MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Teach Aisling

Annual Inspection Annual Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

TEACH AISLING

Teach Aisling
Westport Road
Castlebar, Co Mayo

Date of Publication:
Thursday 10 December 2020

ID Number: AC0172

2020 Approved Centre Inspection Report (Mental Health Act 2001)

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

Most Recent Registration Date:
31 May 2019

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health Services

Inspection Team:
Raj Ramasawmy, Lead Inspector
Martin McMenamin

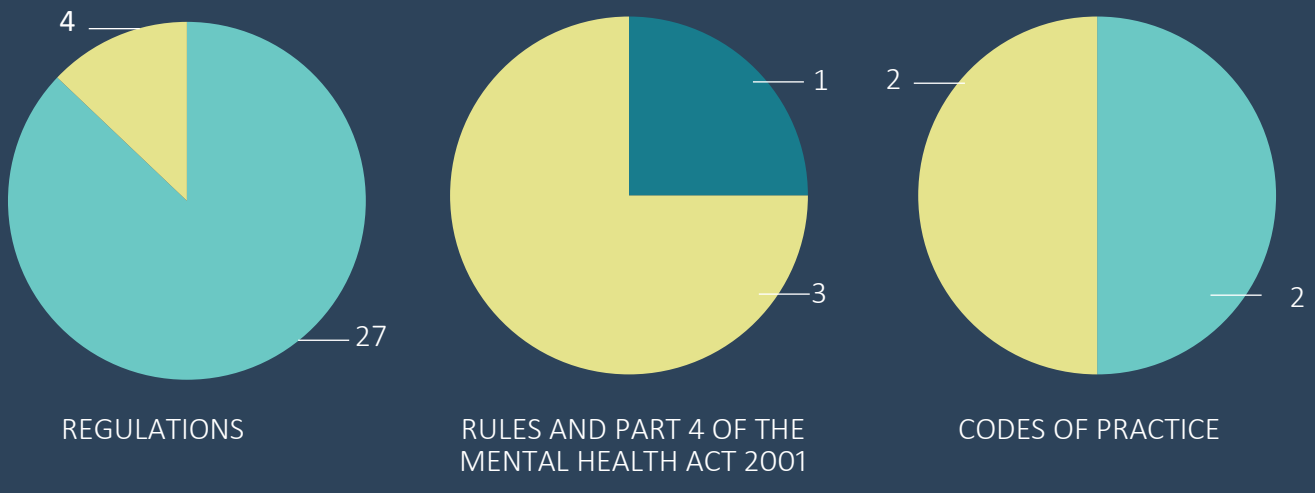
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
14 – 17 July 2020

Previous Inspection Date:
20 – 23 August 2019

Inspection Type:
Announced Annual Inspection

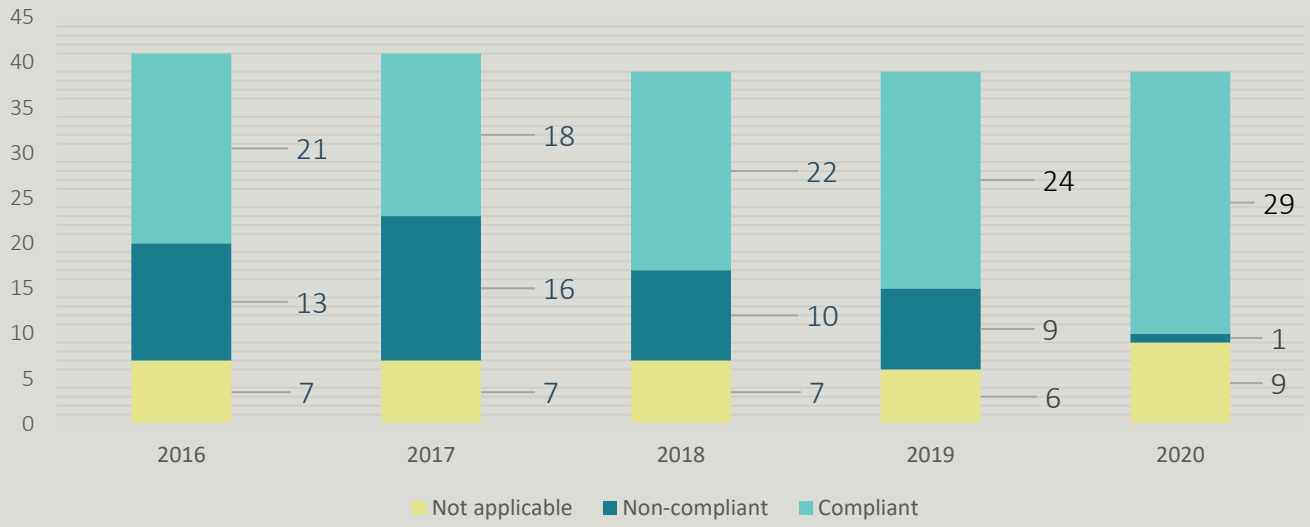
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

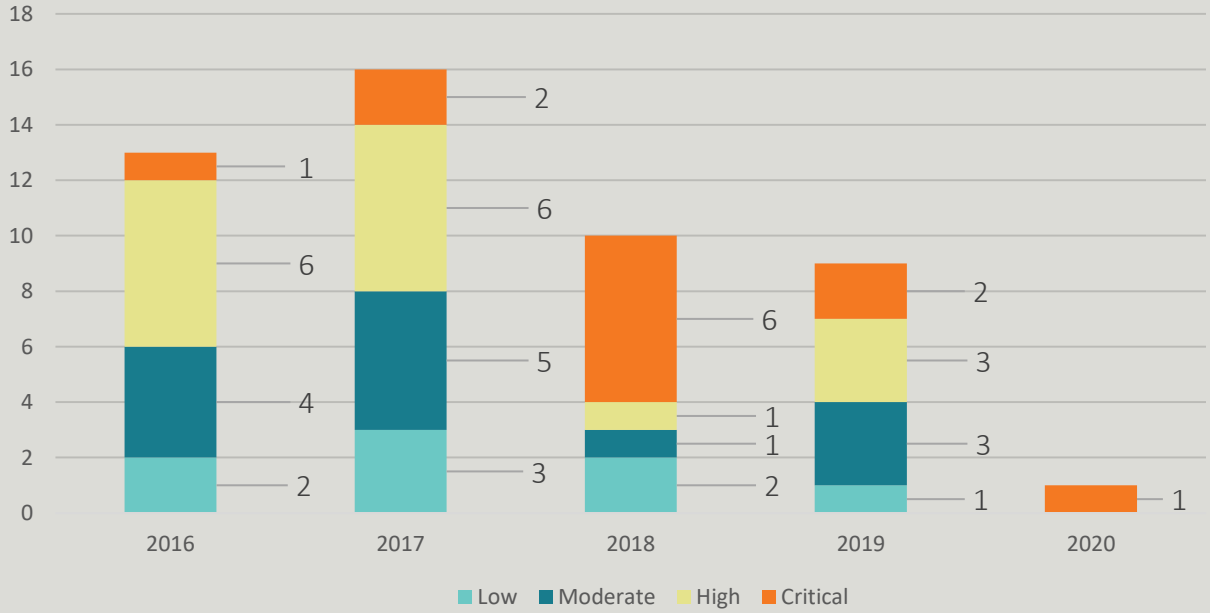
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2016 – 2020



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

Teach Aisling was a seven-bed approved centre located on its own grounds on the outskirt of Castlebar. It was registered as a long-stay unit for residents with enduring mental illness and for mental health rehabilitation. Attached to the main building were two flatlets providing accommodation for two of the residents. Concerns had been expressed about the size and suitability of these two adjoining flatlets in previous inspections.

The suitable placement and care of one resident had been under discussion with the Mental Health Commission for a number of years. Capital funding has been identified to develop a High Support Community residences to accommodate the resident but due to the pandemic this has been delayed. It is currently in planning process with estates.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	62%	53%	69%	73%	97%
Regulations Rated Excellent	1	2	2	13	N/A

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Condition 1: *To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance and building works to ensure the premises are safe and meet the assessed needs of the resident group. The registered proprietor shall provide a progress update on the programme of*

maintenance and building works to the Mental Health Commission in a form and frequency prescribed by the Commission.

Finding on this inspection: The approved centre was not in breach of Condition 1. The approved centre was compliant with Regulation 22: Premises at the time of inspection.

Safety in the approved centre

- Food safety audits had been completed periodically. There were proper facilities for the refrigeration, storage, preparation, and serving of food. Hygiene was maintained to support food safety requirements.
- Ligature anchor points were being replaced by anti-ligature fixtures and fittings.
- Medication was ordered, prescribed, stored and administered in a safe manner.

Appropriate care and treatment of residents

- Each resident had an individual care plan (ICP), developed by the multi-disciplinary team and the resident. Each ICP had appropriate goals, interventions and outlined resources required to achieve the residents' goal.
- The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents as documented in their individual care plans. Individual and group therapy programmes continued with adjustments due to COVID-19 including social distancing, sneeze/cough etiquette and hand/surface hygiene.
- A bespoke therapy programme for one resident was in place, which was working well.
- The six-monthly general health assessments were complete. Residents on antipsychotic medication received an annual assessment that considered glucose regulation, blood lipids, electro-cardiogram and prolactin levels. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

Respect for residents' privacy, dignity and autonomy

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of their doors and observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Noticeboards did not display any identifiable resident information.
- There was a cleaning schedule implemented within the approved centre and the approved centre, was observed to be clean and hygienic. Some maintenance were delayed due to the COVID-19 pandemic.

However:

- One resident was placed in a sitting room for periods of time with no means of egress. Although this meets the definition of seclusion, the Rules Governing the Use of Seclusion were not applied.
- Previous inspections determined that the two single bedsits were of insufficient size and poor layout. Staff reported that the bedsits remain unchanged since the last inspection. Inspection of the two flatlets was not possible on this inspection due to the wishes of the residents.

Responsiveness to residents' needs

- The approved centre's menus were approved by a dietitian to ensure nutritional adequacy in accordance with the residents' needs. Residents had at least two choices for meals.
- Recreational activities were conducted by nurses, occupational therapists, social workers and Peer Support Workers. The activity room in the approved centre had a TV, pool room, games, books, newspapers, walks, quizzes, paper reading, and a new separate music room.
- There was an information booklet that detailed the care and services provided. Residents were provided with written and verbal information on diagnosis and medication.
- There was a robust complaints procedure in place.

Governance of the approved centre

- The approved centre was part of the HSE's Community Healthcare Organisation 2 (CHO2) area. The area management team of Mayo Mental Health Services were responsible for the overall management and governance of the approved centre.
- A multi-disciplinary team (MDT) operational group met monthly and escalated unresolved local matters to the area management team. These meetings had occurred at increased frequency due to the various risk factors associated with COVID-19.
- These indicated that there were clear reporting systems for all disciplines and the management had received training on clinical risk management, the National Incident Management System, and health and safety.
- The service had a local risk register and this was kept up-to-date by management and reviewed regularly at the quality and patient safety committee.
- Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident engagement. All formal complaints were reviewed at the QPS committee meetings and relevant actions identified.
- There was an ongoing programme of training, however this had been interrupted by the recent COVID-19 restrictions.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Wake and Shake Exercise group each weekday

2. Mindfulness group on a weekly basis

3. Purchase of bicycles for therapeutic and recreational purposes

4. New furniture and beddings have recently been upgraded in the approved centre.

5. Development of bespoke documentation record for one resident

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Teach Aisling was located on its own grounds on the outskirt of Castlebar. The approved centre was a purpose-built, single storey building with accommodation for five residents. Attached to the main building were two flatlets providing accommodation for a further two residents. The approved centre was registered as a long-stay unit for residents with enduring mental illness and for mental health rehabilitation.

The approved centre consisted of a central nursing station with a large lounge, activities room and therapy room. There were single bedrooms which were en suite and were along separate female and male corridors, a small sitting room and a laundry facility. There was an enclosed garden which had weeds growing through the astroturf and overgrown trees had not been addressed since the last inspection. An external walkway with laminated glazing allowed residents to enter the kitchen and dining room area directly from the bedrooms through the enclosed garden, an alternative to enter the area through the main sitting room. The unit was overall bright and free from any malodorous odours during the inspection. The main sitting room which needed painting and the external garden work were delayed due to the pandemic as advised by the service.

The programme of internal restructuring of the premises to adapt to meet the needs of one resident has been continued since the last inspection. The other residents were noted to be less restricted as more doors were opened and they could now access their bedrooms and activity area, which was not possible previously. However at times that area was not available due to one resident's need. Concerns had been expressed about the size and suitability of the two adjoining flatlets in previous inspections. Due to service users wishes the inspectors were not able to inspect the flatlets and as such would be addressed at a later stage. The suitable placement and care of one Teach Aisling resident had been under active discussion by senior clinical and business managers for a few years and were still ongoing and it appeared that a resolution was found but due to the pandemic this has been delayed.

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

Resident Profile	
Number of registered beds	***7***
Total number of residents	**7**
Number of detained patients	0
Number of wards of court	1
Number of children	N/A
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	N/A

3.2 Governance

Monthly Quality and Patient Safety (QPS) meetings minutes were provided to the inspection team. They indicated that the QPS management team actively and comprehensively addressed issues such as; Mental Health Commission (MHC) reports and action plans, the risk register, serious incidents, complaints with items such as service development, and staff training and development being regularly discussed. There were clear reporting systems for all disciplines and the management had received training on clinical risk management, the National Incident Management System, and Health and Safety supported by the Quality and Risk Advisor. The service had a local risk register and this was kept up-to-date by management and reviewed regularly at the quality and patient safety committee. The risk register outlined clinical, corporate, health and safety and structural risks.

The area management team of Mayo Mental Health Services (MMHS) were responsible for the overall management and governance of the approved centre. The area management team comprised of the Head of Service, Executive Clinical Director, Business Manager, Area Director of Nursing, Principal Psychologist, Occupational Therapy Manager, Principal Social Worker and Area Lead for Service User Engagement. A multi-disciplinary team (MDT) operational group comprised of consultants, nurse manager, health and social care professionals, administration staff and Peer Support Workers of the approved centres in Mayo. Regular meetings took place including:

- The Executive Management Team meeting
- The Quality and Patient Safety Committee meeting
- The policy Development group meeting

Minutes of recent Management Team meetings were provided to the inspectors. These meetings had occurred at increased frequency due to the various risk factors associated with COVID-19.

The approved centre had adequate numbers of staff and the skill mix was appropriate. There was an ongoing programme of training, however this had been somewhat hampered by the recent COVID-19 lockdown.

The approved centre practice of leaving a patient, although under observation, in a room alone with the exit door locked at times continued. However, both management and the inspection team had noted that a lot of work by the whole team has taken place to prevent this practice from occurring. Alternative options had been explored and, pre COVID-19, there were plans to refurbish a flat for the resident in another approved centre to address this issue. However, this had been put on hold and conversations by the management team were taking place to address same.

Residents were involved in the organisation of their individual treatment programmes. The team reported a therapeutic feel in the approved centre. A placement committee was put in place to work with MMHS and links with the community to promote a community integration for residents of the approved centre. The centre had put in place a variety of processes to allow the continuation of therapeutic activity while observing COVID-19 precautions.

The numbers and skill mix of staff was sufficient to meet resident needs. Health and social care disciplines, including occupational therapy, psychology, social care work and peer support, were accessible to all residents.

At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident engagement. All formal complaints were reviewed at the QPS committee meetings and relevant actions identified.

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 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Rules Governing the Use of Seclusion	✓	Not Applicable	✓	Not Applicable	✗	Not Applicable	✗	Critical	✗	Critical

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 13: Searches	As no searches had been conducted since the last inspection, this regulation was not applicable.
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 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 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

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:

- 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 over the phone on any matter relating to their care whilst in the approved centre.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

The inspection team received three questionnaires from the residents. They were all positive about the service. Furthermore one resident spoke to the inspector and reported that they felt safe and were able to talk to staff.

The Irish Advocacy Network submitted a report in relation to approved centre which was mainly positive. Some areas of improvement were some residents wanted to move in their own accommodation with the ability to be more independent.

6.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Executive Clinical Director
- General Manager
- Regulatory Compliance Advisor
- Acting Assistant Director of Nursing

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.

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 in the approved centre, 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. In addition, 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

The approved centre was compliant with this regulation.

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. There were two accessible water dispensers in the approved centre; one was located in the kitchen and the other was located in the corridor near the small sitting room.

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

COMPLIANT

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

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

INSPECTION FINDINGS

There was suitable and sufficient catering equipment, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. In addition, residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation

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. Also, residents changed out of nightclothes during daytime hours unless specified otherwise 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 in relation to residents' personal property and possessions, which was last reviewed in June 2019. The approved centre had a written operational policy and procedures relating to residents' personal property and possessions, which was last reviewed in June 2019. Resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were also provided for the safe-keeping of 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 ICP and was available to the resident. Additionally, residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP and/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 recreational activities appropriate to the resident group profile: at the time of inspection, outings were suspended due to pandemic events and infection control measures. Recreational activities were conducted by nurses, occupational therapists, social workers and peer support workers. The activity room in the approved centre had a TV, pool room, games, books, newspapers, walks, quizzes, paper reading, and a new separate music room. Additionally, recreational activities were provided seven days a week.

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. In this sense, there was a dedicated room in the approved centre to practice religion. At the time of inspection, the room was for multi-use due to pandemic events. Also, spiritual guidance was conducted weekly, and Communion was offered on Sundays.

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, which was last reviewed in June 2020. The approved centre had an operational policy and procedures relating to visits, which was last reviewed on June 2020**.** Visiting times were appropriate and reasonable; COVID-19 restrictions applied in this respect. A separate visitors' room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits: the visitor's room was used as a shared space to receive all visitors to the centre. In this regard, temperature checks and a visitor log was completed here, where masks and hand sanitiser were provided.

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, which was last reviewed in March 2020. Residents had access to mail, fax, e-mail, internet, telephone, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health.

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, which was last reviewed in August 2018. The approved centre had no deaths since the last inspection.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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 examined on inspection. The ICPs were a composite set of documents, which included the following: allocated space for goals, treatment, care and resources required, and; allocated space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICP's were developed by the multi-disciplinary team (MDT) following a comprehensive resident assessment, within seven days of admission. ICP's were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. ICP's also identified appropriate goals for the resident.

ICP's identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Furthermore, ICP's pinpointed the resources required to provide the care and treatment identified. The multi-disciplinary team (MDT) reviewed the ICP in consultation with the residents every six months. ICP's were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

(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 appropriate and met the assessed needs of the residents, as documented in their individual care plans; such therapeutic and services provided by the approved centre were also directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Furthermore, where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

Additionally, dedicated therapeutic resources were engaged in tailoring individual programmes for each of the seven residents. Interventions and services provided reflected multi-disciplinary team involvement. Adjustments for implementation were made based on COVID-19 guidelines in the approved centre. In addition to nursing and medical staff, the occupational therapist, social worker, and psychologist each engaged individually with residents as required in line with the residents' assessed needs.

The approved centre was compliant with this regulation

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, which was last reviewed on February 2020. No transfer of a resident had taken place in the approved centre since the last inspection.

The approved centre was compliant with this regulation

Regulation 19: General Health

COMPLIANT

(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 medical emergencies policy, which was last reviewed in December 2017. The approved centre had an automated external defibrillator (AED) only: the unit did not use an emergency trolley, as the protocol was to call 999/112. Staff were able to articulate emergency procedures in the event of a medical emergency; an emergency bag and AED were available to staff at all times. Weekly checks were completed on the AED, and records were available of any medical emergency within the approved centre and the care provided. All residents were registered with their general practitioner (GP), although physical care was generally managed through a non-consultant hospital doctor (NCHD). Residents received appropriate general health care interventions in line with their individual care plans. One resident's six monthly general health examination was delayed by two months due to pandemic events and infection control measures.

The six-monthly general health assessment documented the following: physical examination; family/personal history; body mass index (BMI), weight, and waist circumference; blood pressure and smoking status; nutritional status (diet and physical activity, including sedentary lifestyle); medication review (as per prescriber guidelines), and; dental health.

For residents on antipsychotic medication, there was an annual assessment of the following: blood lipids; electrocardiogram (ECG), and; prolactin levels. Adequate arrangements were in place for residents to access general health services and for their referrals 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 that were available according to age and gender, including breast check and cervical screening. Prior to the disruption to the service as a result of pandemic events, there was evidence that residents had been reviewed in terms of their need for national screening programmes: the need for a flu vaccine and physical needs were reflected in the individual care plans. Information was provided to residents regarding the national screening programmes available through

the approved centre. Residents had access to smoking cessation programmes, and a smoking assessment was completed on relevant residents.

The approved centre was compliant with this regulation

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, which was last reviewed in November 2018. Required information was provided to residents and/or their representatives at admission, including the approved centre's information booklet that detailed the care and the services. Additionally, the booklet was available in the required formats to support resident needs and information was clearly and simply written. The information booklet contained the following: 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 also provided with details of their multi-disciplinary team.

Residents were provided with 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's needs; the approved centre used a link on the computer provided by the HSE in this respect. 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. Furthermore, residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

There was evidence of the policy relating to resident privacy and dignity being implemented throughout the approved centre, including: residents being called by their preferred name; the general demeanour of staff; the manner in which staff address and communicate with residents; staff appearance and dress; staff discretion when discussing the resident's condition or treatment needs; and, staff seeking the resident's permission before entering their room, as appropriate.

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 bedrooms in the approved centre were en suite. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas and, if they were, the windows were fitted with opaque glass. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation

Regulation 22: Premises

COMPLIANT

(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

Appropriate sized communal areas were provided in the approved centre. There was suitable and sufficient heating with a minimum temperature of 18° C (65° F) in bedroom areas and 21° C (70° F) in day areas and in bedroom areas where residents sit during the day. Rooms were ventilated, and private and communal areas were suitably sized and furnished to remove excessive noise or acoustics. The lighting in communal rooms suited the needs of residents and staff; it was sufficiently bright and positioned to facilitate reading and other activities.

Appropriate signage and sensory aids were not provided for residents to move around: it was noted on inspection that there was no signage on doors in the approved centre. Sufficient space was provided for residents to move around, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. It was also noted on inspection that the approved centre had a lot of work completed to minimise ligature points.

On inspection, the foyer in the approved centre needed painting; although such work had been approved, inspectors were informed that due to pandemic events this had been delayed. Additionally, the grass in the garden area needed to be replaced and the trees cut. However, other parts of the unit were clean and free from any malodours. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistance equipment; records of such were maintained. The

approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have temperatures no higher than 43° C. Furthermore, current national infection guidelines were followed.

There was a sufficient number of toilets and showers in the approved centre, and there was at least one assisted toilet. The approved centre had a designated cleaning room. All resident bedrooms were appropriately sized to address the resident's needs, with new sofas, tables, and chairs having been acquired. The approved centre also provided suitable furnishings to support independence and comfort, as well as assisted devices and equipment to address resident needs.

The approved centre was compliant with this regulation. Though the requirement of the approved centre being kept in a good state of repair externally and internally was not met, this was due to the pandemic event and associated infection control measures within the approved centre, and was therefore not deemed a reason for non-compliance.

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

COMPLIANT

(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 a written policy and procedures on the ordering, prescribing, storing and administration of medicines, which was last reviewed in March 2019. The policy included:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing 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 that detailed the following: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; a Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident; and the signature of the medical practitioner/nurse prescriber for each entry.

All entries in the MPAR were legible, and medication was reviewed and rewritten at least six-monthly or more frequently where there is a significant change in the resident's care or condition. This was documented in the clinical file. When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file. Furthermore, direction to crush medication was only accepted from the resident's medical practitioner.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Additionally, medication dispensed or supplied to the resident was stored securely in a locked storage unit (e.g. drugs trolley or drawers), with the exception of medication that was recommended to be stored elsewhere (e.g. refrigerator).

The approved centre was compliant with this regulation

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, which was last reviewed in March 2020.

The approved centre was compliant with this regulation

Regulation 26: Staffing

COMPLIANT

(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, which was last reviewed in February 2019. The numbers and skill mix of staffing in the approved centre were sufficient to meet resident needs. Furthermore, 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 Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

Staff in Approved Centre		
Staff Grade	**Day**	**Night**
Clinical Nurse Manager 2	1	1
Registered Psychiatric Nurse	5	4
Multi task attendants	2	

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Assistant Director of Nursing	1	
Clinical Nurse Manager 3	1	
Consultant Psychiatrist	1	

Non Consultant Hospital Doctor	1
Occupational Therapist	1
Social Worker	1
Psychologist	1
Art Therapist	1

Whole time equivalent (WTE)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

The approved centre was compliant with this regulation

Regulation 27: Maintenance of Records

COMPLIANT

(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, which was last reviewed in January 2019. All residents' records were secure, up to date, in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. All resident records were physically stored together, where possible. Additionally, 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 records were maintained in good order; for example, no loose pages. Records were appropriately secured throughout the approved centre from loss or destruction and tampering, as well as unauthorised access or use. Additionally, documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation

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 November 2018.

There was a nominated person responsible for dealing with all complaints who was available in the approved centre. The approved centre’s managements of complaints processes was well publicised and accessible to residents and their representatives, including: the provision of information about the complaints procedure to residents and their representatives at admission or soon thereafter. This information may be provided within the resident information booklet.

The complaints procedure, including how to contact the nominated person, was publicly displayed. If the nominated person was not based in the approved centre, contact details were displayed publicly. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint can be made. All complaints, whether written or oral, 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 a complaint being made. Furthermore, minor complaints were documented. All complaints that were not minor were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the residents individual care plan (ICP). Also, the complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them; this was documented.

The approved centre was compliant with this regulation

Regulation 32: Risk Management Procedures

COMPLIANT

(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 as well as a Safety Statement, which were last reviewed and dated March 2019. The risk management policy and associated safety statement addressed all requirements.

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. Additionally, the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were identified, assessed, treated, reported and monitored; clinical risks were also documented in the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre; corporate risks were also documented in the risk register. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and/or their representatives were involved in individual risk management processes.

Incidents were recorded and risk-rated in a standardised format; all clinical incidents were reviewed by their multi-disciplinary team at their regular meeting. Additionally, a record was maintained of this review

and recommended actions. 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; information provided was anonymous at resident level.

The approved centre was compliant with this regulation

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation

Regulation 34: Certificate of Registration

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. 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)

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating CRITICAL

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated January 2020.

The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy. The training record was available to the inspector. A record of attendance at training in the use of seclusion was maintained.

Monitoring: An annual report on the use of seclusion had not been completed.

Evidence of Implementation: One Resident was placed alone in a room and egress prevented, for periods of time. This meets the definition of seclusion under the Rules Governing the Use of Seclusion and Bodily Means of Mechanical Restraint. However, the approved centre did not comply with any of the Rules Governing the Use of Seclusion, including completing the Seclusion Register, Orders for Seclusion, Ending of Seclusion, Recording of Seclusion, Monitoring of a person in seclusion or Clinical Governance of Seclusion.

The approved centre did not comply with any of the Rules Governing the Use of Seclusion

9.0 Inspection Findings – Mental Health Act 2001

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

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.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated June 2020. It addressed the following:

- The provision of information to the resident
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: The clinical file of a resident that had been physically restrained was examined on inspection. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Completed clinical practice forms had been placed in the resident's clinical file.

The approved centre was compliant with this code of practice

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

Transfer: The transfer policy, which was last reviewed in February 2020, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in February 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.

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 evidenced a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and relevant members of the multi-disciplinary team. A preliminary discharge summary had been sent to the relevant agencies and a comprehensive discharge summary had been sent within 14 days that detailed diagnosis, prognosis and medication. As applicable, a follow up appointment had been arranged for the resident.

The approved centre was compliant with this code of practice

Appendix 1: Corrective and Preventative Action Plan

Rules Governing the Use of Seclusion					
Reason ID : 10001414		The approved centre did not comply with any of the Rules Governing the Use of Seclusion			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Implementation of the Mental Health Commission's Rules of Seclusion. Application of Mayo Mental Health Service Seclusion policy. Training of staff involved in seclusion and its use, provided by nurse practice development co-ordinator. Two staff in the Approved Centre have being identified as 'Champions' for the implementation or the rules governing seclusion and will provide ongoing training and support to colleagues.	A review of each episode of seclusion by the MDT to ensure compliance with the rules governing its use. Six monthly audit of all the episodes of seclusion.	No barriers identified. Implementation of the rules of seclusion on October 15, 2020 Training provided by nurse practice development co-ordinator to staff of the approved centre- Oct 2020.	15/10/2020	Executive Clinical Director & Area Director of Nursing
Preventative Action	All episodes of seclusion will be recorded as prescribed in the register for seclusion and seclusion care plan in the clinical file. Six monthly audits of seclusion to be reviewed by the clinical team, Area Director of Nursing and Executive Clinical Director.	A review of each episode of seclusion by MDT. Audit of the process will ensure: adherence to best practice with regard to the use of seclusion & provide an action plan for future seclusion episodes. Audit to be completed six	No barriers identified. Six monthly audit due in April 2021	30/04/2021	Treating Consultant Psychiatrist & CNM3

		monthly by 2 staff members and external auditor using Mayo Mental Health Service Audit tool (based on the MHC Rules of Seclusion and the HSE Best Practice Guideline).			

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.

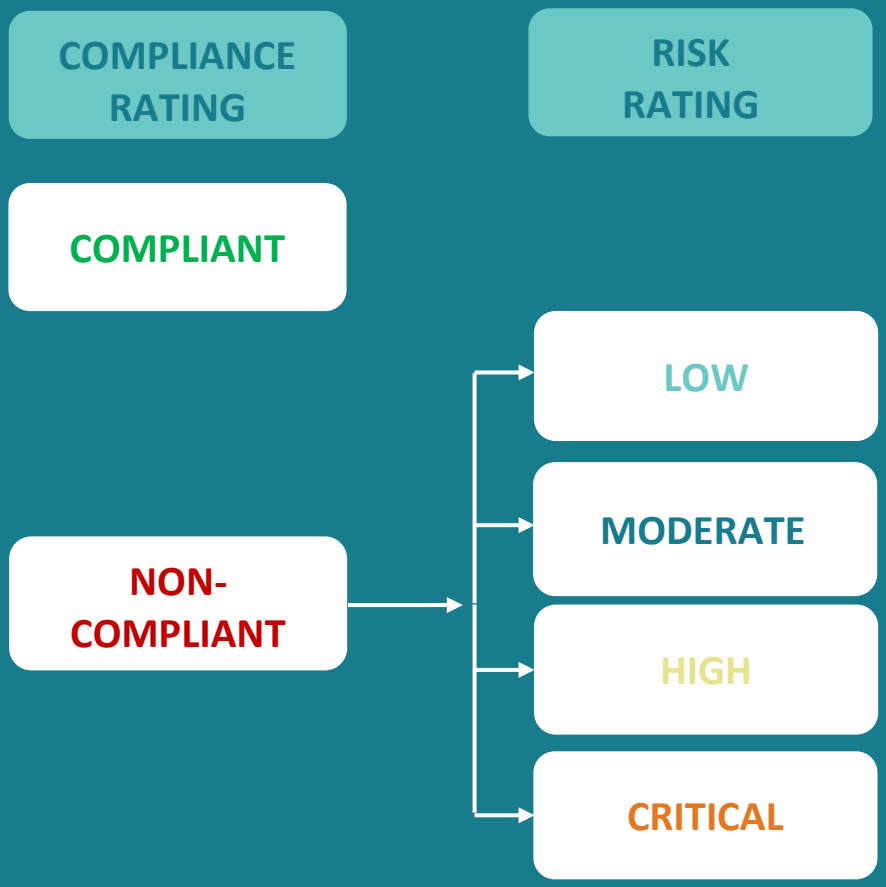
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. 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, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

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.