MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Acute Mental Health Unit, Cork University Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

ACUTE MENTAL HEALTH UNIT, CORK UNIVERSITY HOSPITAL

Acute Mental Health Unit, Cork University Hospital, Wilton, Cork

Date of Publication:
Thursday 01 April 2021

ID Number: AC0078

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life

Most Recent Registration Date:
4 February 2020

Conditions Attached:
Yes

Registered Proprietor:
HSE

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

Inspection Team:
Karen Mc Crohan, Lead Inspector
Noeleen Byrne
Rajeev Ramasawmy

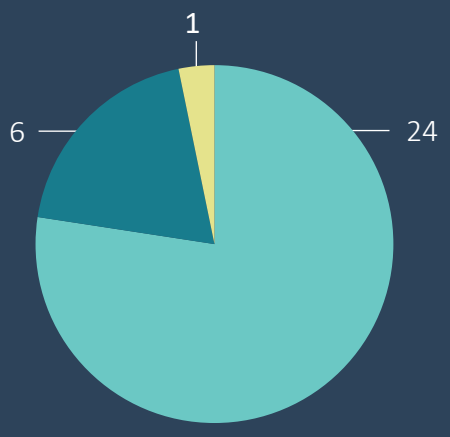
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
15 – 18 September 2020

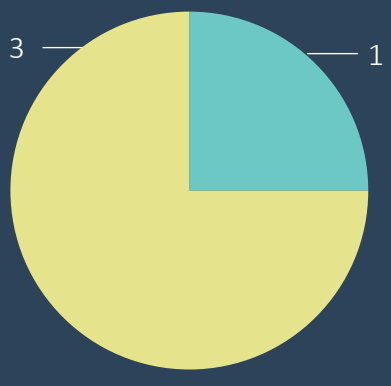
Previous Inspection Date:
8 – 11 October 2019

Inspection Type:
Announced Annual Inspection

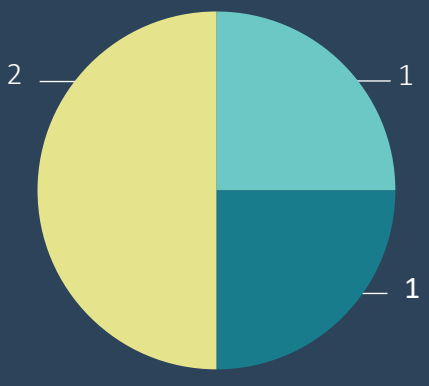
2020 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



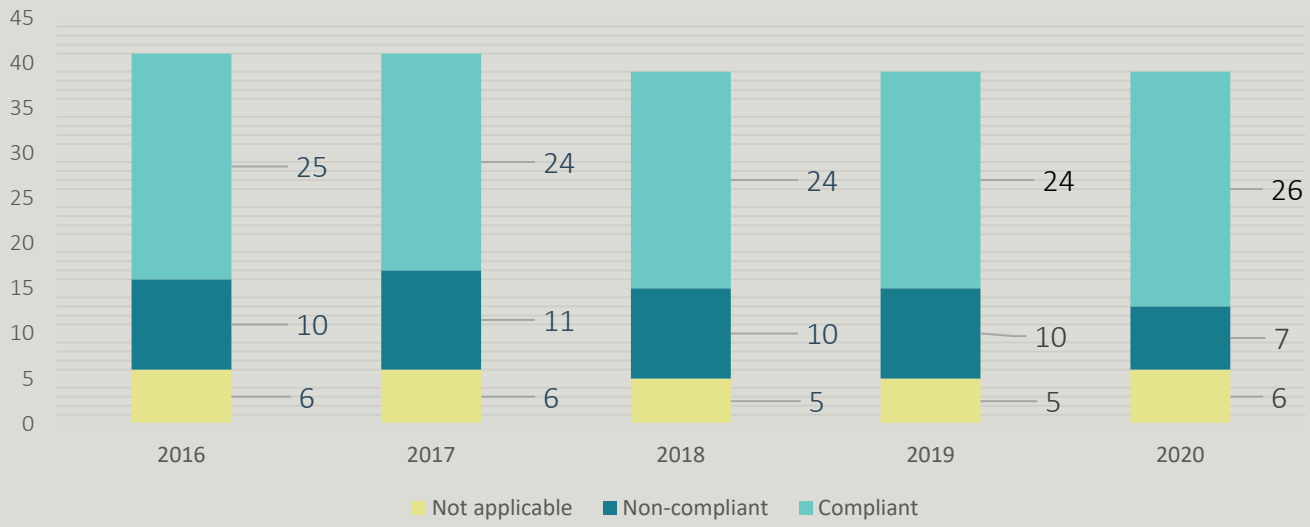
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2016 – 2020

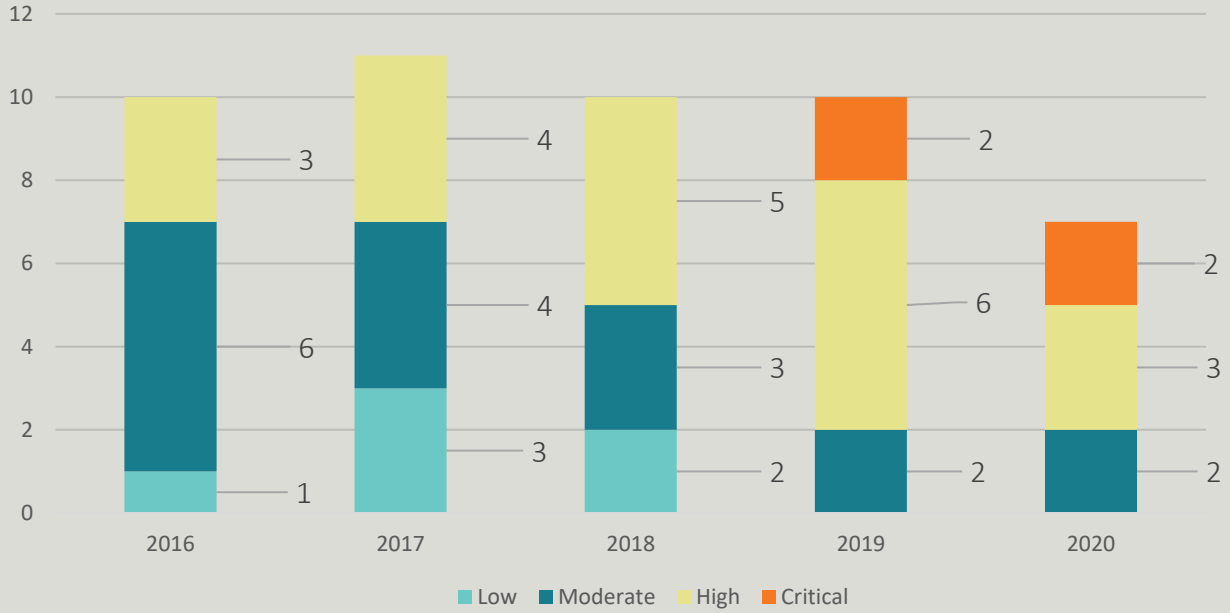
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

The Acute Mental Health Unit (AMHU) was a 50-bed unit and provided inpatient beds for the population of South Lee catchment area in Cork. It was located within the grounds of Cork University Hospital's campus in Wilton, Cork city. It contained three units: the acute male unit (West Ward), the acute female unit (East Ward) and the psychiatry of later life (POLL) unit. There was an additional six-bed high observation area on the ground floor but was not functioning as such; instead, the six beds were being used as additional beds for the admissions unit.
The approved centre used an in-reach model of care, with eight multi-disciplinary sector teams. The multi-disciplinary team specialities included General Adult and Psychiatry of Later Life team.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	71%	69%	71%	71%	79%
Regulations Rated Excellent	0	4	5	7	N/A

Conditions to registration

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

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

Finding on this inspection: The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 15: Individual Care Plan at the time of inspection.

Condition 2: *To ensure adherence to Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines, the approved centre shall audit their Medication Prescription and Administration Records (MPARs) on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 2 and the approved centre was non-compliant with Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines 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.
- 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 and stored in a safe manner.

However:

- The administration of medication was not always recorded.

Appropriate care and treatment of residents

- Where vacancies existed across the multi-disciplinary teams, cross cover ensured that all residents' assessed needs were met.
- Therapeutic services and programmes provided by the approved centre were directed toward restoring and maintaining optimal levels of physical and psychosocial functioning of resident and included cooking skills, daily morning exercises, bingo, sensory connections programmes, SONAS, walks, and a sensory room. There was also the use of reminiscence cards and one-to-one art therapy. Prior to pandemic events, there was a wellness and recovery group, a relaxation group, an art therapy in an open studio, and a mindfulness group.
- For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation and blood lipids. However, there was not an annual assessment of ECG (electrocardiogram) in three of the files inspected.

However:

- Residents had limited access to a dietitian, speech and language therapist and physiotherapist on an urgent referral basis only.
- Individual care plans did not meet an acceptable standard:
    - Two ICPs did not adequately contain appropriate goals for the resident.
    - One ICP did not adequately contain care and treatment (interventions) for the resident.
    - One ICP did not adequately contain resources for the resident.
    - One ICP was not in place within seven days.
- The six-monthly general health assessment did not document Body Mass Index (BMI), weight, waist circumference, and blood pressure.
- All residents' records were not in good order as they were very bulky and difficult to follow. They were not maintained in good order as several files had loose pages.

Respect for residents' privacy, dignity and autonomy

- The accommodation consisted of 46 single bedrooms and two double bedrooms, all with en suites.
- 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.
- There was a visiting room where residents could meet their visitors in private.

Responsiveness to residents' needs

- Self-directed activities included TV, boardgames, jigsaw puzzles, and arts and crafts. The approved centre had an exercise room, which had a treadmill, cross trainer, and exercise bike; it also had a foosball table on the ground floor. Recreational groups were facilitated on the male and female units, which included walking groups.
- 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 Cork Kerry Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 4. The approved centre was governed under the Cork Mental Health Service.
- Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation.
- The risk of COVID-19 was actively managed through the approved centre's risk management processes. In response to the COVID-19 crisis, a South Lee COVID-19 Outbreak Management group was established. An Outbreak Management Plan was developed to assist in the local management of COVID-19 within the approved centre. An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.
- The area lead for mental health engagement attended the Cork Mental Health Service Management Team meetings. Within the approved centre, resident and family member engagement was facilitated through regular community meetings, suggestion boxes, and engagement with the complaints process. Formal complaints were reviewed at the Cork Mental Health Service Management Team meetings.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Establishment of three new working groups; Individual Care Planning, Medication and Nursing Documentation.

2. Introduction of revised resident information documentation in relation to diagnosis and medication.

3. Provision of scrubs for staff during COVID-19 as part of an employee safety initiative.

4. Development of an ambulance checklist and resident property form.

5. Implementation of a distressed resident response team pilot.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Acute Mental Health Unit (AMHU) provided inpatient beds for the population needs of the South Lee catchment area in Cork. It was a secure unit located within the grounds of Cork University Hospital's campus in Wilton, Cork city. The purpose-built, two-storey building had a direct entrance; with a large reception area, which was staffed 24 hours a day by security personnel.

The approved centre contained three units; the acute male unit (West Ward), the acute female unit (East Ward) and the psychiatry of later life (POLL) unit. There were 50 beds in total; the accommodation consisted of 46 single bedrooms and two double bedrooms, all with en suites. The acute male and female admission units were located on the ground floor, both units had 18 beds each. There was an additional six-bed high observation area on the ground floor. However, the high observation area was not functioning as such; instead, the six beds were being used as additional beds for the admissions unit. The eight-bed POLL unit was located on the first floor, alongside administration offices and therapy rooms. Residents had access to spacious day rooms, quiet rooms, a gym and a number of internal gardens. The link corridor between the reception hallway and the admissions unit contained interview rooms and three visitors' rooms.

The approved centre used an in-reach model of care, with eight multi-disciplinary sector teams. The multi-disciplinary team specialities included General Adult and Psychiatry of Later Life team.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**45**
Number of detained patients	9
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	7
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Cork Kerry Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 4. The approved centre was governed under the Cork Mental Health Service. The Cork Mental Health Service Management Team convened on a monthly basis. The meeting minutes evidenced discussions on key topics such as risk management; quality and patient safety; compliance; mental

health engagement and finance and service planning. The Cork Mental Health Service Quality and Safety Committee met bi-monthly. Local governance was enhanced by a monthly Acute Mental Health Unit (AMHU) Local Management meeting, which had multi-disciplinary attendance. The AMHU Local Management meeting was a forum to discuss local operational issues such as risks, including COVID-19; staff training; bed capacity and compliance. The findings from various working groups were also discussed at the AMHU Local Management meeting. This included the audit, policy and individual care plan working groups. Furthermore, the approved centre had a local incident meeting, in which the frequency was recently augmented from quarterly to monthly. The approved centre maintained relationships with University Hospital Cork through contact with their Clinical Director.

Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk management procedures did not actively reduce an identified risk to the lowest practicable level of risk. A serious reportable event, pertaining to a fall which resulted in a fracture, was not reported to the Mental Health Commission within 48 hours. Furthermore, the incident was not reviewed in line with the HSE's Incident Management Framework.

The risk of COVID-19 was actively managed through the approved centre's risk management processes. In response to the COVID-19 crisis, a South Lee COVID-19 Outbreak Management group was established. At the onset of the COVID-19 crisis, the COVID-19 Outbreak Management group convened weekly, which was subsequently reduced to fortnightly. The approved centre implemented the HSE/Health Protection Surveillance Centre (HPSC) *Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic setting* guidance document. An Outbreak Management Plan was developed to assist in the local management of COVID-19 within the approved centre.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. Where vacancies existed, across the multi-disciplinary teams, cross cover ensured that all residents' assessed needs were met. However, residents had limited access to a dietitian, speech and language therapist and physiotherapist on an urgent referral basis only.

The area lead for mental health engagement attended the Cork Mental Health Service Management Team meetings. Within the approved centre, resident and family member engagement was facilitated through regular community meetings, suggestion boxes, and engagement with the complaints process. Formal complaints were reviewed at the Cork Mental Health Service Management Team meetings.

This inspection highlighted some improvement, as the approved centre's number of non-compliances had reduced from ten (2019) to seven (2020). Management had monitored performance through key performance indicators; compliments and complaints; incident reports and audit findings. Despite the previous inspection findings, pertaining to Regulation 15 Individual Care Plans; Regulation 23 Ordering, Prescribing, Storing, and Administration of Medicines and Regulation 27 Maintenance of Records, reoccurring issues had not been addressed. Furthermore, Regulation 27 Maintenance of Records was a reoccurring non-compliance, as the clinical files were not maintained in good order, which had resulted in a designated critical risk rating in 2019 and 2020.

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	
Regulation 15: Individual Care Plan	✗	High	✗	High	✗	High	✗	Critical	✗	High
Regulation 19: General Health	✓		✗	Moderate	✓		✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High	✗	High	✗	High	✗	High	✗	Critical
Regulation 26: Staffing	✗	Moderate	✗	High	✗	High	✗	High	✗	High
Regulation 27: Maintenance of Records	✗	Moderate	✗	High	✗	High	✗	Critical	✗	Critical
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	Moderate
Code of Practice on the Use of Physical Restraint	✗	High	✗	Low	✗	Low	✗	High	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
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.

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.

One resident requested to speak with the inspection team. The resident reported that the unit was noisy at night. Four service user-questionnaires were returned to the inspection team. The feedback was mainly positive, in which all residents reported that they always felt safe. One of the residents reported that they would like more group activities.

The Irish Advocacy Network (I.A.N) provided the inspection team with a report on the approved centre. This report was compiled from resident feedback to the I.A.N. The positive aspects of the approved centre, reported by residents, included the variety of therapy classes provided and the availability of smaller day rooms. Art therapy was reported to be excellent. Furthermore, residents described the nursing staff, healthcare assistants and cleaning staff as very caring. In terms of areas requiring improvement, some residents reported that they did not know who their consultant was and did not know when their consultant would be visiting the approved centre next.

6.0 Feedback Meeting

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

- Registered Proprietor
- Interim Clinical Director / Executive Clinical Director
- Area Administrator
- Acting Area Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker
- Principal Psychologist
- Assistant Director of Nursing
- Clinical Nurse Manager III

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. Any relevant information provided to the inspection team at the feedback meeting was included within the report.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals and a source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre. For residents with special dietary requirements, their 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 in the approved centre, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. 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 had procured a new food trolley since the previous inspection and no issues were noted.

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. At the time of the inspection, no residents wore nightclothes during the day.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in June 2020.

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 and 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. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan 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 on weekdays and weekends. Self-directed activities included TV, boardgames, jigsaw puzzles, and arts and crafts. The approved centre had an exercise room, which had a treadmill, cross trainer, and exercise bike; it also had a foosball table on the ground floor. Recreational groups were facilitated on the male and female units, which included walking groups.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in June 2020. Visiting times were by appointment and lasted a maximum of 30 minutes. Justifications for visiting restrictions implemented for a resident were documented in the clinical file. Three pods were 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; visitors were not permitted on the wards. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting pods were suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in June 2020.

Residents had access to mail, e-mail, internet, and telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The approved centre did not examine incoming and outgoing communications.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in June 2020. 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.

The clinical file of one resident was examined on inspection in relation to the search process. Risk was assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches and the request for consent and the received consent were documented for every search. The resident search policy and procedure was communicated to all residents and relevant staff were documented to have read and understood the policy on searches.

Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched. A

written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in June 2020. The end-of-life care of one resident 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 residents was protected, including provision of a single room within the approved centre during the provision of end of life care. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care.

The end-of-life care of the resident was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the residents' representatives, family, next of kin, and friends. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

The registered proprietor shall ensure that each resident has an individual care plan.

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

INSPECTION FINDINGS

All individual care plans (ICPs) were a composite set of documents. ICPs had allocated space and sections for reviews, were identifiable and uninterrupted, and were stored within the clinical file, and were not amalgamated with progress notes. Five ICPs were inspected. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment; however, one ICP was not in place within seven days of admission. ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

Two ICPs did not adequately contain appropriate goals for the resident, while one ICP did not adequately contain care and treatment (interventions) for the resident. One ICP did not adequately contain resources for the resident. ICPs were reviewed weekly by the MDT in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals. ICPs of child residents included their educational requirements.

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

a) **Two ICPs did not adequately contain appropriate goals for the resident.**
b) **One ICP did not adequately contain care and treatment (interventions) for the resident.**
c) **One ICP did not adequately contain resources for the resident.**
d) **One ICP was not in place within seven days.**

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, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. 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.

The art therapist in the approved centre worked with a facilitator that focused on hearing voices and unusual beliefs. Only individual sessions were run, due to pandemic events. Therapeutic services and programmes provided by the approved centre were directed toward restoring and maintaining optimal levels of physical and psychosocial functioning of resident and included cooking skills, daily morning exercises, bingo, sensory connections programmes, SONAS, walks, and a sensory room. There was also the use of reminiscence cards and one-to-one art therapy. Prior to pandemic events, there was a wellness and recovery group, a relaxation group, an art therapy in an open studio, and a mindfulness group.

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 in June 2020.

The clinical file of a resident who had been transferred from the approved centre was examined on inspection. Full and complete written information for the resident was transferred when they moved from the approved centre. Information accompanied the resident upon transfer, to a named individual. A letter of referral, including a list of current medications, was sent as part of the transfer documentation, as was a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

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

INSPECTION FINDINGS

The approved centre had a medical emergencies policy, which was last reviewed in June 2020.

The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED), both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

On inspection, five clinical files were reviewed. Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly general health assessment documented the physical examination, family and personal history, smoking status, and nutritional status, including sedentary lifestyle. However, not all of the clinical files documented the residents' Body Mass Index (BMI), weight, waist circumference, and blood pressure. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation and blood lipids. However, there was not an annual assessment of ECG (electrocardiogram) in three of the files inspected. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

Residents could access national screening programmes that were available according to age and gender, including Breast Check, cervical screening, retina check (diabetics only), and bowel screening.

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

a) None of the inspected files had BMI, weight, and waist circumference recorded.
b) Two of the files had no blood pressure recorded.
c) Three of the files had no ECG recorded within the clinical file.

Regulation 20: Provision of Information to Residents

COMPLIANT

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in June 2020.

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident, 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 and 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

Residents had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics, and the lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces.

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.

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

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators were guarded. Current national infection control guidelines were followed.

The approved centre was compliant with this regulation.

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

NON-COMPLIANT

Risk Rating CRITICAL

(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. The policy was last reviewed in June 2020 and contained:

- 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.

However, the written policy did not reference appropriate and suitable practices relating to, the recording of administration and the disposal of, Schedule 3 drugs.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident and detailed the following: a record of any allergies or sensitives to any medications, including if the resident had no allergies; the administration route for the medication; 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 of the medical practitioner or nurse prescriber for each entry. However, the MPAR did not detail a record of all medications administered to the resident; one MPAR did not include a record of resident refusals.

All entries in the MPARs 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. When a resident's medication was withheld, the justification was noted in the MPAR and also 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 why the medication was to be crushed, and the medical practitioner documented in the MPAR that the medication was to be crushed. However, the pharmacist was not consulted about the type of preparation to be used. There was no pharmacist assigned to the approved centre.

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. Medication dispensed or supplied to the resident was stored securely in a

locked storage unit, with the exception of medication that was recommended to be stored elsewhere, for example, in a refrigerator.

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

a) **The registered proprietor did not ensure that the approved centre had written operational policies relating to the recording of administration and the disposal of Schedule 3 controlled drugs, 23 (1).**
b) **The registered proprietor did not ensure that one MPAR had accurately signed records of the administration of all medications refused, 23 (1).**

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in July 2020.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the use of CCTV. The policy was last reviewed in July 2020 and included the purpose and function of using CCTV for observing residents in the approved centre.

There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. A resident was monitored solely for the purposes of ensuring the health, safety, and welfare of that resident. The use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras used to observe a resident were incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form, and did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to staffing. The policy was last reviewed in July 2020. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staffing were not sufficient to meet resident needs, as residents in the approved centre had limited access to a dietitian, speech and language therapist, and physiotherapist on an urgent referral basis only. An appropriately qualified staff member was on duty and in charge at all times; this was documented. The Mental Health Commission 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 available to staff throughout the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) & 26(5) have been 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	0
Clinical Nurse Manager (CNM) 3	1	0
Clinical Nurse Manager (CNM) 2	3	1
Registered Psychiatric Nurse	11	8
Healthcare Assistants	1	1
Occupational Therapist	1	0
Activities Nurse (CNM) 2	1	0

Ward or Unit Breakdown			
Ward or Unit	Staff Grade	Day	Night

West Ward (Male)	Clinical Nurse Manager 2 Registered Psychiatric Nurse	1 4	1 (shared) 3

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
East Ward (Female)	Clinical Nurse Manager 2 Registered Psychiatric Nurse	1 4	1 (shared) 3

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Psychiatry of Later Life	Clinical Nurse Manager 2 Registered Psychiatric Nurse Healthcare Assistants	1 3 1	 2 1

In-reach to Approved Centre*			
	Staff Grade	**Day**	**Night**
	Consultant Psychiatrist	14	On Call
	Non Consultant Hospital Doctor	16	On Call
	Social Worker	1 per MDT	0
	Psychologist	1 per MDT	0

Whole time equivalent (WTE); Multi-disciplinary Team (MDT); Clinical Nurse Manager (CNM)

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

The approved centre was non-compliant with this regulation because residents within the approved centre had limited access to a dietitian, speech and language therapist, and physiotherapist on an urgent referral basis only, 26 (2).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating CRITICAL

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in July 2020 and included:

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

Not all residents' records were secure, up-to-date, in good order, and constructed, maintained, and used in accordance with national guidelines and legislative requirements. Several clinical files were bulky and information was difficult to locate within the file. All resident records were physically stored together. 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. However, due to the amount of information presented within the clinical files, the records were difficult to follow.

All records were not maintained in good order, as several clinical files had loose pages. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use; there was a press in the office and secure offsite storage facilities in this regard. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

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

a) **All residents' records were not secured and in good order as they were very bulky and difficult to follow.**
b) **Residents' records were not maintained in good order as several files had loose pages.**

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 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process. The resources and facilities were provided by the approved centre to support patients accessing Mental Health Tribunals remotely.

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 July 2020 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

Information displayed on noticeboards in the approved centre informed residents, their representatives, family, and next of kin of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented and all non-minor complaints 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 resident’s individual care plan (ICP). Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them, and this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating **MODERATE**

(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 comprehensive written operational policy and procedures in relation to risk management. The policy was last reviewed in August 2018 and addressed all policy related regulatory requirements, including:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. However, the risk management procedures did not actively reduce identified risks to the lowest practicable level of risk; a serious reportable event, pertaining to a fall which resulted in a fracture, was not reported to the Mental Health Commission within 48 hours. Furthermore, the incident was not reviewed in line with the HSE 's Incident Management Framework.

Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation; health and safety risks were documented within the risk register, as appropriate. 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 documented in the risk register.

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

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; information provided was anonymous at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and included evacuation procedures.

The approved centre was non-compliant with this regulation because a serious reportable event, pertaining to a fall which resulted in a fracture, was not reported to the Mental Health Commission and was not reviewed in line with the HSE's Incident Management Framework, 32 (1).

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 with two conditions to registration attached. The certificate was displayed prominently in the main reception area.

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)

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

a) the patient gives his or her consent in writing to the continued administration of that medicine, or

b) where the patient is unable to give such consent –

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. Following administration of medication for a continuous period of three months, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment or equivalent. The patient was deemed to lack capacity to consent to treatment.

A Form 17, for the administration of medicine for more than three months to an involuntary patient, contained the following: the name of the medication(s) prescribed; confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medication(s); and details of the discussion with the patient. While the patient was assessed as being able to understand the nature, purpose, and likely effects but was unwilling to consent to the continued administration of the medication(s), the treatment could be discontinued immediately if the consultant psychiatrist considered that it was in the best interests of the patient; this was recorded in the clinical file.

After a three month period, the administration of medication may only be continued if it was approved and authorised by two consultant psychiatrists as set out in Form 18.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

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

NON-COMPLIANT

Risk Rating **MODERATE**

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 July 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 one patient who was physically restrained was examined on inspection. Physical restraint (PR) was used in rare, exceptional circumstances and was in the best interests of the resident, where the resident posed an 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. PR was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using PR. PR was initiated by a registered medical practitioner (RMP), a registered nurse (RN) or other members of the multi-disciplinary team (MDT) in accordance with the policy on PR. There was a designated staff member responsible for leading in the physical restraint 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 patient no later than three hours after the start of the episode of PR. PR last for a maximum of 30 minutes. The episode was also recorded in the clinical file. The Clinical practice form (CPF) was completed by the person initiating and ordering the use of PR no later than three hours after the episode. The CPF was signed by the CP within 24 hours. However, the resident was not informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of PR unless the information may be prejudicial to the resident's mental health, well-being or emotional condition. The reason for not informing the resident was not documented 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. A same sex staff member was present at all times during the use of PR. The resident was afforded the opportunity to discuss the episode with members of

the MDT involved in their care. The completed CPF was placed in the clinical file. Each episode of PR was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was non-compliant with this code of practice because there was no documentary evidence that one resident was informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint, 5.8.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in October 2019, included all of the policy-related criteria for this code of practice.

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

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

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

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

Evidence of Implementation:

Admission: A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the presenting problem, past psychiatric history, and medical history. The resident's family member, carer, or advocate was involved in the admission process, with resident consent.

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

Discharge: The resident's discharge plan included the following: estimated date of discharge; documented communication with the relevant general practitioner, primary health care team, and Community Mental Health Care Team; a follow up plan; and, a reference to early warning signs of relapse and risks. The discharge meeting was attended by residents, relevant members of the multi-disciplinary team, and family, carer, or advocate, where appropriate. The discharge assessment included psychiatric and psychological needs, current mental state examination, and a comprehensive risk assessment and risk management plan. Discharge was coordinated by a key worker. A preliminary discharge summary was sent to the general practitioner, primary care team, and Community Mental Health Care Team within

three days. A comprehensive discharge summary was issued within 14 days. Discharge summaries included diagnosis, prognosis, and medication. A family member, carer, or advocate was involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001513		**Two ICPs did not adequately contain appropriate goals for the resident. One ICP did not adequately contain care and treatment (interventions) for the resident. One ICP did not adequately contain resources for the resident. One ICP was not in place within seven days.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Weekly Audit carried out to include 3 charts from each team and individual feedback provided to each team. Should an ICP not be in place within 7 days, and incident form is complete and CD notified	weekly audits	These Audits are being conducted weekly-achieved	31/03/2021	The ICP committee nominates 1-2 people to conduct the ICP audits for a month at a time. Clinical Director
Preventative Action	Training: ICP training has taken place with NCHD's (including Jan 2021 cohort) MDT ICP Training has been provided by 2 Clinical Psychologists. Monthly MDT ICP Meeting to review audits, training. ICP Lead identified for each MDT	all actions have been acheived as follows: Training complete on 23/09/2020 and 01/10/2020 further training planned when level 5 restrictions cease. ICP Lead identified - achieved and on-going (Minutes available). Achieved and on-going	acheived	31/01/2021	ICP Leads. Consultant Psychiatrist has delivered ICP training Consultant Psychiatrist

Regulation 19: General Health					
Reason ID : 10001517		None of the inspected files had BMI, weight, and waist circumference recorded. Two of the files had no blood pressure recorded. Three of the files had no ECG recorded within the clinical file.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	New proforma for admission. Physical exam currently in final stage of development. Audit regarding 6 monthly physicals to ensure all components addressed	New proforma.3 monthly audit of admission physical and 6 monthly physical exam.	achievable.	31/03/2021	Clinical Director in conjunction with identified Consultant Psychiatrist and NCHD on rotation
Preventative Action	New Proforma being introduced with all items on this preform. Audit of 6 monthly physical	3 monthly audit of admission physical and 6 monthly physical exam.	achievable	31/03/2021	Clinical Director in conjunction with identified Consultant Psychiatrist and NCHD on rotation

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10001521		**The registered proprietor did not ensure that one MPAR had accurately signed records of the administration of all medications refused, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1. Policy regarding Medication management has been fully reviewed and accepted by MHC 2. Nurse training has taken place re MPAR'S and Controlled Drugs 3. Monthly Audit of MPAR'S	1. Complete- submitted to MHC 2. Complete and on-going. 3. Monthly Audit of MPAR'S	Achieved in September 2020 and ongoing	30/09/2020	1. Consultant Psychiatist, ADON and CNM3 2.ADON 3. Consultant Psychiatist and ADON
Preventative Action	Monthly audit of MPARS	monthly audit	Achieved	31/01/2021	Identified Consultant Psychiatrist and CNM3

Regulation 26: Staffing					
Reason ID : 10001522		**Residents within the approved centre had limited access to a dietitian, speech and language therapist, and physiotherapist on an urgent referral basis only, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Senior SLT now in post in AMHU. Physiotherapy referrals can be made to Cork University Hospital. Urgent dietetic referrals facilitated by CUH for eating disorders. Eating Disorder Dietician for Cork Kerry Community Healthcare has been approved and recruitment will begin. Access to dietetics has been placed on the risk register and escalated to Head of Service. Head of Service has approved access to private dietician if timely access to dietician cannot be delivered by CUH.	Confirmation of funding received. Staff advised of availability of private dietician and process to access same.	Achieved. Funding available and recruitment process due to commence in relation to the dietetics post.	30/06/2021	SLT Manager, Dietetic Manager, CUH Physiotherapy Department
Preventative Action	SLT post in place. Access to	Montly review of risk register	Achieved with monthly review of risk register	31/01/2021	A/Head of MHS

	physiotherapy in place. Access to urgent dietetics and access to dietician placed on risk register which is reviewed monthly Access to private dietician if timely access to dietician cannot be delivered by CUH.				

Regulation 27: Maintenance of Records					
Reason ID : 10001523		**All residents' records were not secured and in good order as they were very bulky and difficult to follow. Residents' records were not maintained in good order as several files had loose pages.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At time of Inspection, the assigned ward clerk who worked 3 days per week had been sick leave for a period of time. A ward clerk has been employed 5 days a week with a role for addressing file maintenance.	Achieved	Achieved	31/12/2020	Staff Officer
Preventative Action	1. Ward Clerk is in place 2. Maintenance of records audit on-going	2 ward clerks(1 working 3 days and 1 working 2 days and monthly audits in place	achieved, audits ongoing	31/12/2020	MDT Completion of monthly audit

Regulation 32: Risk Management Procedures					
Reason ID : 10001525		**A serious reportable event, pertaining to a fall which resulted in a fracture, was not reported to the Mental Health Commisson and was not reviewed in line with the HSE's Incident Management Framework, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CD and HOD have circulated updated information from the Patient Safety & Risk Advisor, regarding SRE's and the reporting requirement.	complete	acheived	30/09/2020	Clinical Director Heads of Discipline Patient Safety and Risk Advisor
Preventative Action	1. Monthly review of incidents. 2. CNM3 and ADON review incident reports on receipt and escalate any incidents of concern. 3.Risk advisor has agreed further training re SRE's and Incident Reporting.	All have been completed and training has been arranged for April 2021	Achieved and ongoing	30/04/2021	In relation to 1. Clincial Director, Area Administrator,, ADON, CNM3 In relation to 2. CNM3 and Patient Safety and Risk Advisor In relation to 3. CNM3 and Patient Safety and Risk Advisor

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10001506		**There was no documentary evidence that one resident was not informed of reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint, 5.8. In two episodes of physical restraint, the registered medical practitioner did not complete a medical examination of the resident no later than three hours after the start of an episode of physical restraint, 5.4. In two episodes, the clinical practice form was not signed by the consultant psychiatrist within 24 hours, 5.7(c). In three episodes of physical restraint, the resident was not informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint, 5.8. Two episodes of physical restraint were not reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode, 9.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Physical Restraint Booklet which addresses all components of Code of Practice has been introduced	in place	achieved	31/01/2021	Clinical Director and ADON
Preventative Action	Audits on Physical Restraint in line with Code of Practice on Physical Restraint. Training: ADON and CNM3 completed training with nursing on all shifts (day and night shift).	Monthly audits. Audit findings will also inform if more targeted training is required. Training complete with all nursing shifts. Training complete with consultant group.	acheived and ongoing	31/01/2021	CNM2

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

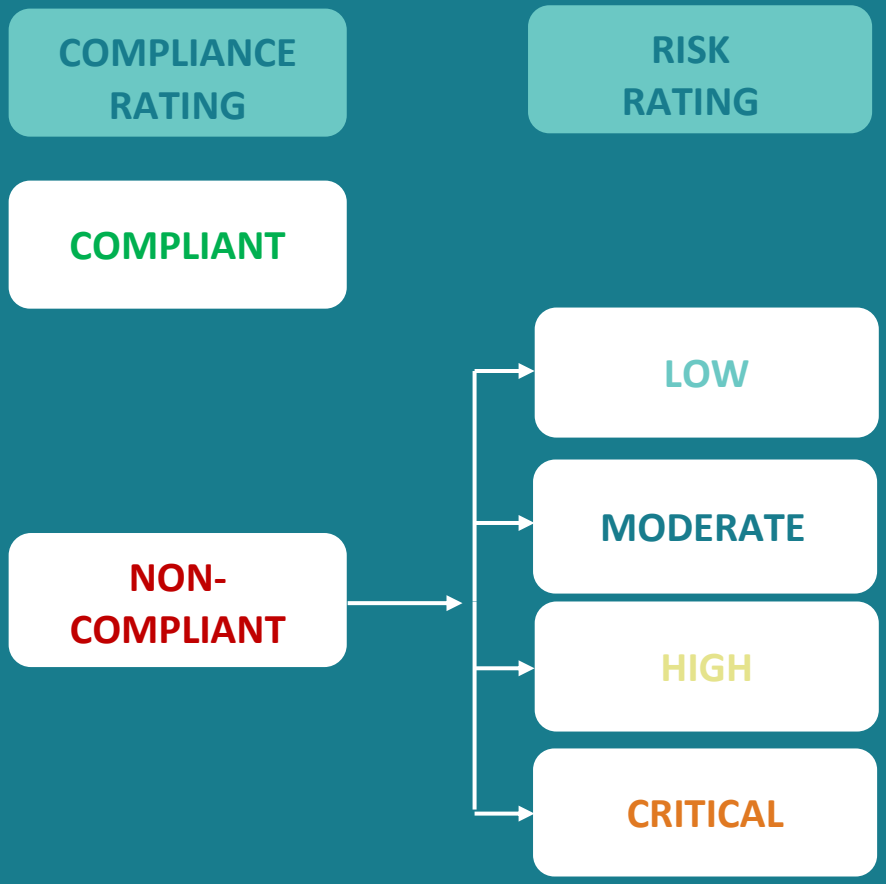
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

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



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

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

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