MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Acute Psychiatric Unit, Tallaght Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

ACUTE PSYCHIATRIC UNIT, TALLAGHT HOSPITAL

Acute Psychiatric Unit, Tallaght Hospital, Tallaght, Dublin 24

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2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care, Continuing Mental Health Care/Long Stay, Psychiatry of Later Life Mental Health Rehabilitation, Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
1 March 2020

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Brady, Head of Service, Mental Health – CHO7

Inspection Team:
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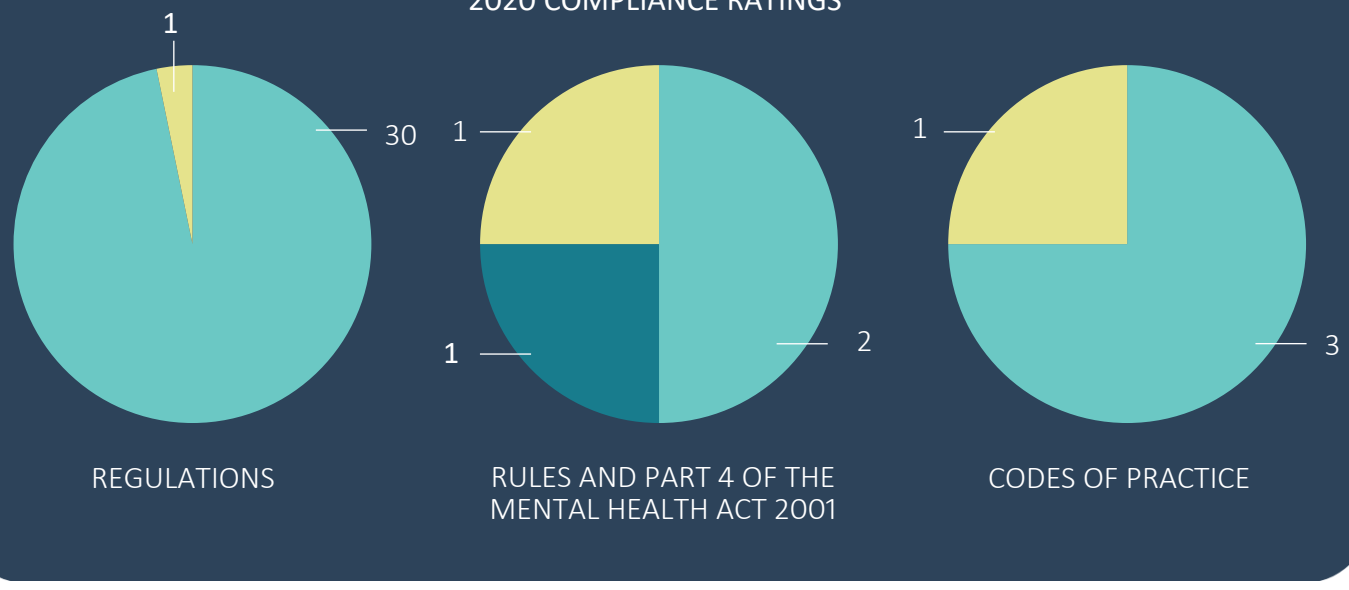
Inspection Date:
21 – 24 July 2020

Previous Inspection Date:
16 – 19 July 2019

Inspection Type:
Announced Annual Inspection

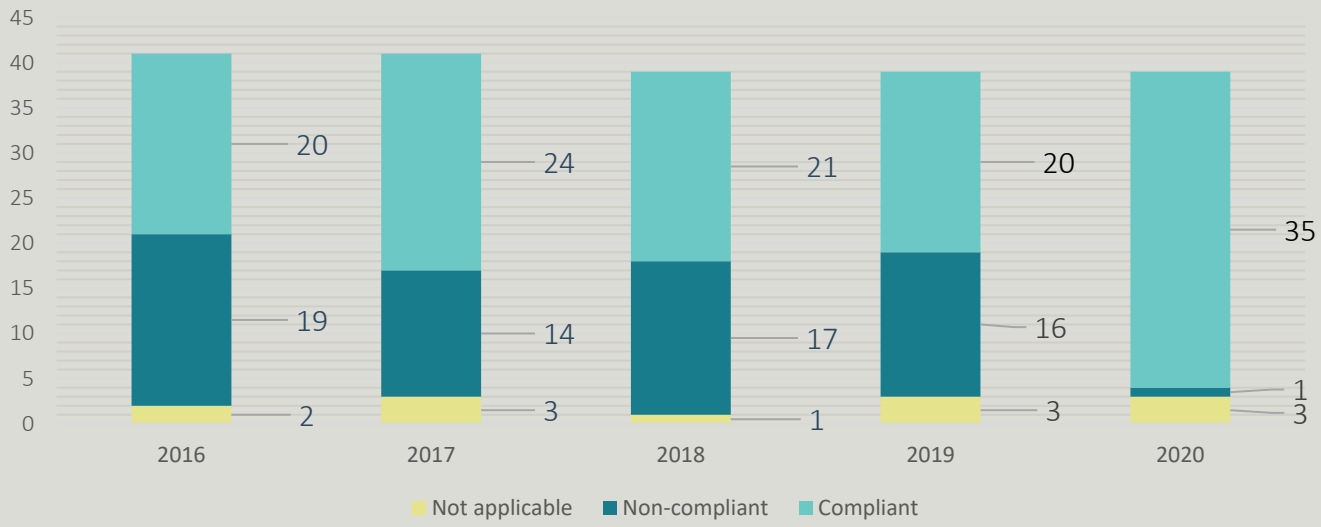
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

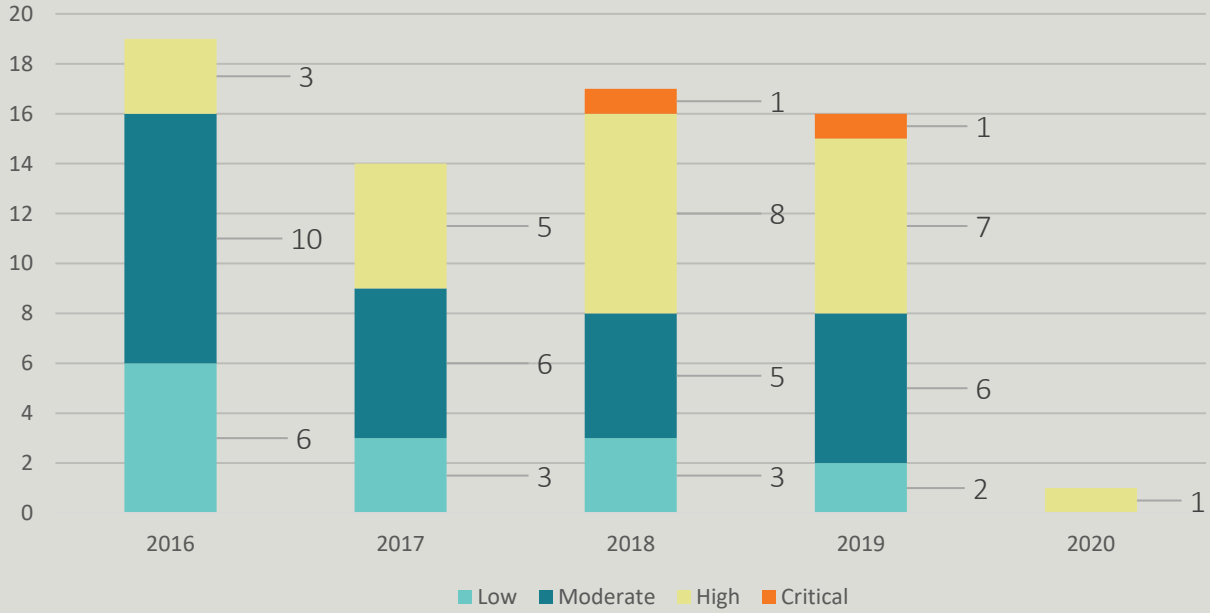
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2016 – 2020



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 approved centre was located on the ground floor of Tallaght University Hospital. The approved centre consisted of three wards: Cedar (female admissions), Rowan (male admissions) and Aspen (high observations), which accommodated 52 residents at full capacity.
The approved centre used an in-reach model of care, with twelve multi-disciplinary teams. However, due to the risk of COVID-19 a reduced number of multi-disciplinary teams were visiting the approved centre. The multi-disciplinary team specialities included General Adult, Psychiatry of Later Life team and Rehabilitation and Recovery team.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	51%	63%	55%	55%	97%
Regulations Rated Excellent	0	1	3	3	N/A

Conditions to registration

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

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

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

Condition 2: *To ensure adherence to Regulation 26(4) and 26(5): Staffing, the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Finding on this inspection: The approved centre was not in breach of Condition 2.

Condition 3: *To ensure adherence to Regulation 19(1)(b): General Health, the approved centre shall audit the provision of six-monthly general health assessments 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.*

Finding on this inspection: The approved centre was not in breach of Condition 3 and the approved centre was compliant with Regulation 19: General Health at the time of inspection.

Condition 4: *To ensure adherence to Regulation 22(3): Premises the approved centre shall develop a costed, funded and time-bound plan for works to be carried out to the seclusion facilities. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation of this plan 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 4 and the approved centre was non-compliant with Rules on the Use of Seclusion and Mechanical Restraint at the time of inspection. It was compliant with Regulation 22: Premises.

Condition 5: *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 5 and the approved centre was compliant with Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines at the time of inspection.

Condition 6*: To ensure adherence to Regulation 27: Maintenance of Records the approved centre shall audit their records and reports 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 6 and the approved centre was compliant with Regulation 27: Maintenance of Records 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. Hygiene was maintained to support food safety requirements.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre.
- There was a minimisation of ligature points to the lowest practicable level, based on risk assessment.
- Medication was ordered, prescribed, stored and administered in a safe manner.

However:

- Not all furniture and fittings were of a design and quality in the seclusion rooms so as not to endanger patient safety; hard edges were observed around the windows in both seclusion rooms.

Appropriate care and treatment of residents

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident.
- External therapeutic services included music therapy, and yoga. Some externally provided therapeutic services were on hold due to pandemic events, such as dog therapy and Zumba. The psychology service provided a weekly group supporting recovery. Introduction of new activities to the therapeutic programme which included soothing Yoga, Art Therapy and a 'Keeping well during COVID-19' group. In response to the COVID-19 visiting restrictions, the therapeutic programme timetable was expanded to include evenings, Saturdays and Bank Holidays.
- The six monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

- 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.

However:

- Seclusion facilities were not furnished, maintained, and cleaned as the floor of the seclusion room in Rowan Ward was marked and the radiator was dirty. There was graffiti on the bathroom door of the seclusion rooms.

Responsiveness to residents' needs

- Recreational activities included self-directed activities, such as board games, jigsaws, books, TV, and internet. The approved centre also facilitated movie nights and provided access to recreational activities on weekdays and during the weekend.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- Complaints were processed in a timely manner.
- There was a choice of food at mealtimes.

Governance of the approved centre

- The approved centre was part of Dublin South, Kildare & West Wicklow Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 7. The approved centre was governed by the Dublin South Central Mental Health Services.
- In relation to the management of COVID-19, a multi-disciplinary Crisis Management Meeting was established. The meeting included discussions on bed occupancy; COVID-19 testing; visiting restrictions; staff resources; infection prevention and control and training.
- The approved centre had a standardised process for the management of risks and incidents. The risk management procedures actively reduced identified risks to the lowest practicable level of risk.
- The area lead for mental health engagement attended the Dublin South Central Mental Health Area 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 Quality and Patient Safety Committee meeting.
- The approved centre demonstrated a commitment to improving quality. This was evidenced in the approved centre's attainment of two awards for continuous quality improvement in the implementation of the HSE Tobacco Free Campus Policy and the Making Every Contact Count (MECC) initiative.
- Performance was routinely monitored through key performance indicators; compliments, complaints and service user feedback; incident reports and audit findings. The inspection identified a significant

improvement from the previous year as the approved centre's non-compliances reduced from sixteen to one.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Attainment of two awards for continuous quality improvement in the implementation of the HSE Tobacco Free Campus Policy and the Making Every Contact Count (MECC) initiative.

2. Introduction of new activities to the therapeutic programme which included soothing Yoga, Art Therapy and a 'Keeping well during COVID-19' group. Furthermore, in response to the COVID-19 visiting restrictions, the therapeutic programme timetable was expanded to include evenings, Saturdays and Bank Holidays.

3. Development of a Nicotine Replacement Therapy (NRT) Protocol, in conjunction with the Pharmacist and Drugs and Therapeutic Committee in Tallaght University Hospital.

4. Introduction of new seclusion documentation which was developed with multi-disciplinary team input.

5. Completion of individual care plan (ICP) train the trainer training by a cohort of staff.

6. Establishment of a Nutrition and Hydration Steering Group.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the ground floor of Tallaght University Hospital. The unit was clearly signposted and accessible from the main hospital lobby. The approved centre consisted of three wards: Cedar (female admissions), Rowan (male admissions) and Aspen (high observations), which accommodated 52 residents at full capacity.

The accommodation facilities on each of the three wards consisted of shared dormitories, with a limited number of single bedrooms. Cedar and Rowan ward had access to a shared corridor which contained a dining room, laundry room and a variety of multi-functional rooms such as a games room, family room and reading room. An art room, therapy room and snoezelen room were also available for therapeutic activities. The Aspen ward had a separate open plan dining and sitting room. The approved centre had two enclosed gardens; one for both the Cedar and Rowan wards and one for the Aspen ward.

The approved centre used an in-reach model of care, with twelve multi-disciplinary teams. However, due to the risk of COVID-19 a reduced number of multi-disciplinary teams were visiting the approved centre. The multi-disciplinary team specialities included General Adult, Psychiatry of Later Life team and Rehabilitation and Recovery.

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

Resident Profile	
Number of registered beds	***52***
Total number of residents	**29**
Number of detained patients	5
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 Dublin South, Kildare & West Wicklow Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 7. The approved centre was governed by the Dublin South Central Mental Health Services. The Dublin South Central Mental Health Area Management Team meeting convened on a monthly basis, with the exception of one meeting in July 2020. The meeting minutes evidenced discussions on key topics such as risk management; quality and patient safety; finance; service

plans; estates and staff resources. Local governance was further enhanced by a monthly Unit Management Meeting, which had multi-disciplinary attendance. The Unit Management Meeting was a forum to discuss local operational issues such risk management; the tobacco free campus and physical health; compliance, and the approved centre's premises. Due to COVID-19, the Unit Management Meeting was not facilitated between February and July 2020. However, this meeting recommenced in July 2020 via teleconference. A Quality and Safety Committee met monthly, in addition to other additional working groups and committees. Examples included a Nutrition and Hydration Steering Group; Compliance Meeting; Individual Care Planning Meeting and a Policy Meeting. Furthermore, a quarterly Mental Health Integrated Management Group facilitated discussions with Tallaght University Hospital's management team regarding the premises and major capital projects.

In relation to the management of COVID-19, a multi-disciplinary Crisis Management Meeting was established. The Crisis Management Meeting initially convened twice per week but was subsequently reduced to fortnightly. The meeting minutes demonstrated discussions on bed occupancy; COVID-19 testing; visiting restrictions; staff resources; infection prevention and control and training. This meeting was utilised as a forum to communicate updates between the various multi-disciplinary teams as the number of teams visiting the approved centre was reduced due to COVID-19. For a short period of time, at the peak of the COVID-19 crisis, the bed capacity of some of the shared dormitories was reduced to facilitate increased social distancing. In response to COVID-19 visiting restrictions, the therapeutic programme timetable was expanded, to include evenings, Saturdays and Bank Holidays, and the Tobacco Free campus was temporarily suspended.

The approved centre had a standardised process for the management of risks and incidents. The risk management procedures actively reduced identified risks to the lowest practicable level of risk. Issues pertaining to the internal doors, COVID-19; staff resources, ligatures and the current seclusion facilities were some of the risks identified by the heads of disciplines.

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. Health and social care disciplines, including occupational therapy, psychology and social work, were accessible to all residents.

The area lead for mental health engagement attended the Dublin South Central Mental Health Area 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 Quality and Patient Safety Committee meeting.

The approved centre demonstrated a commitment to improving quality. This was evidenced in the approved centre's attainment of two awards for continuous quality improvement in the implementation of the HSE Tobacco Free Campus Policy and the Making Every Contact Count (MECC) initiative. Performance was routinely monitored through key performance indicators; compliments, complaints and service user feedback; incident reports and audit findings. The inspection identified a significant improvement from the previous year as the approved centre's non-compliances reduced from sixteen to one.

3.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Rules Governing the Use of Seclusion	✗	Low	✗	High	✗	High	✗	High	✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, 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.

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.

No resident, of the approved centre, requested to speak with the inspection team during the inspection. However, during the walkabout, the inspection team spoke with one resident informally and they were very complementary of the care and treatment received. Eleven completed service user experience questionnaires were returned to the inspection team. The questionnaire feedback was all positive in which the service was described as 'wonderful' and 'brilliant'. One questionnaire noted that the nursing staff within the approved centre were very busy.

The inspection team did not receive any feedback from the Irish Advocacy Network in relation to the approved centre.

6.0 Feedback Meeting

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

- Head of Mental Health (Registered Proprietor)
- Clinical Director
- Director of Nursing
- Principal Clinical Psychologist
- Occupational Therapy Manager
- Dietetic Manager
- Assistant Director of Nursing
- Clinical Nurse Manager III (Nominated Contact)

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, 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 and residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. 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 September 2019. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile, including self-directed activities, such as board games, jigsaws, books, TV, and internet. The approved centre also facilitated movie nights and provided access to recreational activities on weekdays and during the weekend.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

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 September 2019. At the time of the inspection, all visits to the approved centre had been stopped due to pandemic events and infection control measures. There was a separate visitors' room available in the approved centre and this was suitable for 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 2018. Residents had access to mail, a phone and internet unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others.

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 September 2018 and included all requirements related to:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

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. Where consent was not received, this was documented and the process relating to searches without consent was implemented. A written record was kept of all environmental searches.

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 April 2019. No deaths had occurred in the approved centre since the previous inspection and no end of life care was provided.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinic file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT weekly, in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate, 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.

Activities were provided directly by occupational therapy or by external providers under their management. External therapeutic services included music therapy, and yoga. Some externally provided therapeutic services were on hold due to pandemic events, such as dog therapy and Zumba. In the context of pandemic events, occupational therapy group work had been limited and replaced by more one-to-one interventions. The psychology service provided a weekly group supporting recovery.

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 July 2017. The clinical file of one resident who had been transferred was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer, to a named individual, including a letter of referral that contained a list of current medications, a resident transfer form, and the required medication for the resident during the transfer process.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a medical emergencies policy, which was last reviewed in July 2017. The approved centre had an emergency trolley and staff had access at all times to an AED, both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Three clinical files were examined in relation to provision of general health services during the inspection process. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing, e.g. lab results. Residents could access national screening programmes according to age and gender, including Breast Check, retina check, cervical screening, and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre and residents had access to smoking-cessation supports.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in April 2019. The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information is clearly and simply written. It contained details of: housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and, residents' rights.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

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. 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. Though some minor issues were noted, these had also been noted by service management and were in the process of being resolved at the time of the inspection. 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 and 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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident, and; a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in May 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 procedure on the use of CCTV. The policy was last reviewed in April 2019. The policy 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 or other monitoring systems 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

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to staffing. The policy was last reviewed in October 2019. 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 sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times. This was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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**
Director of Nursing	1	-
Assistant Director of Nursing	1	-
Clinical Nurse Manager 3	1	1
Clinical Nurse Manager 2	3	-
Clinical Nurse Manager 1	3	-
Registered Psychiatric Nurse	10	8
Healthcare Assistant	3	-
Occupational Therapist	2	-
Dietitian	0.5	-

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Cedar Ward	Clinical Nurse Manager 2	1	-
	Clinical Nurse Manager 1	1	-
	Registered Psychiatric Nurse	4	3
	Healthcare Assistant	1	-

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Rowan Ward	Clinical Nurse Manager 2	1	-
	Clinical Nurse Manager 1	1	-
	Registered Psychiatric Nurse	4	3
	Healthcare Assistant	1	-

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
Aspen Ward	Clinical Nurse Manager 2	1	-
	Clinical Nurse Manager 1	1	-
	Registered Psychiatric Nurse	2	2
	Healthcare Assistant	1	-

In-reach to Approved Centre*			
	Staff Grade	**Day**	**Night**
	Consultant Psychiatrist	16	1
	Non Consultant Hospital Doctor	22	1
	Social Worker	7	-
	Psychologist	10	-

Whole time equivalent (WTE)

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

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in October 2019. Resident records were secure, up-to-date, and were physically stored together in a secure office on each ward. All resident records were reflective of the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up-to-date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 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, including remote access to the tribunals. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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 June 2018 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. 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.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented 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 ICP. Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them: this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management as well as a Safety Statement. The policy and Safety Statement were last reviewed and dated October 2019. The risk management policy and associated safety statement addressed all requirements.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

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

Health and safety risks were identified, assessed, treated, reported, monitored and documented within the risk register as appropriate. Incidents were recorded and risk-rated in a standardised format and all

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also 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.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated April 2020. It contained protocols that were developed in line with best international practice, including:

- The storage of Dantrolene.
- The management of cardiac arrest.

Training and Education: All staff involved in ECT had been trained in line with best international practice. Similarly, all staff involved in ECT had appropriate training in Basic Life Support techniques documented.

Evidence of Implementation: The approved centre had a dedicated ECT suite, which included appropriate waiting and recovery facilities. There was a facility for monitoring EEG on two channels and materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, a record of maintenance was kept, and there was confirmation of servicing of ECT machines. The approved centre had up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia prominently displayed. There was a named consultant psychiatrist (CP) in the approved centre with overall responsibility for ECT management, and a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical record of one involuntary patient receiving ECT was reviewed. As the patient had been assessed as not having capacity to provide consent, ECT was administered according to section 59(1)(b) of the Mental Health Act 2001, and a *Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent* was completed by two consultant psychiatrists. The Form 16 was placed in the patient's clinical file and a copy was sent to the Mental Health Commission within five days. Both CPs assessed and recorded how ECT would benefit the patient, any discussion with and views expressed by the patient, any assistance provided in relation to the discussion and views expressed, and the patient's capacity to consent to ECT. The patient was informed of their right to access an advocate of their choosing at any stage. Each session of ECT was documented in the clinical file together with details of the dose and duration of seizure attained.

A pre-anaesthetic assessment was also recorded in the patient's clinical file and included all requirements, such as a duration of fasting, detailed medical history and full physical exam. Anaesthetic risk was assessed and recorded by the anaesthetist, and the variation in risk was recorded before the ECT treatment. A consistent anaesthetic induction agent was used throughout the programme of ECT, unless contraindicated. The doses of anaesthetic agents used, the patient's response, the monitoring of recordings before and after treatment, and the patient's recovery were recorded, dated, signed and placed in the clinical file by the anaesthetist.

The ECT was only given by a registered medical practitioner and was administered by constant current, brief pulse ECT machine. The stimulus dosing, or recommended starting dose regimes, as relevant, was used and documented in the ECT record.

The approved centre was compliant with this rule.

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion, which was last reviewed in October 2019. The policy addressed the following:

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

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

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: Seclusion facilities were not furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, as the floor of the seclusion room in Rowan Ward was marked and the radiator was dirty. Residents in seclusion did not have access to adequate toilet and washing facilities as there was graffiti on the bathroom door of the seclusion rooms. Not all furniture and fittings were of a design and quality so as not to endanger patient safety; hard edges were observed around the windows in both seclusion rooms. The seclusion room was not used as a bedroom.

One episode of seclusion was reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests, when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage resident's unsafe behaviour were considered.

Seclusion was initiated by a registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion. The seclusion order did not last longer than eight hours and the resident was informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless detrimental to the resident. The resident was informed of the ending of an episode of

seclusion and cultural awareness and gender sensitivity was demonstrated. Residents' clothing respected their right to dignity, bodily integrity, and privacy.

A registered nurse undertook direct observation for the first hour following the initiation of a seclusion episode, with continuous observation thereafter. A written record of the resident's well-being was made by a nurse every 15 minutes, including the level of distress and behaviour displayed by the resident. Following risk assessment, a nursing review took place every two hours. During this review, at least two staff entered the seclusion room. A medical review of the patient was undertaken no later than four hours after the commencement of the episode of seclusion and reviewed every four hours.

The seclusion initiation was recorded in a clinical file and seclusion register by the person who initiated seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of the episode. A copy of the seclusion register was placed in the clinical file. The episode was reviewed by members of the multi-disciplinary team and documented in clinical file within two working days.

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

a) **Residents did not have access to adequate toilet facilities, as there was graffiti evident on the door of the Seclusion bathroom, 8.1.**
b) **Seclusion fittings were not maintained and cleaned to ensure respect for resident dignity because the floor of the Seclusion room in Rowan ward was marked and the radiator unit in the Seclusion room in Rowan ward was dirty, 8.2.**
c) **The hard edges around the windows in both seclusion rooms meant that the fittings were not of a sufficient quality so as to ensure patient safety, 8.3.**

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. There was documented evidence that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment and that the patient was able to consent.

A written record of consent contained the names of the medications prescribed; a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications, and; details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the patient in relation to the discussion and their decision-making.

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated October 2019. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.

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.

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

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

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

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

The approved centre was compliant with this code of practice.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated April 2019. It contained protocols that were developed in line with best international practice, including:

- The procedure for the storage of Dantrolene.
- Management of cardiac arrest.
- Management of anaphylaxis.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had responsibility for ECT management, and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The file of one voluntary patient who had received ECT was reviewed. The patient had received appropriate verbal and written information explaining the nature, purpose, and side-effects of the treatment proposed and was informed of their right to access an advocate of their choosing. An assessment of capacity to consent was undertaken and documented. Evidence of systematic monitoring on cognitive functioning throughout the programme of ECT was documented.

There was documented evidence that a cognitive assessment, in line with best international practice, had been completed after each programme of ECT. A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the resident's clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with each resident and their next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical files, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in September 2017, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in July 2017, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in March 2020, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of a resident who had been discharged evidenced a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and relevant members of the multi-disciplinary team. A preliminary discharge summary had been sent to the relevant agencies and a comprehensive discharge

summary had been sent within 14 days that detailed diagnosis, prognosis and medication. As applicable, a follow up appointment had been arranged for the resident.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Rules Governing the Use of Seclusion					
Reason ID : 10001563		**Residents did not have access to adequate toilet facilities, as there was graffiti evident on the door of the Seclusion bathroom, 8.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Hygiene services unable to remove graffiti despite repeated attempts using different cleaning agents. Request to Technical Services Department (TSD) to paint over graffiti - they advised that painting not compatible with the finish on the door. Above revisited when draft inspection report was issued. No change in the above. Water proof health promotion sticker/notice fixed to door covering graffitied area.	Monitored by CNM3 via the CAPA's	Achieved	25/01/2021	CNM 2 Rowan ward
Preventative Action	A daily environmental check is carried out on all the units by the CNM1 / Nurse in Charge. It Identifies damages and hazards on the unit in real time. The CNM/ Nurse in Charge logs a work request to TSD to repair/review/replace item as soon as practicable. The CNM 2 is cc into the correspondence.	Daily environmental checksof the unit Communal areas shared by Cedar and Rowan staff	Achievable,ongoing	25/01/2021	CNM1 / CNM2 / Nurse in Charge
Reason ID : 10001564		**Seclusion fittings were not maintained and cleaned to ensure respect for resident dignity because the floor of the Seclusion room in Rowan ward was marked and the radiator unit in the Seclusion room in Rowan ward was dirty, 8.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Hygiene services attempted to clean the stained floor and radiator unit. Industrial chemicals were used with	Painting request logged on the Minor maintenance works	Achievable, ongoing	19/04/2021	ADON/ CD/ CNM 2/ 3

	minimal affect. Flooring and radiator unit permanently stained. TSD contacted re painting the radiator unit. Seclusion refurbishment works due to commence in April 2021 depending on Covid restrictions and outbreak control measures.	spreadsheet. Maintenance meetings with ADON and TSD track and follow up works that have been requested ensuring they are time bound.			
Preventative Action	Bi monthly Maintenance Meetings with ADON and TSD to monitor Minor maintenance works. Minutes and Actions recorded	Bi monthly maintenance meetings Issues with maintenance addressed at the monthly Unit Management Meetings	Achievable, ongoing	15/04/2021	ADON/ TSD
Reason ID : 10001565		**The hard edges around the windows in both seclusion rooms meant that the fittings were not of a sufficient quality so as to ensure patient safety, 8.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The service accepts that the seclusion facilities are not of a sufficient quality as to ensure patients safety. A purpose built seclusion suite in Aspen unit has been planned developed and funded. Work is due to start in April 2021 depending on Covid restrictions and outbreak control measures.	Project planning complete. Work due to start in April 2021 (builders currently on site working on Cedar en suite works). Monitoring of the Seclusion refurbishment project is tracked on the Major Maintenance Spreadsheet	Achievable	30/07/2021	Financial manager/ CD/ Area DON/ DON
Preventative Action	Extensive research has been carried out in the development and planning of the seclusion suite with regard to patient safety with the design and fixtures	Seclusion works are tracked on the Major Maintenance Spreadsheet Updates	Achievable	30/07/2021	Financial Manager/ CD/ Area DON/ DON/ ADON

	agreed. Recently built seclusion facilities were examined to select the optimal design and fixture for patient safety, privacy and dignity. Advice from the MHC was sought. Several Approved Centres were visited to get direct feedback on these designs. The Rules and COP around Seclusion was examined to ensure compliance	are discussed at the QPS meetings			

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.

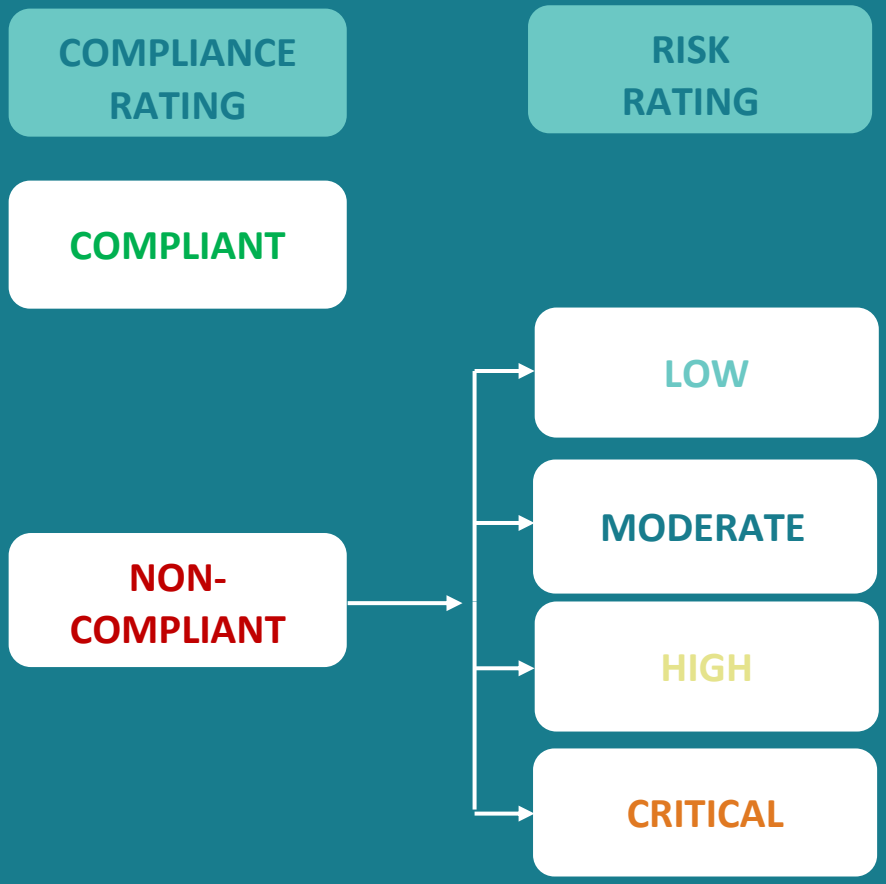
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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