MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

St. Gabriel's Ward, St. Canice's Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

ST. GABRIEL'S WARD, ST. CANICE'S HOSPITAL

St Gabriel's Ward, St Canice's Hospital
Dublin Road, Kilkenny

Date of Publication:
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2020 Approved Centre Inspection Report (Mental Health Act 2001)

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

Most Recent Registration Date:
1 March 2020

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, Acting Head of Services, CHO 5 Mental Health Services

Inspection Team:
Rajeev Ramasawmy, Lead Inspector
Mary Connellan

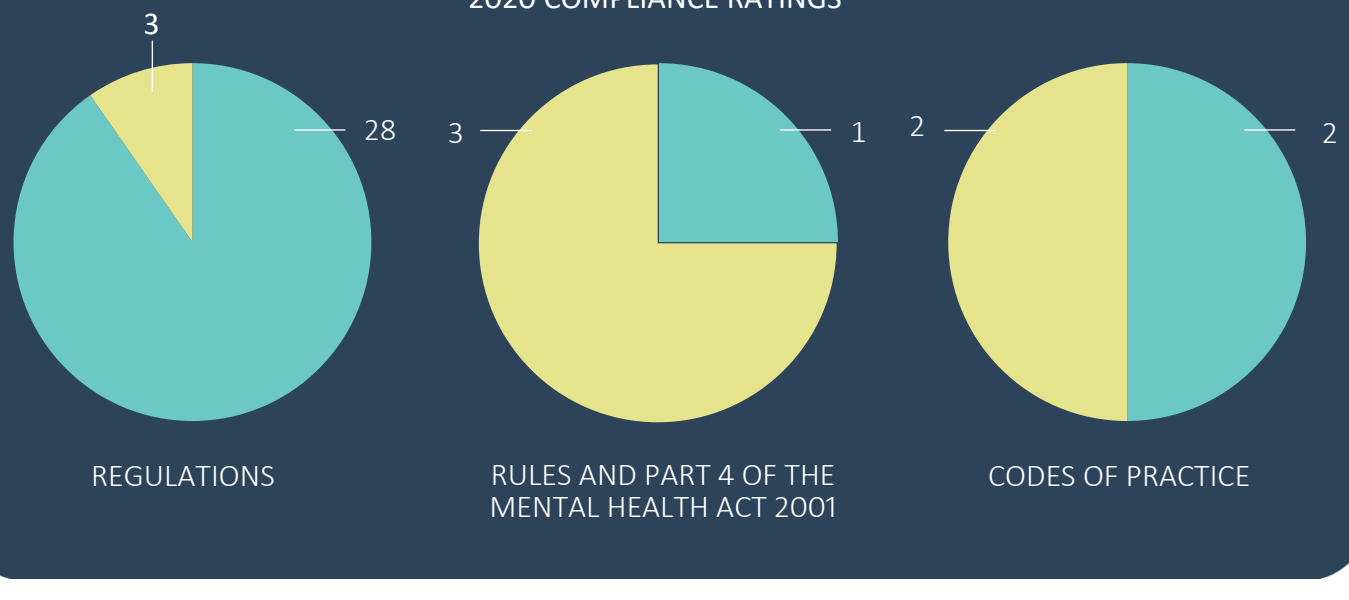
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
4 – 7 August 2020

Previous Inspection Date:
9 – 12 July 2019

Inspection Type:
Announced Annual Inspection

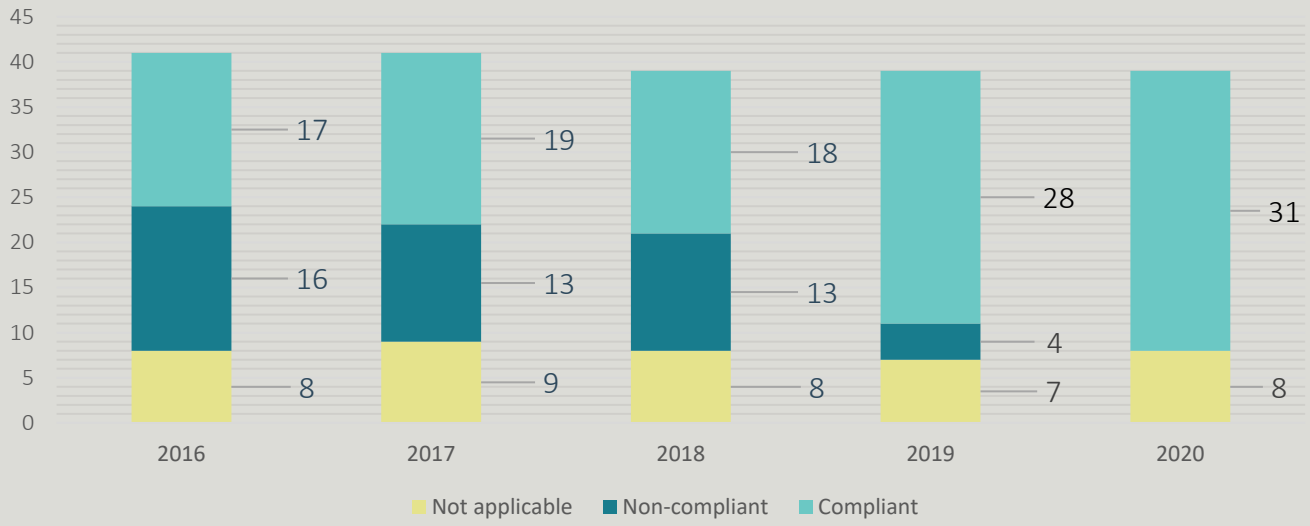
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

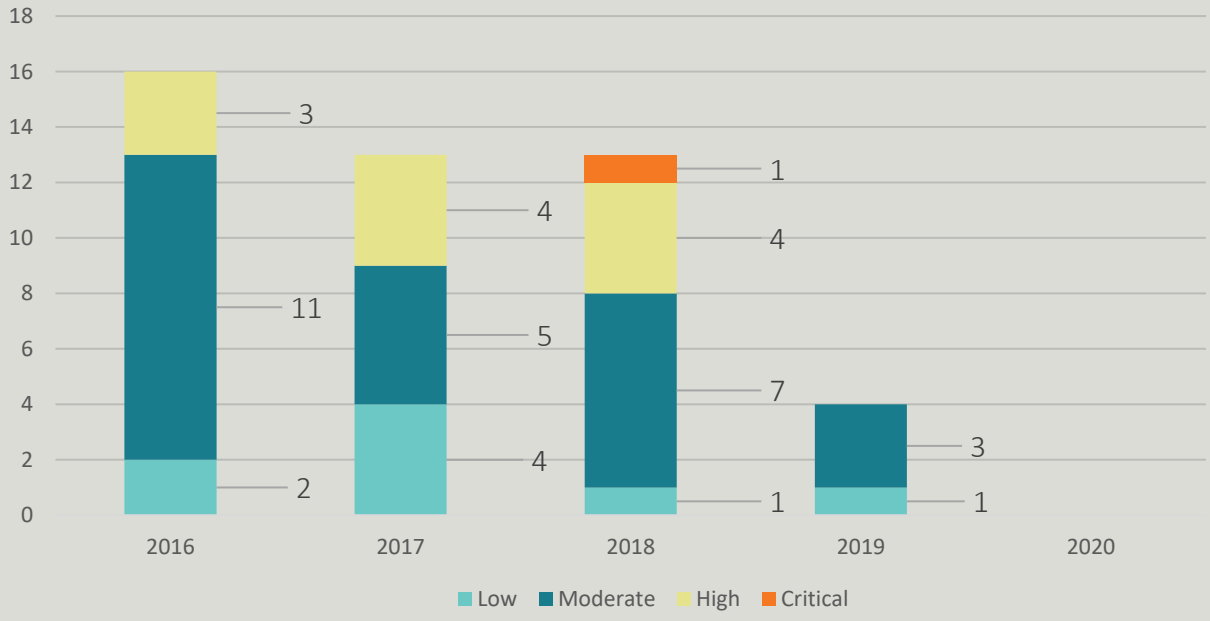
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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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

The approved centre was a 20-bed facility, in the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey 1980's building. The ward was reconfigured into zone A and Zone B to support a cohorting of the frail and vulnerable residents together in one area in line with COVID-19. One area of the ward was used as isolation unit if necessary. The approved centre accommodated residents under the Psychiatry of Later Life and continuing care.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	52%	59%	58%	88%	100%
Regulations Rated Excellent	0	0	2	13	N/A

Conditions to registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

Safety in the approved centre

- There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Kitchen areas were clean.

- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre.
- There was a minimisation of ligature points to the lowest practicable level, based on risk assessment.
- Medication was ordered, prescribed, stored and administered in a safe manner.

Appropriate care and treatment of residents

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident.
- Prior to the COVID-19 pandemic, the Education and Training Board (ETB) provided activities such as art, music, and crafts; at the time of inspection these had not been re-commenced by the ETB but were facilitated by the activities nurse. An exercise group (Blue Seal) had recommenced via Zoom calls online. Other groups provided by Occupational Therapy (OT) included reminiscence therapy, tabletop activities, baking and gardening. Up until COVID-19, a community social worker provided a group to carers which was a therapeutic service provided to families; there were plans for this to resume in September 2020.
- The six monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

- Sleeping accommodation was in single, two or three-bed rooms with toilet and shower facilities en suite.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident, and where residents shared a room, bed screening ensured that their privacy was not compromised. 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.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.

Responsiveness to residents' needs

- Activities included: gardening, film, art, books, newspaper, reminiscence, arts and crafts, board games, music, television, and garden. Due to COVID-19, outings were suspended. The approved centre provided access to recreational activities on weekdays and during the weekend.
- 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

- The approved centre was part of South East Community Healthcare Organisation which was divided into Carlow/Kilkenny/South Tipperary and Waterford/Wexford. St. Gabriel's Ward was governed by the executive team from Carlow/ Kilkenny/South Tipperary team.
- The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed. Clinical audits were furnished to the inspection team.
- Responsibilities regarding risk were allocated at management level and throughout the approved centre and recorded in the risk register which was updated in January 2020 and again for COVID-19 to ensure their effective implementation.
- Incidents were recorded and risk-rated on the National Incident Report Form (NIRF). There was an emergency plan with full evacuation procedure in place. A daily walk around was done by clinical staff to detect and mitigate risk and to escalate issues to the management team, if necessary.
- At the time of inspection, the numbers and skill mix of clinical staff was increased to meet the residents' needs during the pandemic for both day and night duty.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. New Individual Care Plan documentation was introduced.

2. Nursing and Midwifery Quality care Metrics was introduced to include a combined suite of both mental health and older person's services in order to measure the quality of nursing care to an agreed standard.

3. A system of hiring pressure mattresses based on individual needs was sourced and funded.

4. Psychology services introduced Positive Behaviour Support Model which included Level 1 education sessions for staff on responsive behaviours.

5. Social worker and member of clinical staff provided carer support and education sessions for families on Dementia: Diagnosis and treatment.

6. New bedroom furniture and mattresses sourced and updated.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey, brick façade building erected in the 1980s. This building also housed separate facilities and offices used by the community mental health teams.

The approved centre comprised a central nurses' office, sitting room, and day area with bedroom accommodation located on an adjacent corridor. Sleeping accommodation was in single, two or three-bed rooms with toilet and shower facilities en suite. The ward was reconfigured into zone A and Zone B to support a cohorting of the frail and vulnerable residents together in one area in line with COVID-19. One area of the ward was used as isolation unit if necessary. The approved centre accommodated residents under the Psychiatry of Later Life and continuing care.

There was an attractive garden area, which was purpose-built for the resident profile. Residents were observed to use the garden space under the supervision of nursing staff during inspection. Overall, the unit was bright, clean and free from any malodorous odours with a calm and caring ethos noted.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**16**
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	11
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of South East Community Healthcare Organisation which was divided into two executive management teams namely Carlow/Kilkenny/South Tipperary and Waterford/Wexford. St. Gabriel's ward was governed by the executive team from Carlow/ Kilkenny/South Tipperary team. Minutes of the executive management team (EMT) meetings with responsibility for governance of Carlow/Kilkenny and South Tipperary mental health services were provided to the inspection team. The EMT consisted of heads of discipline, the head of service, and the service manager. They met on a monthly basis. An Operational team Meeting at senior management level was initially meeting three times a week to deal with

the early issues of COVID-19 which subsequently suspended as necessary precautions were in place and restrictions were eased. Furthermore, a monthly Quality and Patient Safety Committee meeting attended by both clinical and managerial staff took place to address issues in the approve centre which was then fed to the Quality and Safety Executive Committee (QSEC).

The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed. Clinical audits were furnished to the inspection team.

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 and recorded in the risk register which was updated in January 2020 and again for COVID-19 to ensure their effective implementation. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF). There was an emergency plan with full evacuation procedure in place. A daily walk around was done by clinical staff to detect and mitigate risk and to escalate issues to the management team, if necessary.

At the time of inspection, the numbers and skill mix of clinical staff was increased to meet the residents' needs during the pandemic for both day and night duty. In-reach health and social care disciplines, including occupational therapy, psychology and social work, were accessible to all residents. At the time of inspection, the WTE occupational therapist had left and the management team stated that a replacement had been sought and awaiting a date to commence in September 2020. There was no social worker for the Psychiatry of Later Life team and a commencement date of September 2020 was given at feedback meeting.

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

There were no non-compliant areas on inspection.

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 Tribunal	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.
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. To that end, the inspection team engaged with residents in a number of different ways:

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

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

The inspection team received two questionnaire which were both positive and complimentary of the service.

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:

- Clinical Director
- Head of Mental Health Services
- Area Director of Nursing
- Clinical Risk Manager
- Principal Social Worker
- Occupational Therapy Manager
- Assistant Director of Nursing X 2
- Clinical Nurse Manager 3
- Clinical Nurse Manager X 2

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 was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs; these included a picture, date of birth, and staff familiarity with residents. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. Additionally, 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 also had at least two choices for meals. A source of safe, fresh drinking water was always available to residents in easily accessible locations in the approved centre.

For residents with special dietary requirements, it was documented in each clinical file as required that nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans: a diet sheet for each resident was kept in the file in the kitchen for catering staff. At the time of inspection, the dietitian was not visiting the approved centre unless it was an emergency referral.

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; food was supplied from the main kitchen of St. Canice's Hospital and transported to the approved centre. On inspection, it was found that the kitchen in the approved centre was very clean and had adequate facilities for the storage of a small amount of food stuffs. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Furthermore, hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

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 nightclothes during daytime hours unless specified otherwise in their individual care plans.

Individual laundry baskets were introduced, and the residents' family took home washing by arrangement or laundry was sent to the local laundry within the campus of St. Canice's Hospital.

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 on 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 and 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; there was a weekly timetable of recreational activities. However, this timetable was assessed daily due to the resident profile. Activities included: gardening, film, art, books, newspaper, reminiscence, arts and crafts, board games, music, television, and garden. Due to COVID-19, outings were suspended. The approved centre provided access to recreational activities on weekdays and during the weekend.

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. At the time of inspection, no religious minister attended the approved centre because of COVID-19. Rather, mass was streamed live on Sundays. There was no specific room for religious purposes, but the day room was used for such on occasion.

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 relating to visits. The policy was last reviewed on 2019. Visiting times were appropriate and reasonable; two visitors were allowed per visit with a maximum of three people in the visitor's room to include the resident. COVID-19 protocols in the approved centre were followed and included signing in and temperature check. A separate visitors' room or visiting area 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 visiting room was suitable for visiting children.

All staff were very familiar with the Health Protection Surveillance Centre guidance and one staff member was on duty with responsibility for coordinating the visits to ensure that there was a limited number of people in the approved centre at any one time. As much as was practicable, and taking into account resident needs, the garden area was used. The visiting room had been relocated to enable direct access to the garden, limiting the amount of people being in the approved centre at any one time.

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 on 2018. Residents had access to mail, fax, e-mail, internet, telephone, or any device for the sending or receiving of messages or goods unless otherwise risk assessed with due regard to the residents' well-being, safety, and health. During COVID-19 lockdown, two iPads and a smart phone were procured to facilitate resident communication with families.

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 relating to searches. The policy was last reviewed on May 2018. It 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.

There were no searches conducted since the last inspection.

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 relating to the care of the dying. The policy was last reviewed on July 2018. The case file of one resident who was receiving end of life care was reviewed on inspection. The end-of-life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs; this was documented in the resident's individual care plan. Religious and cultural practices were respected, insofar as was practicable. The privacy and dignity of the resident was protected, with the provision of a single room during end-of-life care. Family were facilitated to stay with the resident, and representatives, family, next of kin, and friends were involved and accommodated. The death of the resident was notified to the Mental Health Commission as soon as was practicable and, in any event, no later than 48 hours after the death of the resident.

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 (ICP's) were reviewed on inspection. All ICP's were a composite set of documents. They included allocated space for goals, treatment, care, and resources required; all ICP's also included space for reviews. All ICP's reviewed were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICP books finished after seven reviews; this was weekly for some residents and on a quarterly basis for continuing care residents unless specified more often. ICP's were developed by the multi-disciplinary team (MDT) following a comprehensive 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, as appropriate.

The ICP's identified 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 identified the resources required to provide the care and treatment identified. ICP's were reviewed by the MDT in consultation with the resident, weekly for some residents and three monthly for continuing care residents. Moreover, ICP's were also 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. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Prior to the COVID-19 pandemic, the Education and Training Board (ETB) provided activities such as art, music, and crafts; at the time of inspection these had not been re-commenced by the ETB but were facilitated by the activities nurse. An exercise group (ciel bleu) had recommenced via Zoom calls online. Other groups provided by Occupational Therapy (OT) included reminiscence therapy, tabletop activities, baking and gardening. Up until COVID-19, a community social worker provided a group to carers which was a therapeutic service provided to families; there were plans for this to resume in September 2020.

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. At the time of inspection, social work was not routinely provided internally; however, it was provided on a case-by-case basis.

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. The policy was last reviewed on September 2019. The case file of a resident who had been transferred was reviewed on inspection. Full and complete written information for the resident was transferred when they moved from the approved centre to another facility. Information was sent in advance or accompanied the resident upon transfer, to a named individual. Information issued as part of the transfer documentation included: a letter of referral, including list of current medications; a resident transfer form; and the required medication for the resident during the transfer process. As it was an emergency transfer, communications between the approved centre and receiving facility were documented and followed up with written referral.

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 written operational policy and procedures relating to medical emergencies. The policy was last reviewed on March 2020.

The policy in the approved centre was to call 999 for any medical emergency. No emergency trolley or emergency drugs were kept in the approved centre as there were no medical personnel available 24/7. Three clinical files were reviewed on inspection. Residents received appropriate general health care interventions in line with individual care plans. Additionally, residents' general health needs were monitored and assessed as indicated by the residents' specific needs, not less than every six months. At a minimum, the six-monthly general health assessment documented the following: physical examination; family and personal history; Body-Mass Index (BMI), and waist circumference; blood pressure; smoking status; nutritional status, and dental health.

For residents on antipsychotic medication, there was an annual assessment of the following, unless more regular review is indicated by physical examination: glucose regulation (fasting glucose/HbA1c); blood lipids; electrocardiogram (ECG); and prolactin. Furthermore, adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. The following national screening programmes were not applicable to the three case files reviewed but were available: breast check; cervical screening; retina check (diabetics only) and bowel screening.

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 relating to the provision of information to residents. The policy was last reviewed on May 2018. Required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed the care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. The booklet contained details of housekeeping arrangements, including arrangements for personal property and mealtimes. It also contained details of complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies; and residents' rights.

Residents were provided with details of their multi-disciplinary team. Residents were also provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view provision of such information may 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. Moreover, the content of medication 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. Additionally, 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

Residents the approved centre were called by their preferred name. The manner in which staff addressed and communicated with residents, as well a staff appearance and dress were respectful. Staff demonstrated discretion when discussing the resident's condition or treatment needs. Staff also sought 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. Where residents shared a room, bed screening ensured that their privacy was not compromised. 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; if so, windows had opaque glass. The noticeboard did not display resident names or other identifiable information; it faced away from the door of the nursing office and closed threefold when not in use. Residents were facilitated to make private phone calls; due to the COVID-19 pandemic the approved centre procured a smart phone as well as iPads with WIFI access.

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

Since the COVID-19 pandemic, the approved centre had been split into three zones, (A, B, and C) to allow access to personal space safely. Appropriately sized communal rooms were provided. There was suitable and sufficient heating within the approved centre, and rooms were ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. Furthermore, the lighting in communal areas 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 provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including outdoor spaces. Since the COVID-19 pandemic, a new smaller garden had been developed to facilitate residents in zone C; there was also a large, well maintained garden for zone B, which was also used for family visits in line with recommended guidelines. Additionally, 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. Minimisation of ligature points to the lowest practicable level occurred, based on risk assessment.

The approved centre was kept in a good state of repair, both internally and externally. Moreover, there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive 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 to have surface temperatures no higher than 43 °C. Furthermore, current national infection guidelines were followed.

In terms of facilities and furnishings, there was a sufficient number of toilets and showers for residents in the approved centre. There was at least one assisted toilet. The approved centre had a designated sluice room, and a designated cleaning room, as appropriate. All resident bedrooms were appropriately sized to address the resident needs. In addition, the approved centre provided suitable furnishings to support resident independence and comfort. The approved centre provided assisted devices and equipment to address the resident needs.

Due to COVID-19, fire doors had been installed where previously corridors accommodated the large number of residents. Accommodation, other than single rooms and potential single occupancy in zone C, was shared with two, three, or four residents per room. Each room had its own en suite and there were separate assisted bathrooms also.

The approved centre was compliant with this regulation.

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 relating to the ordering, prescribing, storing and administration of medicines. The policy was last reviewed on October 2018. It contained all necessary processes, including:

- 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. Five MPAR's were reviewed on inspection. All five detailed a record of allergies or sensitivities to any medications, including if the resident has no allergies. The MPAR's also detailed the following: the administration route of the medication; a record of all medications administered to the resident; a clear record of the date of discontinuation for each medication; The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature for each entry were evident.

All MPAR entries were legible, and 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. Where a resident's medication was withheld, the justification for such was noted in the MPAR and documented in the clinical file. Direction to crush medication was only accepted from the resident's medical practitioner; the medical practitioner provided a documented reason as to why medication was to be crushed. The pharmacist was consulted about the type of preparation to be used, and the medical practitioner documented in the MPAR that the medication was to be crushed.

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 unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit except for medication which was recommended to be stored elsewhere, such as a refrigerator. Moreover, scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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. The policy was last reviewed on 2019.

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 relating to staffing. The policy was last reviewed on March 2020. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The following is a table of clinical staff assigned to the approved centre. The numbers and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty and in charge at all times; this was documented. In addition, 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.

As the impact of COVID-19 affected the ability of the approved centre to fulfil its regulatory requirements in relation to staff training on this inspection, Section 26(4) and 26(5) was deferred until 2021.

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

Staff in Approved Centre		
Staff Grade	Day	Night
Assistant Director of Nursing	1 WTE (9-5)	
Clinical Nurse Manager 3	1	
Clinical Nurse Manager 2	2	
Registered Psychiatric Nurse	15	
Occupation Therapist	0	
Social Worker	0	
Psychologist	0	

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
St Gabriel Ward	Clinical Nurse Manager 2	1	
	Registered Psychiatric Nurse	4	2
	Occupation Therapist	1	
	Social Worker	0	
	Psychologist	0	
	Health Care Assistants	2	2
	Activity Nurse (9-5)	1	

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Consultant Psychiatrist	1	
Non-Consultant Hospital Doctor	1	
Occupation Therapist	1	
Social Worker	1	
Psychologist	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 relating to the maintenance of records. The policy was last reviewed on March 2020 and included all required aspects. 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. In addition, 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. Additionally, 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. Furthermore, 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 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 relating to the complaints process. The policy was last reviewed on May 2018 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. The provision of information about the complaint's procedure to residents and their representatives happened at admission or soon thereafter; this information was provided within the resident information booklet. 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.

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 relating to risk management. The policy was last reviewed on July 2019. The risk management policy addressed all requirements.

The policy and procedures included requirements relating to risk management and incidents and adverse events. The Assistant Director of Nursing (ADON) had responsibility to ensure the effective implementation of the risk management policy. The risk manager was identified and known by all staff. An annual ligature audit took place, thus ensuring the active reduction of identified risks; this was complimented by a daily walk around by a member of staff. Clinical risks and health and safety risks were identified, assessed, treated, reported, and monitored. Both were documented in the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were also identified, assessed, treated, reported, and monitored by the approved centre; corporate risks were documented in the risk register.

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

Incidents were recorded and risk-rated in a standardised format; all clinical incidents were reviewed by the 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; information provided was anonymous at resident level. Additionally, there was an emergency plan that specified responses by approved centre staff to possible emergencies, the emergency plan incorporated evacuation procedures.

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 Mechanical Restraint

COMPLIANT

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

Evidence of Implementation: The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed on June 2020. One episode of mechanical restraint was reviewed on inspection. Mechanical restraint was implemented for the enduring risk of harm to the resident or others and was only used to address an identified clinical need. The resident could not maintain her posture due to months of physical health issues and did not want to try to stand. Mechanical restraint was used only when less restrictive alternatives were unsuitable. The episode was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf.

The clinical file contained a contemporaneous record that specified that there was an enduring risk of harm to the resident or others, that less restrictive alternatives were implemented without success, and the type of mechanical restraint. In addition, the clinical file specified the following: the situation in which mechanical restraint was being applied; the duration of the restraint; the duration of the order; and the review date.

The approved centre was compliant with this rule.

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 operational policy and procedures relating to the use of physical restraint. The policy was last reviewed on June 2020. It addressed the following:

- The provision of information to the resident.
- Who could initiate and who may implement physical restraint.
- Child protection processes where a child was 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: One episode of physical restraint was reviewed on inspection. Physical restraint (PR) was used in rare, exceptional circumstances and in the best interests of the resident, and where the resident posed immediate threat of serious harm to the self or others. PR was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered. Also, PR was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint.

PR was initiated by a registered medical practitioner (RMP), registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated staff member was responsible for leading in the PR of a resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) or duty CP was notified as soon as was practicable; this was recorded in the clinical file. The RMP completed a medical examination of the resident (physical exam) no later than three hours after the start of the episode of PR. The order for PR lasted a maximum of thirty minutes and the episode was recorded in the clinical file. A Clinical practice form (CPF) was completed by the person initiating and ordering the episode of PR no later than three hours after the episode; the CPF was signed by the CP within 24 hours.

The resident was informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of PR unless the information was prejudicial to the resident's mental health, well-being, or emotional condition. As soon as was practicable and with the resident's consent, the resident's next of kin was informed of the use of PR and a record of the communication was placed in the clinical file. Staff

were aware of relevant considerations in the individual care plan pertaining to the resident's requirements and needs in relation to the use of PR (this may have included advance directives).

A same sex staff member was present at all times during the episode of PR. The resident was afforded the opportunity to discuss the episode with members of his or her multi-disciplinary team who were involved in his or her care, as soon as was practicable. Furthermore, the completed CPF was placed in the resident's clinical file. Each episode of PR was reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after the episode.

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 July 2019, included all of the policy-related criteria for this code of practice

Transfer: The transfer policy, which was last reviewed in September 2019, included all the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in July 2019, included all the policy-related criteria for this code of practice.

The approved centre had completed an annual audit for this code of practice.

Evidence of Implementation

Admission: There was a procedure for involuntary admission in the approved centre. The protocol for planned admission referenced the following: pre-admission assessments; eligibility for admission; and referral letters. Furthermore, there was a policy on privacy, confidentiality, and consent.

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

Discharge: The policy for discharge contained a reference to early warning signs of relapse and risks. The discharge meeting was attended by the resident, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate, where appropriate (i.e., with the consent of the resident). The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; and a comprehensive risk assessment and risk management plan. Moreover, the discharge was coordinated by the key worker. A preliminary discharge summary was sent to the general practitioner, primary care, or community mental health team within three days. Additionally, a comprehensive discharge summary was issued within 14 days, which included diagnosis, prognosis, and medication.

The approved centre was compliant with this code of practice.

Appendix 1 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.

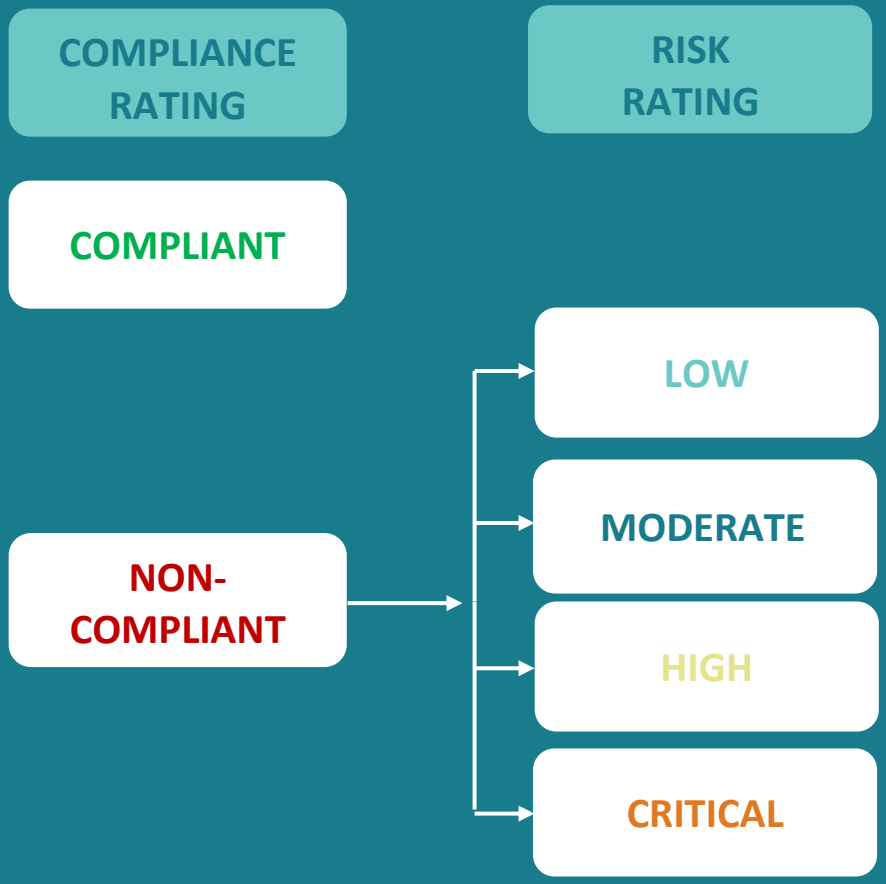
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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