ICP's are important method of communicating the patients Goals and aspirations. THE MDT are committed to improving the detail contained within the ICP plan. MDT appointed an ICP lead within the team to ensure the ICP's are reflective of residents goals, needs and aspirations taking into account all aspects of their current presentation and needs.	ICP Audit results to be included in the South Lee Audit review meeting to monitor progress and encourage broader ICP understanding and learning across the MDT.	This is Achievable & realistic	30/04/2021	MDT supported by ICP lead
Reason ID : 10001999		**One individual care plan did not specify the treatment and care required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment in accordance with best practice. Two individual care plans did not identify all necessary resources.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Nursing staff have completed a Camberwell Assessment of Need (short version) on each resident. A redacted copy of this assessment has been provided to MHC. The results of these assessments of needs will be discussed and reviewed on an ongoing basis at	Assessments complete	Complete	30/04/2021	Unit ADON and MDT

	Multidisciplinary Team Meetings to inform the Residents Individual Care Plan.				
Preventative Action	ICP's and correct completion of ICP's is an integral compononet of the care and resident care planning requirement. Accurate ICP's are an important method of communicating the patients Goals and aspirations. THE MDT are committed to improving the detail contained within the ICP plan. MDT to appoint an ICP lead within the team to ensure the ICP's are reflective of residents goals, needs and aspirations and their current presentation.	Ongoing performance will be measured by Audit with the Audit results feeding into the South Lee Audit Group.	This is both Achievable and Realistic	30/04/2021	Unit MDT and local management team

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10002001		**The approved centre did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, as following an occupational therapy assessment for all residents, there was no programme or service provided towards restoration or maintenance of physical and psychosocial functioning in conjunction with the identified needs, 16(2). The approved centre did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, as individuals were observed using inappropriate chairs or wheelchairs for long hours and did not have appropriate assessments in place, 16(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	OT assessments of residents were carried out on the 24th and the 25th May 2021, followed by two days of chair trials and education in relation to patient seating system for nursing staff.	Seating Assessments Completed	The Assessments have been completed and appropiate chairs sourced. Some residents choose not to use the prescribed furniture. Support and engagement with these residents continues.	25/05/2021	OT Manager
Preventative Action	Additional OT resource requested to provide support to residents of St. Catherine's	Recruitment post Approval from office of the Chief Officer.	This action is Achievable & Realistic.	30/09/2021	OT Manager

Regulation 19: General Health	
Reason ID : 10002016	**The registered proprietor did not ensure that adequate arrangements were in place for access by residents to general health services and for their referral to other health services as required. Eleven referrals were made to the dietitian; however, assessments had not been completed by the time of inspection. 19(1) a. The six-monthly general health assessments were not adequately completed. In one case the residents' personal/familial history was not completed, and two residents' examination did not document nutritional status, diet, and physical activity. Two residents' waist circumference were not measured and documented, 19(1)(b). For a resident on antipsychotic medication, their prolactin level was not tested and completed, 19(1)(b).**
The approved centre did not provide acceptable CAPA plans for Regulation 19: General Health in time for the publication of this report.	

Regulation 21: Privacy					
Reason ID : 10002010		**The bedroom area was locked from early morning until approximately 21.30 and the day area was locked from 21.30 until morning; a restrictive practice that was not conducive to resident privacy and dignity.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Access to the bedroom area of the unit is now in place. Additional Nurse resource in place to support the open access on the ground floor.	Complete the ground Floor is now accessible to residents.	Complete the ground Floor is now accessible to residents.	30/04/2021	Nurse Management
Preventative Action	Access to the bedroom area of the unit is now in place. Additional Nurse resource in place to support the open access on the ground floor. A digi code allows residents access to the ground floor area as required.	Additional Nursing staff provided to facilitate access complete.	This is now in place.	30/04/2021	Nurse management and Local management.

Regulation 22: Premises					
Reason ID : 10002003		**The physical structure of the approved centre was not maintained with due regard to the safety and well-being of residents as ligature points had not been minimised, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A revised ligature Audit was undertaken by a cross functional group on March 22nd. The cross functional group consisted of the Clinical Director, Area Director of Nursing, Maintenance Officer, Assistant Director of Nursing, Area Administrator and unit Clinical Nurse Manager. The associated ligature audit was updated to reflect the detailed examination of the unit. The rooms were re-scored to account for the element that the bedroom area was planned as an open area accessible by clients at all times. Following the amendment and completion of the audit, the revised Audit has been provided to the maintenance department to commence the remedial works required.	Added as a recurring item to the local management team agenda.	This is both Achievable & realistic	30/09/2021	MDT, Local Management team, Estates Dept.
Preventative Action	Following building and anti works completion the Ligature Audit will be re-completed to ensure ligature risk on the unit is minimised to the lowest level and that the controls in place continue to be appropiate for the unit.	Added as a recurring item to the local management team agenda.	This is both Achievable & realistic	30/11/2021	MDT, Local Management team, Estates Dept.
Reason ID : 10002004		**The approved centre did not have adequate furnishings suitable for residents' needs, as one bedroom did not have curtains fitted, 22(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	MDT review of furniture for the unit, specialist seating assessments were	List of Furniture requirements to be	This is Achievable and Realistic	31/10/2021	Unit CNM2

	undertaken for patients with suitable furniture and training provided to the Nursing staff.	arranged by Nursing to suit the décor requirements and patients needs in the downstairs area.			
Preventative Action	An electronically controlled blind was sourced for the window identified and is now in place.	Action item for tracking at Local management team meetings	Partially complete and achievable to have ongoing unit reviews.	31/10/2021	Nurse Management
Reason ID : 10002005		**Three bedrooms were not in a state of good repair, 21(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The 3 bedrooms not in good repair are on a schedule for complete refurbishment. This refurbishment had initially been scheduled to be undertaken in 2020 however due to Covid and outbreaks on the Hospital campus these works were deferred. These works are now back on the works progam for for completion in September 2021.	Works are scheduled for September 2021	This is Achievable and Realistic	30/09/2021	Local Managemnt Team
Preventative Action	These are the last 3 remaining rooms for renovation. The service has identified some other modifications and enhancements to the rooms previously completed. A design element associated with the proposals is being worked on.	Progress will be tracked via the Local Management Team	This is Achievable and Realistic	30/11/2021	Local Management Team
Reason ID : 10002006		**Residents did not have sufficient space to sit downstairs, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Installation of additional TVs in the bedroom areas was considered and discussed at the most recent St. Catherine's management team meeting. The decision was to provide suitable	Agreed that upstairs is now available should a patient desire to remain upsatirs	Complete	30/04/2021	Nurse Management and Local Management Team

	seating in the bedroom areas however that TV units would not be progressed. MDT members fed back that having discussed with residents, they were not in favour of TVs in the room bedrooms. Nurse Management with other MDT members are assessing the seating requirements for residents. Provision is being made to accommodate the wishes for residents who would like to remain upstairs later than is currently possible.	later than other residents to facilitate TV viewing etc.			
Preventative Action	It has been agreed that residents will be facilitated to access to upstairs area of the unit should they wish to continue access to recreation facilities. Additional furniture provided at residents room areas also in place.	Arrangements in Place.	This is both Achievable and Realistic. Additional soft furniture to be procured for the downstairs(in process)	30/11/2021	Nurse Management and Local Managent Team

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10002007		**Two Medication, Prescription and Administration Records did not record all medications administered to the resident, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Medical Staff and Nurse management reviewed all Medication records. In addition a full medical review of all patients was completed, including comprehensive psychiatric assessment with medication review. All patients in St Catherine's are reviewed at regular intervals. The nurses select approximately five patients to be reviewed at the MDT ward round (comprising ICP and full psychaitric assessment). All patients in St Catherine's Ward are reviewed by the MDT at least every six months. If/when more acute issues arise, these are dealt with by the Medical team.	Compliance will be monitored via the local Audit group and will reviewed with the South Lee Audit Committee.	This is both Achievable and Realistic	30/04/2021	Nurse Management
Preventative Action	Medical in conjunction with ward Nurse management reviewed all Medication records. In addition a full medical review of patients was completed. All patients in St Catherine's are reviewed at regular intervals. The nurses select approximately five patients to be reviewed at the MDT ward round. All patients in St Catherine's Ward are reviewed by the MDT at least every six months. If/when more acute issues arise, these are dealt with by the team NCHD. All MDT members to highlight any file	Ongoingly measured by Audit and reviewed at the South Lee Audit meetings.	This is Achievable and Realistic	31/10/2021	Nurse management supported by MDT

	ommissions to expedite any corrective actions required. Nurse managemnt also highlighted errors to the GP service to ensure that all stakeholders understand requirements. Nurse managemnt highlight importance at team hand-over meetings.				
Reason ID : 10002008		**The registered proprietor did not ensure that the approved centre had written operational policies on the process of ordering, prescribing and administration resident medication, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New Medication Policy developed and approved for the unit.	Complete new Policy in place	Complete	31/05/2021	Nurse Management
Preventative Action	Medication Policy was developed by Nurse management and agreed at the Policy group adn hgas been introduced to St Catherines.	Medication Policy has been developed and implemented.	This is both Achievable & Realistic	31/05/2021	Nurse management and Medical

Regulation 26: Staffing					
Reason ID : 10002013		**The registered proprietor did not ensure that the numbers of staff and the skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre: There was insufficient nursing staff to provide safe care, 26(2). The registered proprietor did not ensure that the numbers of staff and the skill mix of staff were appropriate to the assessed needs of residents, the size and layout of the approved centre: There was insufficient occupational therapy input to address identified needs, 26 (2). The registered proprietor did not ensure that the numbers of staff and the skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre: Referrals were made to a dietitian, but no assessments had been conducted, 26 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	"An additional Nursing resource has been introduced into the staffing mix of St. Catherine's. Due to the complex needs and intense rehabilitative input required for this patient cohort, the impact of an extra nurse in St Catherine's between 09:30 and 21:30 will be substantial. From a therapeutic and patient centred standpoint, an additional nurse will be able to supplement and provide additional nursing services including group work, enabling service users to engage with community groups, physical care including assisting with mental health nursing assessment, social skill training and ensuring service users have access to the totality of the unit and grounds. Furthermore, the additional nurse will provide extra support to the existing staff regarding regulatory and compliance needs. They can assist and	Reviewed at Local Management Team meetings	This is Achievable and Realistic	31/10/2021	Local Managemnt Team

	further develop auditing and policy structures within St Catherine's Unit, boosting compliance. Funding was approved to commission a specialised external occupational therapy agency to complete a seating assessment for all residents. At present there is 0.2 OT input to St Catherine's. OT assessments of residents were carried out on the 24th and the 25th May 2021 and will be followed by two days of chair trails and education in relation to the seating system for nursing staff. Head of Service will discuss Occupational Therapist for St Catherine's Ward with Chief Officer in an effort to secure funding for same. All SLT assessments are complete. Karen Macken, Senior Dietitian has provided Dietetic assessments for all patients on the unit Copies of all assessments undertaken are in the Patients files."				
Preventative Action	Resources required to support the unit have been put in place and where not available specialist services contracted to provide the element required. The OT post was approved by the Chief Officer and has been expressed out to the OT panel.	Resourcing is monitored at the local management team and resources deficits are also managed via the local Risk register.	An OT panel exists and the Post has been offerred.	31/10/2021	OT Manager and Local Management Team.

Regulation 27:Maintenance of Records					
Reason ID : 10002009		**The approved centre did not ensure that records were kept in good order as loose pages were noted in clinical files, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Records were reviewed by Ward Clerk from AAMHU and files volumising undertaken where appropriate.	Will be managed via the unit Audit schedule.	This is both Achievable and Realistic.	30/04/2021	MDT and Local Management
Preventative Action	To encourage better records management practices training program to be provided to staff on the unit to assist with records management requirements. Scheule of Ward Clerk file reviews to be implemented for the unit to support local operations.	Schedule to be developed and training plan to be rolled out.	This is both Achievable and Realistic.	31/10/2021	Nurse management and Area Administrator.

Regulation 32: Risk Management Procedures					
Reason ID : 10002011		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre as health and safety risks were not identified, assessed and monitored: falls risks were not adequately identified, assessed or monitored, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A falls risk assessment has been completed on each resident (Redacted assessments submitted by ADON). A post fall assessment has also been introduced and a post fall protocol introduced to St Catherine's Ward.	Assessments completed.	Complete	30/04/2021	Area Management Team
Preventative Action	Cork Kerry Community Healthcare have been developing a Falls Policy for introduction in all its approved centres. This Policy is currently at an advanced stage.	Development of a CHO Falls Policy	This is Achievable and Realistic	31/12/2021	Area Management Team
Reason ID : 10002012		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre as clinical risks were not effectively assessed or mitigated: there was no existing or additional control measures identified for access to a social worker, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team Leader Social worker post approved and commenced 28th June 2021.	Post approved and person in post.	Complete	28/06/2021	Local Management Team
Preventative Action	Recruitment of a Social Work post to support the residents of St. Catherine's. This post was proposed by the HOS and approved by the Chief Officer.	Complete	This action is Complete as resource in place for the unit.	28/06/2021	Area Management

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.

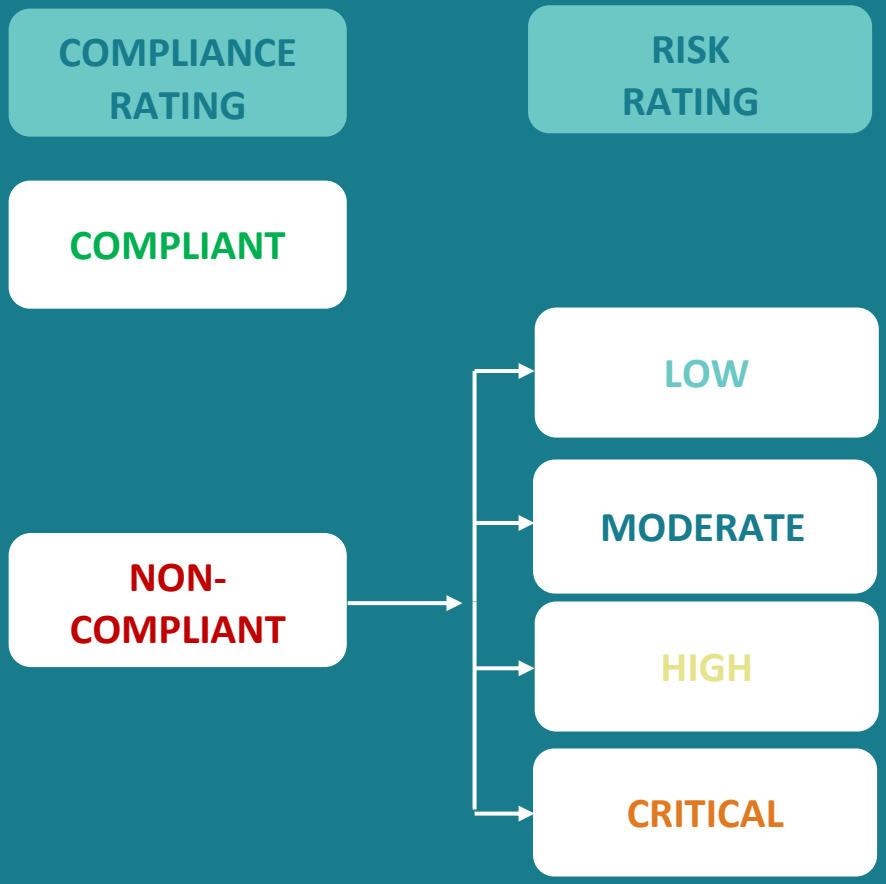
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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 and risk ratings, 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.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



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.