Department of Psychiatry, Letterkenny University Hospital

Annual Inspection Report 2021

Promoting Quality Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, LETTERKENNY UNIVERSITY HOSPITAL

Department of Psychiatry, Letterkenny University Hospital, Circular Road, Letterkenny, Co Donegal

Date of Publication:
Tuesday 28 September 2021

ID Number: AC0175

2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Care for People with Intellectual Disability

Conditions Attached:
Yes

Most Recent Registration Date:
14 September 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Teresa Dykes, General Manager, Mental Health, CHO 1

Inspection Team:
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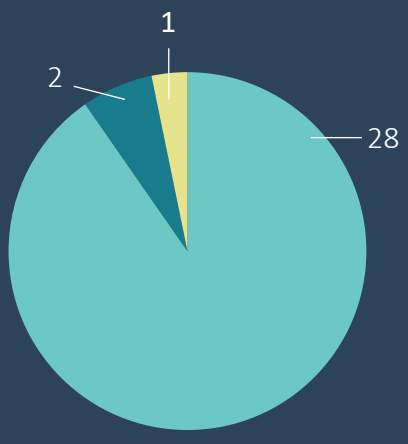
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
15 – 18 June 2021

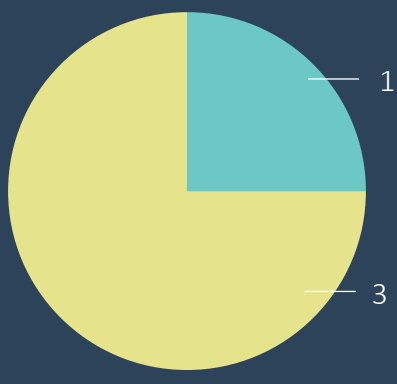
Previous Inspection date:
25 – 28 August 2020

Inspection Type:
Announced Annual Inspection

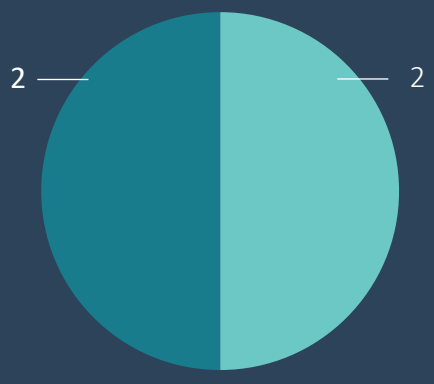
2021 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



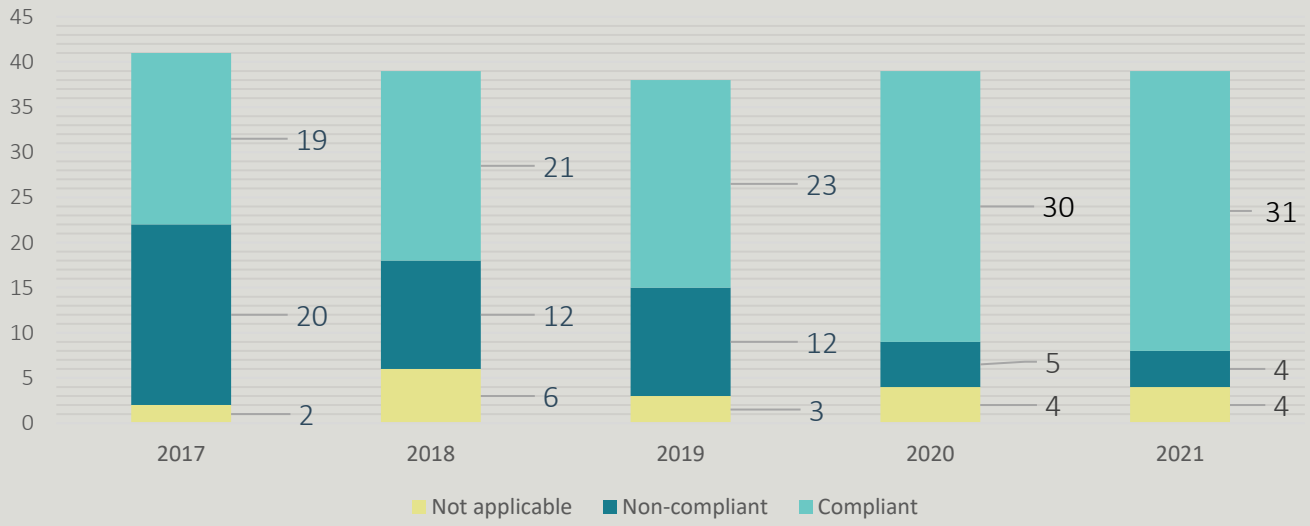
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2017 – 2021

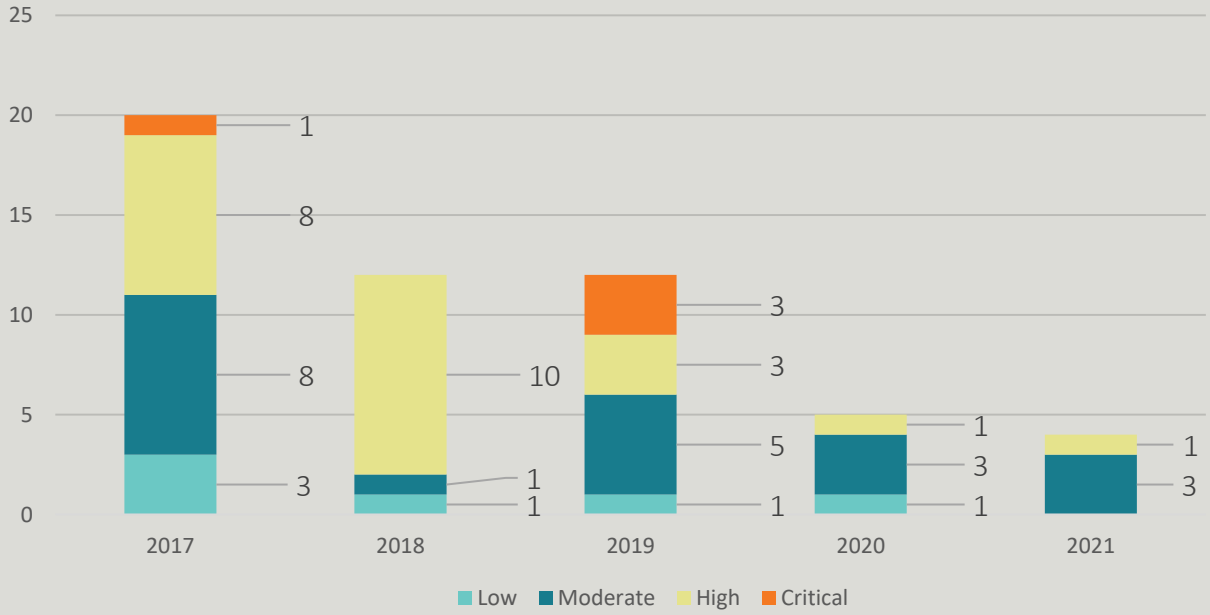
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 Department of Psychiatry (DOP) was located on the campus of Letterkenny University Hospital. The approved centre had 34 beds and was a standalone single storey building. There were six community mental health sector teams, two Mental Health Services for Older Persons (MHSOP) teams and one Mental Health Intellectual Disability (MHID) team that had admitting privileges to the approved centre. The approved centre was not modern and was dated in appearance. An extensive upgrading plan was being progressed.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	49%	64%	66%	86%	89%
Regulations Rated Excellent	0	8	9	N/A	N/A

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

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 22(3): Premises the approved centre shall develop a costed, funded and time-bound plan to minimise ligatures. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation*	While ligature anchor points had not been sufficiently minimised to the lowest practicable level, an extensive ligature reduction plan was being progressed. The approved centre provided regular updates regarding this plan to the Mental Health Commission.

of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.	
The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 22 Premises at the time of inspection.	
Condition 2: *To ensure adherence to Regulation 22(1): Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.*	The approved centre was kept in a good state of repair both externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment; records of such were maintained. The approved centre provided regular updates regarding the programme of maintenance to the Mental Health Commission.
The approved centre was not in breach of Condition 2 and the approved centre was non-compliant with Regulation 22 Premises at the time of inspection.	
Condition 3: *To ensure adherence to Regulation 26(4) and 26(5): Staffing the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*	Health care staff were trained in the Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes. Due to COVID-19 pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.
The approved centre was not in breach of Condition 3 and the approved centre was compliant Regulation 26 Staffing at the time of inspection	

Escalation and enforcement actions since last inspection

There were no escalation and enforcement actions since the previous inspection.

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm and that remedial works were in progress to reduce the risk 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, ligature points had not been sufficiently minimised to the lowest practicable level, but an extensive ligature reduction plan was being progressed.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to the needs of residents.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- Therapeutic activities in the approved centre included: stress management; coping skills; kitchen skills; relaxation groups; recovery group; gardening groups; art groups; and, morning exercise groups. The occupational therapist (OT) had developed an isolation pack for residents in isolation awaiting a COVID-19 test. This pack included a journaling book, colouring pencils, tips for coping in isolation, puzzles, and mindful colouring. The OT, nursing staff, social worker, pharmacist and psychologist ran the scheduled therapeutic groups.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre provided services in a way that respected residents' privacy, dignity and autonomy.

- The accommodation comprised of four 4-bedded rooms; two 2-bedded rooms and eight single rooms. One single room had a bathroom next door, all other bedrooms had an en suite facility.
- 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 kept in a good state of repair externally and internally.

- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

Responsiveness to residents' needs

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

- Recreational activities included books, TV, DVD, board games, table tennis, outdoor games, music instruments, newspaper, exercises, puzzles, and a games console. Recreational activities were provided on weekdays and weekends.
- 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

We found that there was robust governance structures and processes in place.

- The approved centre was part of Community Healthcare Organization 1 (CHO 1) and was governed under the Donegal Mental Health Service. There was an Area Management Mental Health committee for Donegal Mental Health Service.
- There was a service wide Quality and Risk Management group that met monthly. Items discussed that pertained to the approved centre included risk management, restrictive practices, Mental Health Commission CAPAs and compliance.
- There was a monthly operational management group. An Assistant Director of Nursing (ADON) was the chair of this committee with representation from across the clinical and administrative professionals working directly in the approved centre.
- A risk advisor for the wider CHO 1 region was available to the approved centre. The approved centre had a local risk register and applicable risks had been escalated to the Area Management Mental Health Team risk register. Training in risk management had been provided to staff.
- As well as the required audits for the Codes of Practice and Rules, there was evidence of an ongoing audit cycle for a number of the regulations. These were mainly completed by nursing staff.
- There was a local policy group and all policies were up to date at the time of inspection.
- Representatives from the Donegal Advocacy Services attended the approved centre on a fortnightly basis. The complaints procedure and contact details were publicly displayed. Formal complaints were dealt with by a complaints officer.
- There was service user representation on both the Donegal Mental Health Management Team and the Quality and Risk Committee.

COVID-19 response

- The approved centre had a COVID-19 contingency management plan which was in line with the HSE Health Protection Surveillance Centre (HPSC) for acute hospital settings. There had been a COVID-19 management committee that had met regularly. Visiting and resident leave continued to be suspended in line with national guidance.
- At the time of inspection and since the start of the COVID-19 pandemic, an area previously designated for the care of older persons was the admission/isolation area for all residents admitted to the approved centre. To facilitate increased infection control measures, a second area had been designated for residents who had been in the admission/isolation area for five days.
- A number of policies had been supplemented with an addendum relating to COVID-19.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. An admission pack had been developed for each resident that contained activity materials and a guide to social distancing and self-isolation in hospital.

2. A new easy read information pamphlet *'My Integrated Care Plan'* was available for all residents. This outlined the purpose of a care plan, resident involvement, advocacy information along with contact details and discharge planning.

3. Donegal Mental Health Services Family/Carer Information Packs had been introduced that contained relevant information and addressed key questions for family members of residents in the approved centre.

4. A feedback platform called Care Opinion (Careopinion.ie) had been launched. This online platform facilitated service users of the Donegal Mental Health Service and residents of the approved centre to provide feedback or tell their story of the care provided to them. It is then responded to by staff working as closely to the feedback provided as possible.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Located on the campus of Letterkenny University Hospital (LUH), the Department of Psychiatry (DOP)/approved centre served the county of Donegal, which had a population of 150,000. The exception was the population south of the Pettigo/Laghey line which was affiliated with the approved centre in county Sligo. The former encompassed six community mental health sector teams, namely: Central Sector, South Central Sector and North Central Sector; Inishowen (North East Sector); Dungloe and Falcarragh (North West Sector) and Donegal Town and Killybegs (South West Sector). There were two Mental Health Services for Older Persons (MHSOP) teams and one Mental Health Intellectual Disability (MHID) team that had admitting privileges to the approved centre. Within the county there were three Child and Adolescent Mental Health Service (CAMHS) teams.

The approved centre was a standalone single storey building. Built in 2011, the approved centre joined the general hospital by a link corridor for staff access. At the time of inspection and since the start of the COVID-19 pandemic, an area previously designated for the care of older persons was the admission/isolation area for all residents admitted to the approved centre. There were six beds, two double en suite rooms and two single en suite rooms in this area. The remaining accommodation comprised of four, four bedded rooms; two, two bedded rooms and eight single rooms. One single room had a bathroom next door, all other bedrooms had an en suite facility. There was a high dependency suite with a separate seclusion room. To facilitate increased infection control measures a second area had been designated for residents who had been in the isolation/admission area for five days. Therefore, residents tended to move bedrooms throughout their stay in line with infection control measures taken by the service.

Communal facilities for residents (outside of the isolation suite) included a dining room, an activities room, an information centre, a quiet room, a television room, a library area and an information centre. There was a hairdressing room that was not operational due to the pandemic. There were two internal gardens. Mental Health Tribunal facilities, along with staff offices, were located in an administrative corridor beside the main reception. Although clean and generally well kept the approved centre was not modern and was considered dated on appearance. An extensive upgrading plan was being progressed to ensure the safety and comfort of residents.

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

Resident Profile	
Number of registered beds	***34***
Total number of residents	**22**
Number of detained patients	2
Number of wards of court	1
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 Community Healthcare Organization 1 (CHO 1) and was governed under the Donegal Mental Health Service. The wider Community Healthcare encompassed Sligo/Leitrim and Cavan/Monaghan. There was an Area Management Mental Health committee for Donegal Mental Health Service comprising of the General Manager/Registered Proprietor, Business Manager, Area Lead for Mental Health Engagement, Service User Representative, Area Director of Nursing, Executive Clinical Director and Heads of Discipline for health and social care professionals. Agenda items included human resources and recruitment, finance, service planning and service reform, regulatory/governance matters, risk and the risk register.

There was a service wide Quality and Risk Management group that met monthly. This group fed into the Area Management Mental Health Committee discussed above. There was representation from staff working directly in the approved centre. This meeting was also attended by the general manager and registered proprietor. Items discussed that pertained to the approved centre included risk management, restrictive practices, Mental Health Commission CAPAs and compliance. There was a focus on ligature reduction and management which encompassed capital expenditure for the approved centre. Communal toilet facility upgrading, and works had been completed since the previous inspection.

There was a monthly operational management group. An Assistant Director of Nursing (ADON) was the chair of this committee with representation from across the clinical and administrative professionals working directly in the approved centre. Key agenda items included regulation and compliance, Individual Care Plan (ICP), risk management, incident review, health and safety and the preparedness and management of COVID-19. This committee had not met as frequently during the COVID-19 pandemic and had been substituted by a COVID-19 Management committee. Regular meetings had resumed from the second quarter of 2021.

The person in the approved centre with responsibility for risk management was identified and known by staff. This role was supported by a senior member of the nursing team who was also a member of the service wide Quality and Risk Committee. A risk advisor for the wider CHO 1 region was available to the approved centre. The approved centre had a local risk register and applicable risks had been escalated to the Area Management Mental Health Team risk register. Training in risk management had been provided to staff. Clinical risk assessment training was on going and was facilitated by one of the health and social care professionals working in the approved centre. An extensive ligature reduction plan was being progressed.

There was an organizational chart defining key personnel and lines of responsibility and accountability. The approved centre was adequately staffed. Clinical staff included nursing staff, two occupational therapists, a social worker, a psychologist and a pharmacist. An in-reach model of care was provided by medical staff however the health and social care professionals associated with the community teams did not routinely visit the approved centre. Although not formally assessed by the inspection team, there was evidence that as far as possible mandatory staff training was being facilitated and completed by staff. There were six Therapeutic Management of Violence and Aggression (TMVA) trainers, three who worked directly in the

approved centre. As well as the required audits for the Codes of Practice and Rules, there was evidence of an ongoing audit cycle for a number of the regulations. These were mainly completed by nursing staff. There was a local policy group and all policies were up to date at the time of inspection. A number of policies had been supplemented with an addendum relating to COVID-19.

Representatives from the Donegal Advocacy Services attended the approved centre on a fortnightly basis. This was facilitated via zoom during the COVID-19 pandemic and just prior to the inspection face to face meetings had recommenced. The complaints procedure and contact details were publicly displayed. Formal complaints were dealt with by a complaints officer who was not based in the approved centre. There was service user representation on both the Donegal Mental Health Management Team and the Quality and Risk Committee.

The area lead for Mental Health Engagement was a member of the Area Management Mental Health Team. By invitation or by request the area lead for Mental Health Engagement attended the local DOP Operational Management Group. While they did not have direct involvement with the residents in the approved centre, they worked closely with the Donegal Mental Health Advocacy Service. They linked with residents and or family members who contacted them. The local forum located previously in a café in Letterkenny had joined with neighbouring CHO 1 regional forums throughout the pandemic. At the time of inspection this had reverted back to the Donegal Forum and continued to meet virtually. The area lead attended and facilitated these meetings which were held monthly.

The approved centre had a COVID-19 contingency management plan which was in line with the HSE Health Protection Surveillance Centre (HPSC) for acute hospital settings. There had been a COVID-19 management committee that had met regularly. This was now a fixed agenda item on the local operational management group. Visiting and resident leave continued to be suspended in line with national guidance. The approved centre had reorganized the pathway from admission to discharge for all residents. Formerly residents were segregated according to sex and there had been a separate area for older persons. The latter was now used for all admissions and known as the admission/isolation suite. This allowed for testing and results in a timely manner and facilitated isolation from residents in the approved centre over five days. There was a secondary isolation area if the service required it.

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 18: Transfer of Residents	✗	Moderate	✗	High	✗	Moderate	✓		✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	Critical	✗	High	✗	High
Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001	✗	Moderate		Not applicable	✗	Moderate		Not applicable	✗	Moderate
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Moderate	✗	High	✗	High	✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

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 Donegal Mental Health Advocacy Service 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. Six completed service user experience questionnaires were returned to the inspectors. Two resident's chose to speak with an inspector over the telephone.

Feedback from the two residents over the telephone was positive. Staff were described as excellent. The food was praised. Both residents knew and understood their care plans, one describing their goals as relevant and good. The therapies provided were said to be beneficial and enjoyable.

Five completed forms indicated that the residents knew who their multi-disciplinary team members were, one stating 'no' to this question. Three of the six indicated that they were 'always' involved in setting goals for their individual care plan, two indicated 'sometimes' and one 'never' for this question. All six questionnaires indicated that the resident understood what their individual care plan was. Five of the six ticked that they knew who their multi-disciplinary team members were but only three of the six knew who their keyworker was. All respondents ticked 'yes', that on arrival to the approved centre, a member of staff had explained what was happening in a way that was understood.

Five residents indicated that they always felt able to discuss their worries or concerns with a staff member, the remaining respondent indicating that they did not have worries or concerns. All six residents said 'yes' to having space for privacy and five felt their privacy and dignity were respected with one indicating 'no' for this question. All six indicated that they were happy how staff talked to them. Five residents ticked that they 'always' felt safe in the approved centre and one indicated 'sometimes' as well as 'always' for this question.

On a scale of 1-10, with 1 being poor and 10 being excellent, two residents rated 10 out 10 for overall experience of care and treatment, two rated 9 and 7 respectively and two rated 6 out 10.

5.2 Advocacy

Two representatives from the Donegal Advocacy Service visited the approved centre on a fortnightly basis. In line with national restrictions and infection control measures, the advocacy representatives had engaged with the residents regularly via zoom and using an electronic tablet provided to the residents by the HSE. The representative's details were displayed, and residents could contact the advocacy service outside of the planned meetings. Face to face meetings had resumed the week prior to the inspection.

The Inspector spoke with the advocacy service. Feedback from the residents to the advocates was that the approved centre was a nice place and residents had reported that they had good experiences. It was reported that the food was good and that the therapeutic group work facilitated by the health and social care professionals and nursing staff was also good. It was stated that hot beverages were not available at night time outside of designated times. It was also said by residents to the advocates that it was difficult to change from one consultant team to another.

The inspector spoke with the area lead for mental health engagement. The area lead was a member of the Management Area Mental Health team. An integral part of this role was the development of structures that allow for the involvement of services users, family members and carers in the planning, design, implementation, and evaluation of mental health services. This was facilitated by the establishment of a local forum meeting. The area lead was actively involved in these meetings that were held monthly.

There was service user representation on both the Area Management Mental Health team and the Quality and Risk committees.

6.0 Feedback Meeting

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

- Executive Clinical Director
- General Manager and Registered Proprietor
- Area Director of Nursing
- Assistant Director of Nursing x 1
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 2
- Clinical Nurse Manager 1
- Risk Advisor
- Area Lead for Mental Health Engagement
- Occupational Therapist
- Social Worker
- Principal Social Worker
- Principal Psychology Manager

Apologies were received on behalf of the Occupational Therapy Manager.

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals also. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. Nutritional and dietary needs were assessed, where necessary, and were addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans. No residents were observed to be dressed in night attire during the day throughout the inspection process.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in September 2018.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile. Recreational activities included books, TV, DVD, board games, table tennis, outdoor games, music instruments, newspaper, exercises, puzzles, and a games console. Recreational activities were provided on weekdays and weekends.

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; all residents had access to appropriate religious and chaplaincy services where practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in March 2020.

At the time of inspection, visitations to the approved centre had been suspended due to COVID-19 restrictions and infection control measures.

A separate visitors' room or visiting area was provided where residents could meet visitors in private once visits re-commenced, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting room was suitable for children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents had access to mail, fax, e-mail, Internet, telephone, or any device for the sending or receiving of messages, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in November 2020 and it included the following requirements:

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

Risk was assessed prior to a search of a resident or their property appropriate to the type of search being undertaken. Resident consent was sought prior to all searches; the request for and the received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents. Relevant staff could articulate the searching processes as set out in the policy.

The clinical file of one resident was examined on inspection in relation to the search process. The resident was informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was of the same gender as the resident being searched. A written record of every search of a resident was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A

written record was kept of all searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in February 2020.

No resident had died in the approved centre since the last inspection and compliance for this regulation was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents, and included relevant space and sections for goals, treatment, care, and resources required. In addition, all ICPs included allocated space and sections for reviews, were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. 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. Additionally, the social worker had developed an information leaflet for residents explaining the ICP process in the approved centre.

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. There was a weekly schedule of therapeutic activities in the approved centre which included the following: stress management; coping skills; kitchen skills; relaxation groups; recovery group; gardening groups; art groups; and, morning exercise groups. The occupational therapist (OT) had developed an isolation pack for residents in isolation awaiting a COVID-19 test. This pack included a journaling book, colouring pencils, tips for coping in isolation, puzzles, and mindful colouring. The OT, nursing staff, social worker, pharmacist and psychologist ran the scheduled therapeutic groups.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved qualified health professional in an appropriate location. The approved centre had two dedicated OTs, a dedicated social worker, and a psychologist. Residents had access to a dietitian and speech and language therapy by referral. Daily therapeutic activities included the following: gentle exercise; open art; health promotion and prevention; me time; sleep hygiene; advocacy service; word wheel and newspaper group; gardening group; relaxation therapy; discussion and cookery skills; recovery through activity; and, relaxation and reflection.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

NON-COMPLIANT

Risk Rating **MODERATE**

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in November 2020.

The clinical file of one resident who had been transferred from the approved centre to another facility was reviewed on inspection. Full and complete information regarding the resident was not transferred when they moved from the approved centre to another facility. While there was a documented written letter of referral and a transfer form, information pertinent to the resident transfer was not noted in the transfer letter, instead it was documented in the clinical file. The clinical file was not sent with the resident.

As this was an emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral.

The approved centre was non-compliant with this regulation because not all relevant information about the resident was provided to the receiving approved centre, hospital or other place, 18 (1).

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy and procedures, which included emergency procedures. The policy was last reviewed in January 2020.

The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator, both of which were checked weekly. Residents received appropriate general health care interventions in line with individual care plans. General health needs were monitored and assessed as indicated by the residents' specific needs, at least every six months.

One clinical file was examined during the inspection process in relation to the provision of general health services. The six-monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, and the resident's body-mass index, weight, and waist circumference. A medication review was documented.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

Required information was provided to residents and their representative at admission, including the approved centre's information booklet that detailed the care and services; the booklet was available in the required formats to support resident needs and information was clearly and simply written. The booklet contained details of the following: housekeeping arrangements, including arrangements for personal property and mealtimes; complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies; and, residents' rights. Residents were provided with details of their multi-disciplinary team.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Residents were called by their preferred name, and the general demeanour of staff was appropriate and respectful. The manner in which staff addressed and communicated with residents was respectful and professional, as was staff appearance and dress. Staff displayed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering the room, as appropriate. All bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to the resident.

Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas; if so, the windows had opaque glass. Noticeboards did not display resident names or other identifiable information. Additionally, residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

Residents had access to personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in bedroom and day areas where residents sat during the day. Rooms were ventilated, and private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. The lighting in communal rooms suited the needs of residents and staff; it was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces were minimised in the approved centre. However, ligature points had not been sufficiently minimised to the lowest practicable level.

The approved centre was kept in a good state of repair both externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment; records of such were maintained. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed not to have dangerously high temperatures. Current national infection control guidelines were followed.

There were a sufficient number of toilets and showers for residents in the approved centre. There was at least one assisted toilet per floor. The approved centre had a designated sluice room and a designated cleaning room, as appropriate. All resident bedrooms were appropriately sized to address resident needs.

The approved centre provided suitable furnishings to support resident independence and comfort. The approved centre provided assisted devices and equipment to address resident needs.

The approved centre was non-compliant with this regulation because the physical structure was not developed and maintained with due regard to the specific needs 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 policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in November 2019 and included:

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

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

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition; this was documented in the clinical file. The pharmacist was consulted about the type of preparation to be used for medications. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as a refrigerator.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and operational procedures relating to health and safety. The policy was last reviewed in May 2019.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Clear signs were in the reception area and seclusion room where CCTV cameras or other monitoring systems were located throughout the approved centre. The registered proprietor ensured that the existence and use of CCTV or other monitoring systems was disclosed to the resident and their representative. A resident was monitored solely for the purpose of ensuring their health, safety, and welfare. The usage of CCTV or other monitoring systems had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe a resident were incapable of recording or storing a resident's image on tape, disc, hard drive, or in any other form. CCTV cameras or other monitoring systems used to observe a resident must not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to staffing. The policy was last reviewed in May 2019 with an addendum in relation to COVID-19 dated February 2021. The policy included the recruitment and selection processes of the approved centre, including the Garda vetting requirements.

The number and skill mix of staffing was sufficient to meet the resident needs. An appropriately qualified staff member was on duty and in charge at all times; this was documented. All healthcare staff were trained in the Mental Health Act 2001. 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. Clinical personnel who worked directly in the approved centre included nursing staff, medical staff who visited, two occupational therapists, one social worker, one psychologist and a pharmacist.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022. Staff training in relation to the Mental Health Act is documented in the table below.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (79)	79	100 %
Medical (21)	21	100 %
Occupational Therapist (2)	2	100 %
Social Worker (1)	1	100 %
Psychologist (1)	1	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 maintenance of records. The policy was last reviewed in June 2019. The policy included:

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

Resident records were secure, up-to-date, and in good order. Five clinical files were examined on inspection. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and 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 were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process, including remote access to the tribunals. Staff attended Mental Health Tribunals and provided assistance as necessary when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in November 2020 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan. Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them. This was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in February 2021. The risk management policy and associated safety statement addressed all requirements.

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

Individual risk assessments were completed prior to and during the following: resident seclusion; physical restraint; specialised treatments, such as electroconvulsive therapy (ECT); at admission, to identify individual risk factors, including general health risks, risk of absconding and risk of self-harm; resident transfer; resident discharge; and, in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk

management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with three conditions to registration attached. The certificate was displayed prominently directly inside the front door beside 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)

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated 2021.

The policy addressed the following:

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

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

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. Seclusion facilities were furnished, maintained, and cleaned to ensure respect for resident dignity and privacy, as far as practicable taking into account Rule 5.1 (direct observation). All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

One seclusion episode contained within the resident's clinical file was inspected. In this episode, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

The resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident was informed of the ending of seclusion. A written record of the resident was made by the nurse every 15 minutes, which included the level of distress and behaviour of the resident. The resident received a medical review by the registered medical practitioner every four hours.

This episode of seclusion was recorded in the resident's clinical file and this use of seclusion was recorded in the seclusion register. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the resident's clinical file and available to inspectors. This episode of seclusion was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services".

The Mental Health Act, 2001 ("the Act") does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2021. It addressed the following:

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

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

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

Evidence of Implementation: The clinical file of one resident who was physically restrained was reviewed on inspection. Physical restraint (PR) was used in rare, exceptional circumstances and was in the best interests of the resident, where the resident posed immediate threat of harm to the self or others. PR was only used after all alternative interventions to manage the residents unsafe behaviour had been considered. The use of PR was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using PR. PR was initiated by a registered medical practitioner (RMP), registered nurse (RN) or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated staff member was responsible for leading in the physical restraint of the resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) or duty CP was notified as soon as practicable; this was recorded in the clinical file.

The RMP completed a medical examination of the resident (physical examination), no later than three hours after the episode of PR. The order for PR lasted a maximum of 30 minutes. The episode of PR was recorded in the clinical file. The Clinical practice form (CPF) was completed by the person initiating and ordered the use of PR no later than three hours after the episode. The CPF was signed by the CP within 24 hours. The resident was informed of the reasons for, likely duration of, and circumstances leading the discontinuation of PR unless the information may have been prejudicial to the resident's mental health, well-being, or emotional condition. The resident's next of kin or representative was informed of the use of PR and a record of this communication was placed in the clinical file. Staff were aware of relevant considerations in the individual care plan pertaining to the resident's requirements and needs in relation to the use of PR. A same sex staff member was present at all times during the PR episode. The resident

was afforded the opportunity to discuss the episode with members of the MDT involved on their care as soon as was practicable. The completed CPF was placed in the resident's clinical file. Each episode of PR was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

Admission of Children

NON-COMPLIANT

Risk Rating **MODERATE**

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in November 2020. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Evidence of Implementation: The clinical file of a child who had been admitted to the approved centre was reviewed on inspection. The approved centre lacked age-appropriate facilities and a programme of activities appropriate to the child's age and ability; it was not a dedicated Child and Adolescent facility and therefore was not a suitable facility for the admission of a minor. Provisions were in place for the following: to ensure the safety of the child; to respond to the child's special needs as a young person in an adult setting; and, to ensure the right of the child to have their views heard. Staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff.

The approved centre was not deemed to be an appropriate accommodation for the admission of a child; nonetheless, a single room with ensuite facilities was provided. There was 1:1 staffing support for the child throughout the course of the admission. The child had their rights explained to them and information about the ward and facilities were provided in a form and language that they could understand; the clinical file recorded the child's understanding of the explanation given. Advice from the Child and Adolescent Mental Health Service was available as the child was under the care of a Child and Adolescent psychiatrist in the community. The commission was notified of all children admitted to the approved centre. Consent for treatment was obtained for one or both parents.

The approved centre was non-compliant with this code of practice because there were not age-appropriate facilities and a programme of activities appropriate to age and ability.

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

COMPLIANT

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

INSPECTION FINDINGS

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

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT located in the main hospital. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had responsibility for ECT management.
A named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed his or her capacity to consent to receiving treatment, and this was documented in their clinical file. The voluntary patient was deemed capable of consenting to receiving ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable the voluntary patient to make a decision on consent to ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that they could understand. The voluntary patient was informed of his or her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, a current mental

state examination. Cognitive assessments were completed and recorded by consultant psychiatrists before and after each ECT session.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The consultant psychiatrist in consultation with the resident reviewed the resident's progress and the need for continuation of ECT. The reasons for terminating a programme of ECT was documented in the clinical file.

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 separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in November 2020, included all of the policy-related criteria for this code of practice.

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who was admitted to the approved centre was reviewed on inspection. A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the following: presenting problem; past psychiatric history; family history; medical history; current and historic medication; where relevant, social and housing circumstances; current mental health state; risk assessment; full physical examination; and, and other relevant information. The resident's family member, carer, or advocate was involved in the admission process, with the resident's consent.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed on inspection. The discharge plan included the following: estimated date of discharge; documented communication with the relevant general practitioner, primary care team and community mental health team (CMHT); a follow-up plan; and, a reference to early warning signs of relapse and risks. The discharge

meeting was attended by residents, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate, where appropriate and with the consent of the resident.

The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and, informational needs. Discharge was coordinated by a key worker. The preliminary discharge summary was sent to the general practitioner, primary care team, and CMHT within three days. The comprehensive discharge summary was issued 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 family member, carer, or advocate was involved in the discharge process, where appropriate. A timely follow-up appointment was made for within one week, as there was a recent history of self-harm or a suicide risk.

The approved centre was non-compliant with this code of practice because it did not comply with Regulation 18: Transfer of Residents, 30.1.

Appendix 1: Corrective and Preventative Action Plan

Regulation 18: Transfer of Residents					
Reason ID : 10002078		**Not all relevant information about the resident was provided to the receiving approved centre, hospital or other place, 18 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Memo to be issued by ECD to all medical and nursing staff ensuring all parts of the Transfer process are completed and provided to the receiving facility	Audit of Regulation 18 and of Code of Practice	Realistic	30/09/2021	ECD
Preventative Action	*Audit *MHC Compliance with standards and feedback of audits to be communicated to all MDT staff	Audit	Achievable	31/10/2021	CNM's DOP Operational Management Group

Regulation 22: Premises					
Reason ID : 10002075		**The physical structure was not developed and maintained with due regard to the specific needs of residents as ligature points were not minimised to the lowest practicable level, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	As identified through the AC Ligature Audit, HSE estates are engaging in structural works as per Capital funding. The plan includes refurbishment of all en suites and adjustments made to specific windows. Contract for works to go to tender end September 2021, once contract appointed a schedule of works will be developed and agreed with major works planned to commence January 2022, subject to notification early January 2022 that funding is available in 2022.	*Annual Ligature Audit. *Quarterly AC walkabout with ADON; Business Manager; CQPS CNM3 and Maintenance Foreman. *Agenda item under DMHS Quality and Risk group and DMHS Area Management Team meetings.	Achievable in minimising the risk to as low as reasonably possible, however completion date depends on available funding and suitable access being available to the AC to do the works.	30/09/2022	HSE Estates; DMHS Business Manager.
Preventative Action	Annual Ligature Audit continues to be reviewed and updated as required. Ligature Risk Management plan in place detailing engineering controls, clinical risk assessments, MDT reviews and internal monitoring controls have been effective in minimising risk to as low as reasonable practicable	*Annual Ligature audit. *Quarterly AC walkabout with ADON, Business Manager; CQPS CNM3 and Maintenance Foreman. *Agenda item under DMHS Quality and Risk group and DMHS Area Management Team meetings.	Achievable in minimising the risk to as low as reasonably possible.	30/06/2022	AC ADON, Estates Manager.

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10002074		**There were not age-appropriate facilities and a programme of activities appropriate to age and ability.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	If a CAMHS bed cannot be sourced by the relevant CAMHS team and therefore in the event of a emergency admission of a child to the AC, age appropriate activities will be provided as required. A specific 1:1 programme of activity will be provided in the designated OT room or other appropriate space based on the individual needs of the child or activity as identified in their ICP	A resource pack detailing activities and resources available and specific assessment of activity needs (pre-teen activity checklist, adolescent activity checklist) will be compiled. A timetable/programme of activities will be drawn up with the child and copy added to their ICP	Achievable	01/10/2021	Senior OT/Primary Nurse
Preventative Action	All MDT staff will be informed of activity programme specific to the child admission. The DMHS policy will be updated to reflect same provision	All child admissions will have access to assessment of activity programme needs/individuals intervention by OT and/or assigned primary nurse.	Achievable	01/10/2021	Senior OT

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10002073		**The approved centre was non-compliant with this code of practice because it did not comply with Regulation 18: Transfer of Residents, 30.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All MDT staff to read and sign the DMHS Policy on Transfer of Residents	Review of compliance rate of Policy sign off	Achievable	31/12/2021	Heads of Discipline and all discipline line managers
Preventative Action	Completion of Audit of Regulation 18	Audit	Achievable	31/12/2021	CQPS CNM3

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.

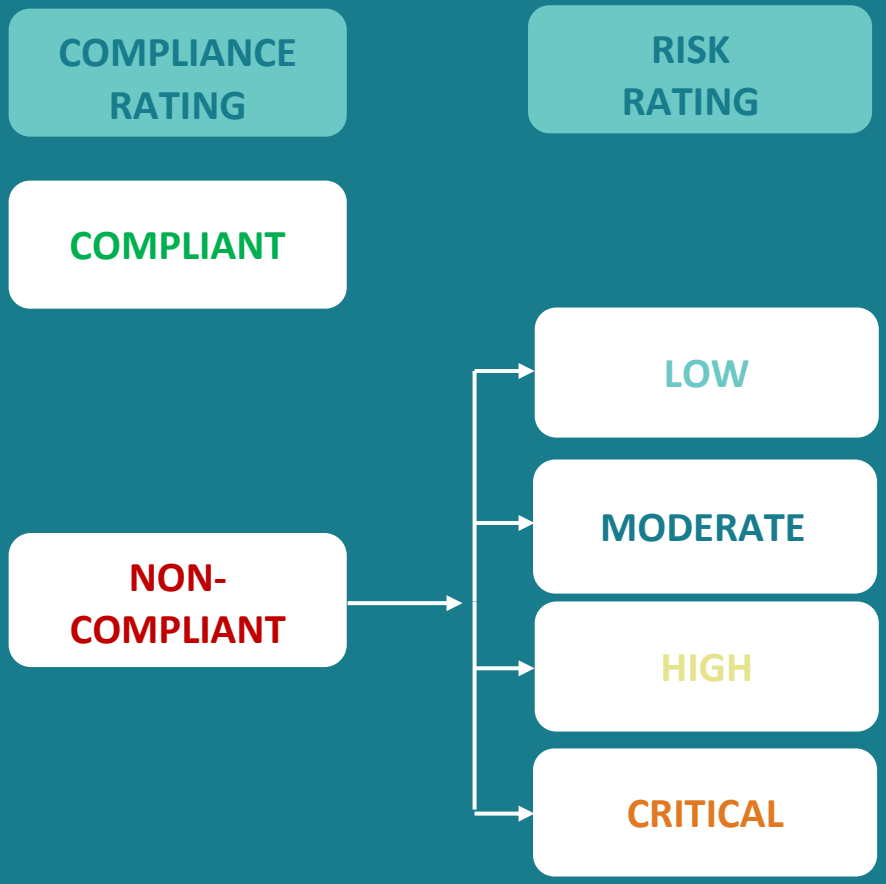
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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