Centre for Mental Health Care and Recovery, Bantry General Hospital

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mental health commission

Annual Inspection Report 2021

Promoting Quality Safety and Human Rights in Mental Health

CENTRE FOR MENTAL HEALTH CARE AND RECOVERY, BANTRY GENERAL HOSPITAL

Centre for Mental Health Care & Recovery, Bantry General Hospital, Bantry, Co. Cork

Date of Publication:
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2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

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

Inspection Team:
Karen Mc Crohan, Lead Inspector
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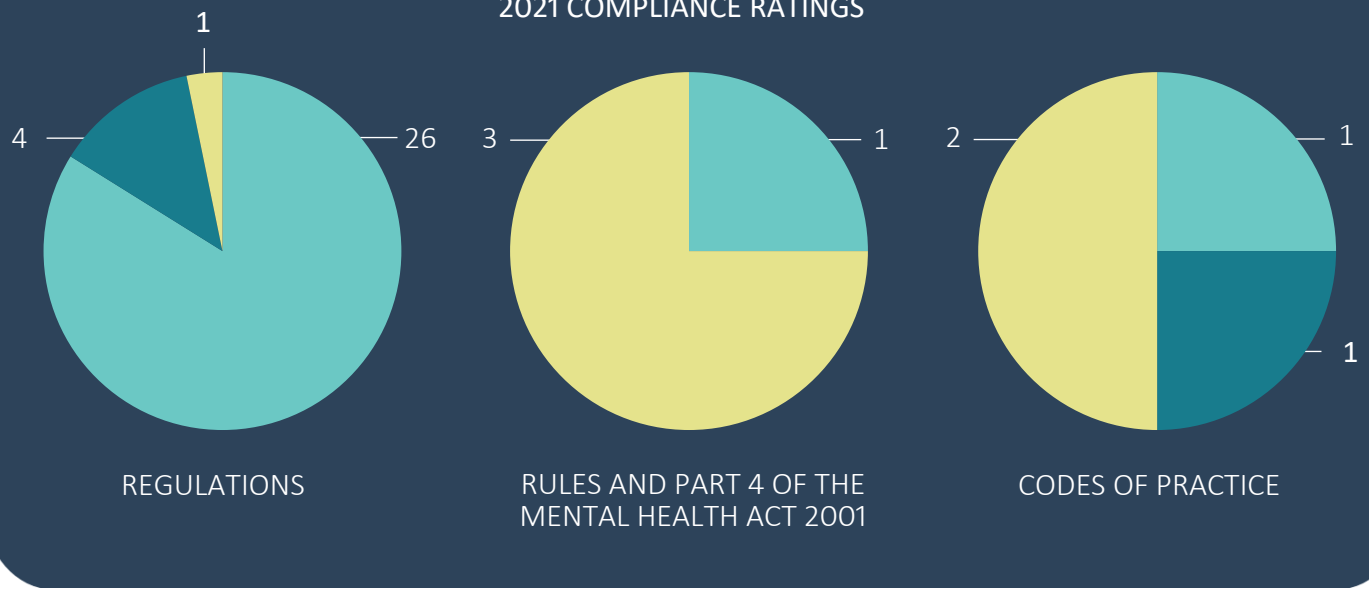
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
11 – 14 May 2021

Previous Inspection date:
18 – 20 August 2020

Inspection Type:
Announced Annual Inspection

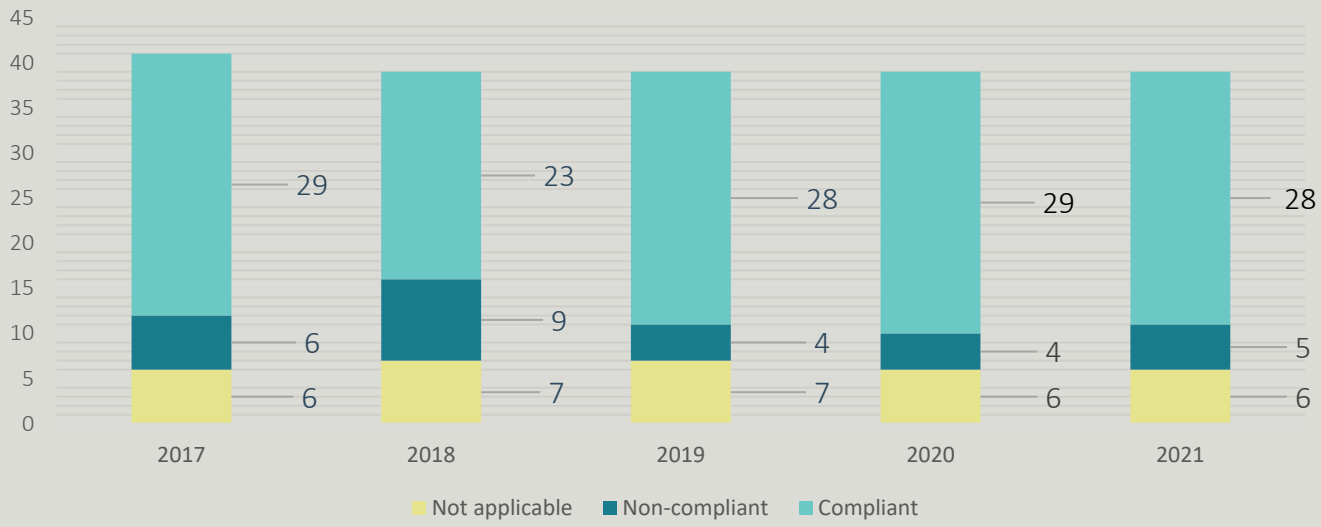
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

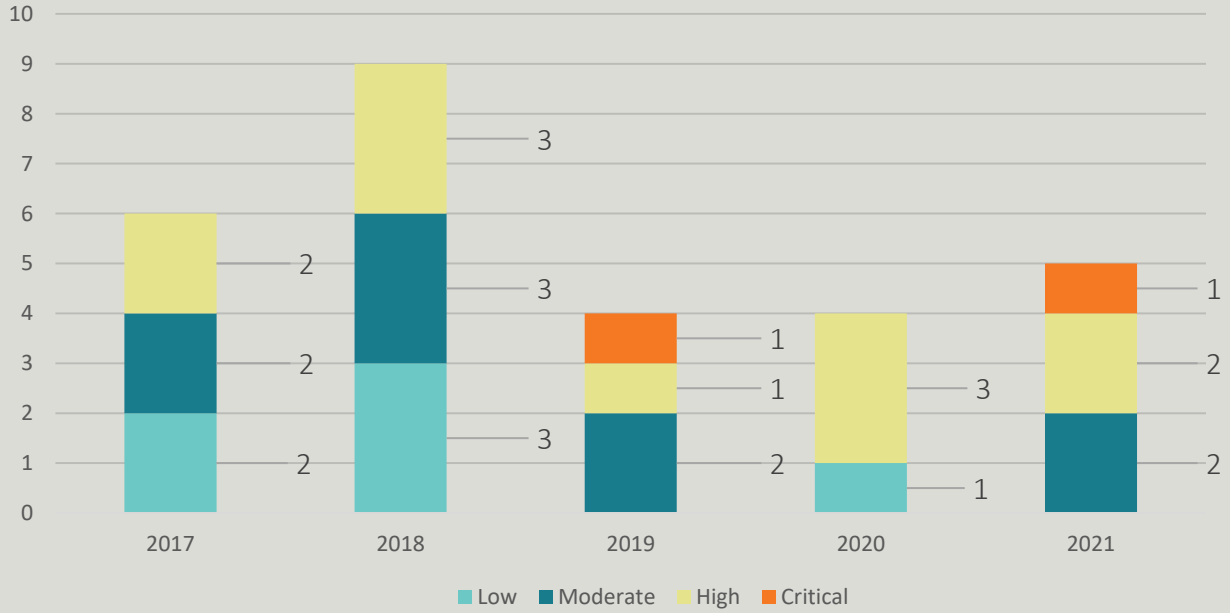
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2017 – 2021



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

The Centre for Mental Health Care and Recovery provided acute mental health care and was located on the grounds of Bantry General Hospital. The approved centre was an 18-bed, three-storey building with the main clinical area and sleeping accommodation located on the upper floor. The dining room and staff offices were located on the ground floor, with the occupational therapy room and resident garden on the lower ground floor.

The approved centre served West Cork, which included the wider areas around Skibbereen, Clonakilty/Dunmanway, and Bantry. Three multi-disciplinary teams were responsible for the care and treatment of the residents within the approved centre.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	83%	72%	88%	88%	85%
Regulations Rated Excellent	5	5	7	N/A	N/A

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

Conditions to registration

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

Escalation and enforcement actions since last inspection

There were no escalation or enforcement action in place at the time of inspection.

In response to the critical risk found in relation to Regulation 22: Premises on this inspection, the Mental Health Commission took enforcement action of an Immediate Action Notice. Enforcement action is ongoing.

Safety in the approved centre

We found that the approved centre had safe practices to reduce the risk of harm, but the structure of the approved centre posed significant risk to residents by the presence of ligature anchor points.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- 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.
- Medication was ordered, prescribed, stored, and administered in a secure and safe manner.

However, numerous ligature anchor points were present throughout the approved centre and were not minimised to the lowest practicable level based on risk assessment.

Appropriate care and treatment of residents

We found that although the provision of therapeutic programmes was good, there were inadequacies in assessment, monitoring, and care planning for residents.

- Residents had access to one-to-one occupational therapy, social work, and psychology based on their assessed needs. The therapeutic programme was facilitated by the occupational therapist. At the time of the inspection, group activities included coping skills, relaxation, mindfulness, a gardening group, a baking group, and goal setting for discharge and maintaining well-being.

However:

- The standard of the residents' individual care plans inspected was poor and not reflective of recovery principles.

- The six-monthly health assessment did not record body mass-index, weight, and waist circumference and, therefore, did not adequately monitor for metabolic syndrome.
- The clinical file of one resident's admission was inspected in relation to the admission process. The admission assessment did not include past psychiatric history, family history, medical history, or current and historic medication.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre was too small and cramped to provide care that respected residents' dignity.

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

However:

- Residents did not have access to appropriately sized bedrooms. In particular, space within the four-bedded dormitories was limited, which did not adequately address resident needs.
- Residents did not have access to appropriately sized communal rooms.
- The location of the toilets was not appropriate; some residents did not have a toilet near their bedroom, which resulted in them having to walk down the main corridor to access the facilities.
- The CCTV camera, in the main reception area recorded and stored resident images.
- The CCTV monitor in the main reception area was viewable by security personnel in the approved centre and main general hospital.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of residents.

- The approved centre provided access to recreational activities on weekdays and during the weekend. This included movie evenings, art classes online, individual crafts and hobbies such as knitting, cross word and other types of puzzles, felting, and word searches. Books and DVDs were available to residents.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

- The approved centre was part of Cork Kerry Community Healthcare Organisation. The approved centre was governed under the Cork Mental Health Service. There was also a Quality and Patient Safety Committee for West Cork.
- At the time of the inspection, one sector had a social work vacancy and efforts were being made to fill that post. In the interim, all referrals for social work within that sector were reviewed by the Principal Social Worker. There were difficulties in recruiting non-consultant hospital doctors (NCHDs).
- Identified risks were documented in the approved centre's local risk register and escalated to the Cork Mental Health Service risk register as required.
- The approved centre's policies were developed by the local policy and procedures committee and reviewed within the specified timeframe of three years.
- The approved centre's audit group met quarterly to oversee the established audit schedule.
- The area lead for Mental Health Engagement was a member of the Cork Mental Health Service Management Team and attended local meetings by invitation. Feedback from the area lead for Mental Health Engagement was that there was a good recovery ethos within the approved centre and that residents felt empowered.
- A representative from the Irish Advocacy Network (IAN) was available to speak with residents weekly. This was facilitated via zoom during the COVID-19 pandemic. Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement.
- The approved centre's complaints process was publicised and accessible to residents and their representatives.

COVID-19 response

- In response to the COVID-19 pandemic, the approved centre initially established a weekly COVID-19 meeting. These meetings have since ceased but the approved centre had plans to reconvene as and when required.
- Due to the COVID-19 pandemic, therapeutic groups were restricted to four people and some of these programmes were delivered on a one-to-one basis based on need.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of the National Early Warning Score (NEWS) chart and NEWS staff training. The NEWS was a track and trigger scoring system used by healthcare professionals when recording residents' vital signs.

2. Establishment of a resource library for residents, staff, and students.

3. Introduction of new recreational and therapeutic activities such as art therapy and a movie evening.

4. Development of a revised resident property checklist to improve the process.

5. Introduction of a new resident money handling system.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Centre for Mental Health Care and Recovery was located on the grounds of Bantry General Hospital. The approved centre was a three-storey building, with the main clinical area and sleeping accommodation located on the upper floor. Resident accommodation comprised of three single bedrooms, two two-bedded rooms, one three-bedded room, and two four-bedded rooms. The dining room, the Mental Health Act Tribunal facility, and staff offices were located on the ground floor, with the occupational therapy room and resident garden on the lower ground floor. Access to the approved centre was via the ground floor, where there was a reception area and a security lobby.

The approved centre served West Cork, which included the wider areas around Skibbereen, Clonakilty/Dunmanway, and Bantry. Three multi-disciplinary teams were responsible for the care and treatment of the residents within the approved centre.

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

Resident Profile	
Number of registered beds	***18***
Total number of residents	**6**
Number of detained patients	1
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Cork Kerry Community Healthcare Organisation. The approved centre was governed under the Cork Mental Health Service. The Cork Mental Health Service Management Team convened monthly and the Cork Mental Health Service Quality and Safety Committee met bi-monthly. The West Cork management team managed the approved centre and the surrounding community mental health services. The West Cork Mental Health Services Management team meetings were scheduled bi-monthly. However, the most recent meetings were held in March 2021 and October 2020, as the January 2021 meeting was cancelled. There was also a quarterly Quality and Patient Safety Committee meeting for West Cork.

The approved centre's staffing numbers and skill mix was sufficient to meet resident needs. Three multi-disciplinary teams were responsible for the care and treatment of the residents within the approved centre.

This included medical, nursing, occupational therapy, social work, and psychology staff. At the time of the inspection, one sector had a social work vacancy and efforts were being made to fill that post. In the interim, all referrals for social work within that sector were reviewed by the Principal Social Worker in which cover was arranged. All healthcare staff were trained in the Mental Health Act 2001.

The approved centre had a standardised process for the management of risks and incidents. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. Risks were identified, assessed, treated, reported, and monitored. Identified risks were documented in the approved centre's local risk register and escalated to the Cork Mental Health Service risk register as required. In response to the COVID-19 pandemic, the approved centre initially established a weekly COVID-19 meeting. These meetings have since ceased but the approved centre had plans to reconvene as and when required.

The approved centre's policies were developed by the local policy and procedures committee. In accordance with Regulation 29: Operating Policies and Procedures, all required operating policies and procedures were reviewed within the specified timeframe of three years. The approved centre's audit group met quarterly to oversee the established audit schedule.

The area lead for Mental Health Engagement was a member of the Cork Mental Health Service Management Team and attended local meetings by invitation. The area lead for Mental Health Engagement had previously visited the approved centre and had informal interactions with some of the residents. The feedback from the area lead for Mental Health Engagement was that there was a good recovery ethos within the approved centre and that residents felt empowered.

A representative from the Irish Advocacy Network (IAN) was available to speak with residents weekly. This was facilitated via zoom during the COVID-19 pandemic. Resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and representative engagement. The approved centre's complaints process was publicised and accessible to residents and their representatives. Minor complaints had been dealt with and documented. No formal complaints had been submitted to the complaints officer since the last inspection.

Mental Health Commission Governance questionnaires were completed by each head of discipline and returned to the inspection team. Respondents outlined strategic goals for the service and systems to monitor goal progression. Key risks, identified by the heads of disciplines, included the premises and lack of appropriate therapeutic space, the constraints in completing mandatory training due to COVID-19 and the information technology (I.T) infrastructure. Staffing risks were also highlighted, which included the difficulty in recruiting Non-Consultant Hospital Doctors (NCHDs), a social worker vacancy within one of the sectors and the under resourcing of occupational therapy.

The approved centre had no conditions attached to its registration with the Mental Health Commission. The 2021 annual inspection of the approved centre resulted in the identification of five non-compliances. Regulation 22: Premises was risk rated as critical, as it was a reoccurring high risk non-compliance, and Regulation 15: Individual Care Plans (ICPs) was risk rated as high. Enforcement action by the Mental Health Commission resulted in immediate action notices being issued to the Registered Proprietor for both non-

compliances in May 2021.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 15: Individual Care Plans	✓		✓		✓		✓		✗	High
Regulation 19: General Health	✓		✗	Moderate	✓		✗	Low	✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	High	✗	Critical
Regulation 25: Use of Closed Circuit Television	✗	High	✓		✓		✓		✗	High
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	Moderate	✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team 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.

Two completed service user experience questionnaires were returned to the inspection team. Feedback from the residents was mixed. On a scale of 1-10, with 1 being poor and 10 being excellent, the residents' rating for their overall experience of care and treatment ranged from three to eight. No resident requested to speak with the inspection team during the inspection.

5.2 Advocacy

The Irish Advocacy Network (IAN) representative provided the inspection team with a report on the approved centre. This report was compiled from resident feedback to the IAN. Positive aspects of the service identified by residents were that staff were kind and that the residents could relate to other people who were admitted to the unit. Some residents described the involvement of the gardai in their admission to the approved centre as 'trouble', and the impact of the COVID-19 restrictions on residents was highlighted.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Team Coordinator
- General Manager
- A/General Manager
- Area Administrator
- Assistant Director of Nursing
- Clinical Nurse Manager II
- Staff Officer
- Occupational Therapy Manager
- Principal Social Worker
- Principal Clinical Psychologist

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

Each resident was readily identifiable by staff when receiving medication, health care, and other services. The approved centre used a minimum of two appropriate resident identifiers, and these were: resident date of birth and resident medical record number. The identifiers, detailed in each resident's clinical file, were checked when staff administered medications, undertook medical investigations, and provided 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 choices within the approved centre. Food was properly prepared and comprised of servings from different food groups as per the Food Pyramid. Residents received at least two choices for meals. Residents had sufficient supplies of safe and fresh drinking water from water dispensers in corridors which were easy to access. The needs of residents identified as having special nutritional and dietary requirements were assessed, addressed, and documented 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 appropriate and adequate catering equipment, crockery, and cutlery to suit the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

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 did not wear nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with emergency personal clothing that was appropriate and considered their preferences, dignity, bodily integrity, and religious and cultural practices.

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 policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in June 2020. Residents could bring in personal property and possessions on admission, and these were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP).

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The approved centre had secure facilities for the safe-keeping of residents' valuables.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a range of recreational activities appropriate to the resident group profile during the week and at the weekend. This included movie evenings, individual crafts, and hobbies such as knitting, cross word and other types of puzzles, felting, and word searches. Books and DVDs were available to residents. Artists who had worked in the mental health area for many years provided art classes online.

At the time of the inspection, there was no exercise equipment or exercise classes, and residents were unable to go out for walks due to COVID-19 precautions. However, residents did have access to a large outdoor area.

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

There was a written policy and procedures in relation to visits. The policy was last reviewed in June 2020. Visitors were permitted to come to the approved centre on compassionate grounds only, due to COVID-19 precautions. There was a separate visitor rooms available where private visits could take place on compassionate grounds, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during these visits. The visiting rooms were suitable for child visitors.

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 policy and procedures in relation to resident communication. The communication policy was last reviewed in June 2020. Residents had access to postal mail, the individual ward's cordless telephone, and the approved centre's electronic tablet with internet access. The approved centre did not have Wi-Fi enabled internet at the time of the inspection. There were no restrictions on resident's communication at the time of the inspection. The senior staff member only examined incoming and outgoing resident communication when applicable- specifically if there was reasonable cause to believe the communication may 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 in relation to the implementation of resident searches. The policy was last reviewed in June 2020.

The resident search policy and procedure was communicated to all residents, and staff were able to articulate the searching processes as set out in the policy. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file of one resident who was searched was inspected. The resident’s consent was sought and documented prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during the search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident’s dignity and privacy. One of the staff members who conducted the search was of the same gender as the resident being searched.

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 in relation to caring for residents who are dying. The policy was last reviewed in March 2020. As no resident had died since the last inspection, compliance for this regulation was assessed on the basis of policy alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Five ICPs were inspected. All ICPs were a composite set of documentation, with allocated space and sections for goals, treatment, care, resources required, and reviews. ICPs were stored within the clinical file, were identifiable and were not interrupted. ICPs were not integrated with progress notes.

Four ICPs did not identify appropriate goals for the resident. Four ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Four ICP's did not identify the resources required to provide the care and treatment. Three individual care plans were not developed, reviewed, or updated by the multi-disciplinary team.

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. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

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

a) **Four individual care plans did not identify appropriate goals for the residents.**
b) **Four individual care plans did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.**
c) **Four individual care plans did not identify the resources required to provide the care and treatment.**
d) **Three individual care plans were not developed, reviewed, or updated by the multi-disciplinary team.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. Residents had access to one to one occupational therapy, social work and psychology based on their assessed needs.

The therapeutic programme was facilitated by the occupational therapist. At the time of the inspection, group activities included coping skills, relaxation, mindfulness, and goals setting for discharge and maintaining well-being. There was also a gardening group and a baking group. Due to the COVID-19 pandemic, groups were restricted to four people and some of these programmes were delivered on a one to one basis based on need.

The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

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 a written operational policy and procedures in relation to the transfer of residents. The policy was last reviewed in June 2020.

The clinical file of one resident who had been transferred from the approved centre to another facility in a non-emergency situation was inspected. Full, complete, and relevant written information about the resident was transferred to the receiving hospital. The transfer documentation included a resident transfer form and a letter of referral including a list of current medication.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for responding to medical emergencies. The policy was last reviewed in June 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED).

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Only one resident had been in the approved centre for over six months and their clinical file was inspected. This resident had received a six-monthly general health assessment. Residents received appropriate general health care interventions in line with individual care plans.

The six-monthly general health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, but it did not record body mass-index (BMI), weight, nor waist circumference. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

An electrocardiogram (ECG) heart function assessment was completed on residents who were taking antipsychotic medication and their glucose, blood lipids, and prolactin levels were checked. Residents could access national screening programmes according to age and gender, including retina check for diabetics only.

The approved centre was non-compliant with this regulation because the six-monthly general health assessment did not measure and record the resident's body mass index, weight, and waist circumference, 19 (1)(b).

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

Residents were provided with an information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be damaging 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 residents' 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

Staff interacted with residents in a respectful manner. Staff were discreet when discussing the resident's condition and treatment needs. Staff were dressed respectfully, and they sought the resident's permission before entering their room.

All bathrooms, showers, and toilets had locks on the inside of the door, unless there was an identified risk to a resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating CRITICAL

(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

The approved centre was adequately lit, heated, and ventilated. The temperature was centrally controlled. It was clean, hygienic, and free from offensive odours. Appropriate signage and sensory aids were provided to help residents in finding their way around the approved centre.

There was an adequate number of toilets and showers for residents to use. However, the location of the toilets was not appropriate, having regard to the needs of residents in the approved centre. Some residents did not have a toilet near their bedroom, which resulted in them having to walk down the main corridor to access the facilities.

Residents had sufficient outdoor space to move about in, with a large well maintained garden and table tennis area. Within the approved centre, residents did not have access to appropriately sized bedrooms. In particular, space within the four-bedded dormitories was limited, which did not adequately address resident needs.

Residents did not have access to appropriately sized communal rooms. At the time on the inspection, there were only six residents in the approved centre but the approved centre was registered with the Mental Health Commission to provide care and treatment to up to 18 residents at any one time. Residents had access to a sitting room, which could accommodate six residents, allowing for social distancing due to the COVID-19 pandemic. Occassionally, residents did not have access to the sitting room when it was utilised by the multi-disciplinary team for meetings. Residents also had access to the Bantry Bay lift corridor area, which was a small alcove with limited seating. The approved centre had a large occupational

therapy room on the lower ground floor. However, this was only accessible if there was an occupational therapist present.

At the time of the inspection, the environment was not maintained with due regard to the safety of residents as numerous ligature points were present throughout the approved centre and were not minimised to the lowest practicable level based on risk assessment.

The approved centre had a dedicated sluice room and cleaning room. The approved centre provided suitable furnishings to support resident independence and comfort and provided assisted devices and/or equipment to address resident needs.

The approved centre has been non-complaint with Regulation 22: Premises since 2016.

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

a) **The location of the toilets was not appropriate, having regard to the needs of residents in the approved centre. Some residents did not have a toilet near their bedroom, which resulted in them having to walk down the main corridor to access the facilities, 22 (3).**
b) **Residents did not have access to appropriately sized bedrooms. Space within the four-bedded dormitories was limited, which did not adequately address resident needs, 22 (3).**
c) **Residents did not have access to appropriately sized communal rooms. Residents had access to a sitting room, which could only accommodate six residents allowing for social distancing due to the COVID-19 pandemic.**
d) **The registered provider did not ensure that the environment was maintained with due regard to the safety of residents as ligature points were not minimised to the lowest practicable level, 22 (3).**

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 operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in March 2020.

Five Medication Prescription and Administration Records (MPARs) were reviewed on inspection, and these were the MPARs of residents who were in the approved centre for less than six months. All MPARs included: a record of any allergies or sensitivities to any medications, including if residents had no allergies; administration route of the medication; a record of all medications administered to the residents and a clear record of the date of discontinuation for each medication. The Medical Council Registration Number (MCRN) and signature of every medical practitioner prescribing medication to the residents were documented as required.

All entries in the five MPARs were legible. When a resident's medication was withheld, the justification was noted in the MPAR and 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. Where medication required refrigeration, a log of the temperature of the refrigeration unit was taken daily. Medication dispensed to the resident was stored securely in a locked storage press unless it required refrigeration.

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 a safety statement relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in June 2020.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating HIGH

(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 policy and procedures on the use of CCTV. The CCTV policy was last reviewed in June 2020. The policy articulated the purpose and function of using CCTV for observing residents in the approved centre.

The Mental Health Commission had been informed about the approved centre's use of CCTV. There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. Residents were monitored solely for the purposes of ensuring their health, safety, and welfare.

The CCTV camera, in the main reception area, was capable of recording and storing resident images. The recordings were stored for approximately 30 days and were automatically destroyed thereafter. The CCTV monitor in the main reception area was viewable by security personnel in the approved centre and main general hospital. Therefore, the CCTV monitor was not viewed solely by the healthcare professionals responsible for the residents.

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

a) **The CCTV camera, in the main reception area, was capable of recording and storing resident images, 25(d).**
b) **The CCTV monitor in the main reception area was viewable by security personnel and was not viewed solely by the healthcare professionals responsible for the residents, 25(a).**

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 staffing policy in place, which was last June 2020. The policy covered information and procedures in relation to the recruitment, selection and Garda vetting requirements.

An appropriately qualified staff member was on duty at all times, and this was documented on the nursing roster. The numbers and skill mix of staffing were sufficient to meet resident needs. The approved centre had three multi-disciplinary teams (MDT's). This included medical, nursing, occupational therapy, psychology, and social work staff.

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) have been deferred until 2022.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (24)	24	100%
Medical (8)	8	100%
Occupational Therapist (4)	4	100%
Social Worker (4)	4	100%
Psychologist (4)	4	100%

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 creation of, access to, retention of and destruction of records. The policy was last reviewed in June 2020.

All residents' records were secure, up to date, in good order, with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements.

Resident records were reflective of their status and the care and treatment being provided. Resident records were developed and maintained to a logical sequence, with no loose pages. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation relating to 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 and up-to-date register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 to the Mental Health Act 2001.

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

Operating policies and procedures required by the regulations were all reviewed within the required three-year time frame.

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 adequate facilities and resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend a Mental Health Tribunal as required. Resources and facilities were provided by the approved centre to support patients accessing Mental Health Tribunals remotely (online).

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 in relation to the management of complaints. The policy was last reviewed in June 2020. The policy covered the process for the management of 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, the complaints manager, who was based in the approved centre and who was responsible for dealing with all complaints in the approved centre. The complaints procedure including how to contact the complaints manager was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. 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.

All oral and written complaints were handled promptly, appropriately, and sensitively. Minor complaints and formal complaints were documented in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan.

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 untohouse 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

There was a comprehensive written policy in relation to risk management and incident management processes, which was last reviewed in June 2020. The policy included all of the policy related regulation requirements, including:

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

The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to episodes of physical restraint, and at resident admission, transfer, and discharge. These assessments were completed in

conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were effectively mitigated and minimised in the approved centre.

The requirements for the protection of vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions.

A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate and indemnity scheme statement was available 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 which was displayed prominently in the main reception.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 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 inspected. The consultant psychiatrist had undertaken a capacity assessment. The patient consented to receiving treatment. There was a written record of consent which contained all of the required information.

The written record of consent detailed: the names of the medication(s) prescribed, confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medication.

Details of discussions with the patient were documented, including:

- The nature and purpose of the medications.
- The effects of the medication(s), including any risks and benefits, and any views expressed.
- Any supports provided to the patient in relation to the discussion and their decision-making.

The approved centre was compliant with this regulation.

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: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in March 2021. The policy covered:

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

Training and Education: There was a written record that all staff involved in physical restraint had read and understood the policy.

Monitoring: An annual report was submitted to the Mental Health Commission (MHC) on the use of physical restraint.

Evidence of Implementation: The clinical file of one resident who had been physically restrained was inspected. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident's unsafe behaviour.

Cultural awareness and gender sensitivity were demonstrated in the episode of physical restraint. The resident's next of kin were informed about the physical restraint. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered medical practitioner (RMP), and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the resident within the stipulated timeframe of three hours after the start of the episode of physical restraint.

The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed

by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **MODERATE**

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 a series of separate written policies in relation to admission, transfer, and discharge. The admission and discharge policies were each last reviewed in March 2021 and the transfer policy was last reviewed in June 2020. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident's admission was inspected in relation to the admission process. Their admission was because of a mental illness. The resident was assigned a keyworker. The resident's family member was involved in the admission process with the resident's consent. The resident received an admission assessment, which included: presenting problem, current mental state, and a risk assessment. The resident received a full physical examination. The admission assessment did not include past psychiatric history, family history, medical history, nor current and historic medication.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a keyworker. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident's family. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to primary care within 3 days. A comprehensive discharge summary was issued to relevant personnel within 14 days. The discharge summary included details of diagnosis, prognosis,

medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names, and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was non-compliant with this code of practice because the admission assessment did not include past psychiatric history, family history, medical history, current and historic medication, 15(3).

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10002054		**Four individual care plans did not identify appropriate goals for the residents. Four individual care plans did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Four individual care plans did not identify the resources required to provide the care and treatment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All ICP's were reviewed to ensure ICP's were appropriately set for the service user. Memo issued to All MDT members within CMHCR. Monthly ICP Audits ICP issues highlighted at every sector MDT meeting ICP working group in place.	ICP audits continue monthly. Sample ICP's developed and forwarded to MHC.	The Actions proposed are achievable and realistic	30/07/2021	ICP working group Chair supported by local management & MDT members
Preventative Action	ICP working group in place with focus on appropriate client needs noting in particular emphasis on: Goals Care & Treatment Required Resources MDT review & participation. Specific ICP teaching sessions being considered by the group.	The progress and effectiveness with be monitored by Audit. Random Spot checks are also being considered by ICP group.	The Work on the ICP group is ongoing and members are committed to establishing compliance and ensuring appropriate ICP's are in place for all residents.	30/11/2021	ICP Working Group supported by Local management team and all MDT members.

Reason ID : 10002057		Three individual care plans were not developed, reviewed, or updated by the multi-disciplinary team.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Memo issued to all MDT members for CMHCR residents care plans. Monthly ICP Audit completed. ICP issues highlighted at every sector MDT meeting. ICP working Group created to focus on ICP practices.	Memo issued 24th May 2021. ICP Audits completed monthly. MDT meetings occur weekly. ICP working group meets monthly to review issues and audit results	The Actions proposed are achievable and realistic	30/07/2021	ICP Working Group Chair supported by local management & MDT members
Preventative Action	ICP Working group in place which is tasked with reviewing the ICP's within the approved centre to ensure the ICP's are appropriate for the resident's needs. The working groups main focus is to initially concentrate on the elements Goals Care & Treatment Required Resources MDT review & participation.	The Working group meets monthly to review the audit results, consider what feedback is required for the various MDT meetings to assist in compliance and providing better residents ICP's. Action plans from the Audits are reviewed and communicated to stakeholders.	The ICP working group is committed and dedicated to the improving of residents ICP's and ensuring that the MDT's fully represent participation and the appropriate capture of the relevant information.	30/11/2021	ICP Working Group supported by Local management team and all MDT members. Area DON and ECD have offered assistance in supporting achievement in reaching compliance.

Regulation 19: General Health					
Reason ID : 10002068		**The six-monthly general health assessment did not measure and record the resident's body mass index, weight, and waist circumference, 19 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The audit of admission physicals and the general health assessment will identify any deficits in the implementation of local policy in relation to Regulation 19 - General Health. The requirement of Regulation 19 will also be addressed as part of NCHD induction programme. 6 monthly Physical examination form in place.	Reg. 19 Audit of General Health : Audits are ongoing most recent Audit completed 03/08 appended.	This is Achievable and Realistic the template specifically request details to be completed on front page. Blank Form submitted.	30/08/2021	Medical/Clinical team
Preventative Action	6 Monthly examination form in place. Requirements around Physical Health are now included in the NCHD induction program at rotation. Audit results discussed at consultants meeting.	Audits ongoing quarterly and General health included as specific item for NCHD induction program.	It is achievable and realistic to have full general health assessment completed in line with the regulation. Most recent audit score recorded as 95.8 and is limited in performance due to training access currently impacted by Covid restrictions to training group	30/11/2021	Medical Team.

			sizes creating difficulty in supply.		

Regulation 22: Premises					
Reason ID : 10002058		**The location of the toilets was not appropriate, having regard to the needs of residents in the approved centre. Some residents did not have a toilet near their bedroom, which resulted in them having to walk down the main corridor to access the facilities, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Resident's needs are reviewed in the context of accommodation and residents situated as close as possible to facilities. A working group to review the infrastructure of CMHCR and needs was established and meets every 2 weeks to prioritise the activity.	Rooms and bed spaces are allocated based on the providing the greatest space option available to residents and also giving due consideration to mobility issues and general health of residents in determining the appropriate placement within the unit.	Can be challenging in terms of higher occupancy numbers and residents mobility however all options are reviewed daily by staff on the ward to ensure patients are provided with the greatest allowable space available and the most adjacent space to facilities.	31/10/2021	Local Unit management
Preventative Action	A working group has been established to review the infrastructural needs of CMHCR. Review meetings occur every two weeks to review actions and progress. Architect support to propose options based on scheduled of accommodation.	Initial proposal felt met to meet the needs of the service and following receipt of update from the commission the brief was amended for the Architect. Updated schedule of accommodation issued leading to exclusion of scoping proposals. Supporting	Drawings scoping designs based on revised schedule of accommodation being developed supported by QS services and surveys to assess option's feasibility.	20/09/2021	Project Working Group

		surveys to assist with drawings and feasibility commissioned. Indicative proposal issued to QS for a costing.			
Reason ID : 10002059		**Residents did not have access to appropriately sized bedrooms. Space within the four-bedded dormitories was limited, which did not adequately address resident needs, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Based on occupancy of the Approved centre patients are placed in bed spaces which maximise the resources available in terms in providing patients the maximum space available at that time.	Rooms and bed spaces are allocated based on the providing the greatest space option available.	Can be challenging in terms of higher occupancy numbers however all options are reviewed daily by staff on the ward to ensure patients are provided with the greatest allowable space available.	31/10/2021	Local Unit Management
Preventative Action	A working group has been established to review the infrastructural needs of CMHCR. Review meetings occur every two weeks to review actions and progress. Architect support to propose options based on scheduled of accommodation. Single occupancy	Initial proposal felt met to meet the needs of the service and following receipt of update from the commission the brief was amended for the Architect. Updated schedule of accommodation issued leading to exclusion of scoping proposals. Supporting surveys to assist with	Drawings scoping designs based on revised schedule of accommodation being developed supported by QS services and surveys to assess option's feasibility.	20/10/2021	Local Unit Management Project Working Group

	rooms solution being developed.	drawings and feasibility commissioned. Indicative proposal issued to QS for a costing.			
Reason ID : 10002060		**Residents did not have access to appropriately sized communal rooms. Residents had access to a sitting room, which could only accommodate six residents allowing for social distancing due to the COVID-19 pandemic.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A working group to review the infrastructure of CMHCR and needs was established and meets every 2 weeks to prioritise the activity. In addition to the sitting room residents have access to personal space with the bedroom areas and also an open area upstairs overlooking the garden and with country views. A large activity room is located downstairs and all residents are encouraged to participate in the various activity programs in place. In	Residents during the day are encouraged to participate in group and ward activities to support recovery. Residents are facilitated with personal space as some choose to use personal devices and the sitting room is available and heated outside space is also available.	Can be challenging in terms of higher occupancy numbers and residents mobility however all options are reviewed daily by staff on the ward to ensure patients are provided with the suitable space within the constraints of the unit.	31/10/2021	MDT Team

	addition in the garden area a heated covered area to provide additional communal space for residents.				
Preventative Action	A working group has been established to review the infrastructural needs of CMHCR. Review meetings occur every two weeks to review actions and progress. Architect support to propose options based on scheduled of accommodation.	Initial proposal felt met to meet the needs of the service and following receipt of update from the commission the brief was amended for the Architect. Updated schedule of accommodation issued leading to exclusion of scoping proposals. Supporting surveys to assist with drawings and feasibility commissioned. Indicative proposal issued to QS for a costing.	Drawings scoping designs based on revised schedule of accommodation being developed supported by QS services and surveys to assess option's feasibility.	20/09/2021	Project Working Group

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10002066		**The CCTV camera, in the main reception area, was capable of recording and storing resident images, 25(d). The CCTV monitor in the main reception area was viewable by security personnel and was not viewed solely by the healthcare professionals responsible for the residents, 25(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Security camera feed to the main reception area was deactivated.	The security feed had been deactivated. The link had previously been password protected for access is now disabled.	The action is completed	30/07/2021	Area Administrator/Security officer.
Preventative Action	The security camera feed to the main reception was to support the unit with access to general hospital security. Pinpoint system activates in main reception and security respond to alarms when triggered by CMHCR registration area activation. Additional update and training to be provided to security personal in alarm response.	The security response is available to staff if in a difficulty/potential danger situation in the registration area of CMHCR out of hours.	The facility is already in place additional information training around alarm response for CMHCR.	29/10/2021	Area Administrator/Security officer.

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10002053		**The admission assessment did not include past psychiatric history, family history, medical history, current and historic medication, 15(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Memo issued by the Clinical Tutor to medical staff in relation to importance of accurate completion of documentation as it applied to the code of practice and all documentation.	Memo has been issued by the Clinical Tutor.	This action has been completed	31/08/2021	Clinical Tutor CMHCR
Preventative Action	Audit tool to be revised to identify and capture relevant documentation from both Medical and Nursing components. Importance of Good Documentation practice to be included in Induction Booklet for staff on rotation. Teaching session to be dedicated to highlight defencies noted by the commission over a number of inspections and use the session to focus	Audit tool will be amended to ensure full capture of all disciplines documentation completion. Records of staff trained will be available following teaching session.	Audit group met Monday 30th of August and ADON is progressing amending Audit tool. There is an agreed focus on achieving improved results.	30/11/2021	Clinical Tutor, ADON

	on the due care and attention to detail required when undertaking activities.				

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.

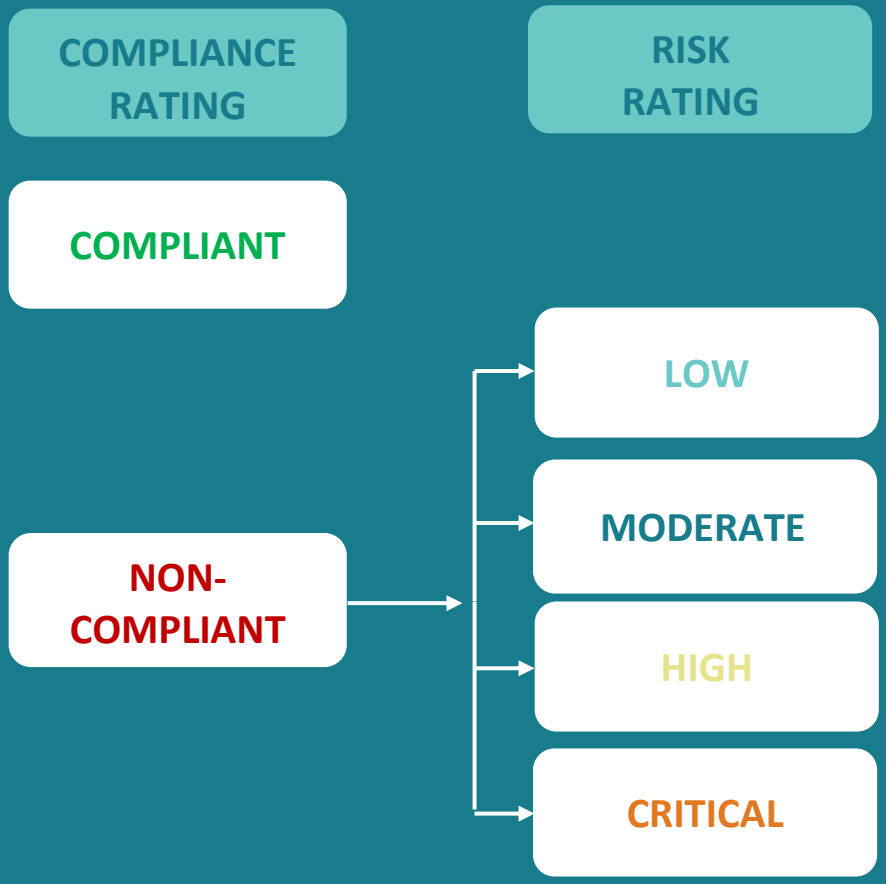
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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