Carraig Mór Centre

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mental health commission

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

CARRAIG MÓR CENTRE

Shanakiel, Cork.

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

Approved Centre Type:
Other

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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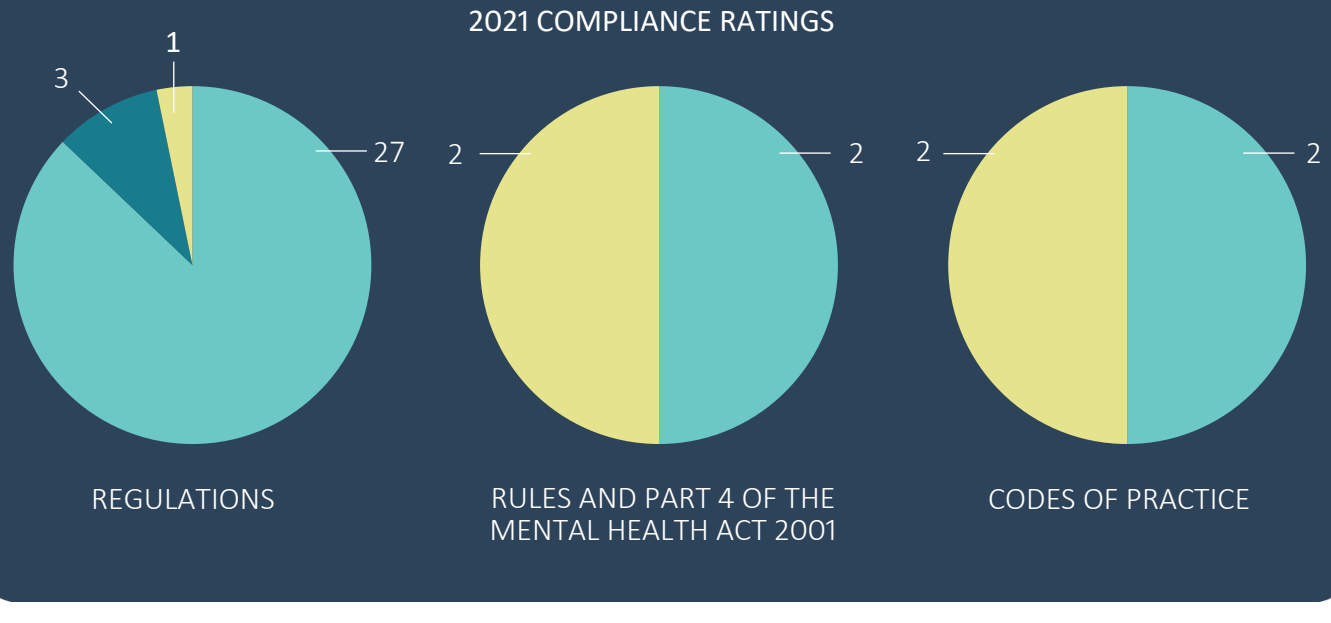
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
27 – 30 July 2021

Previous Inspection date:
13 – 16 October 2020

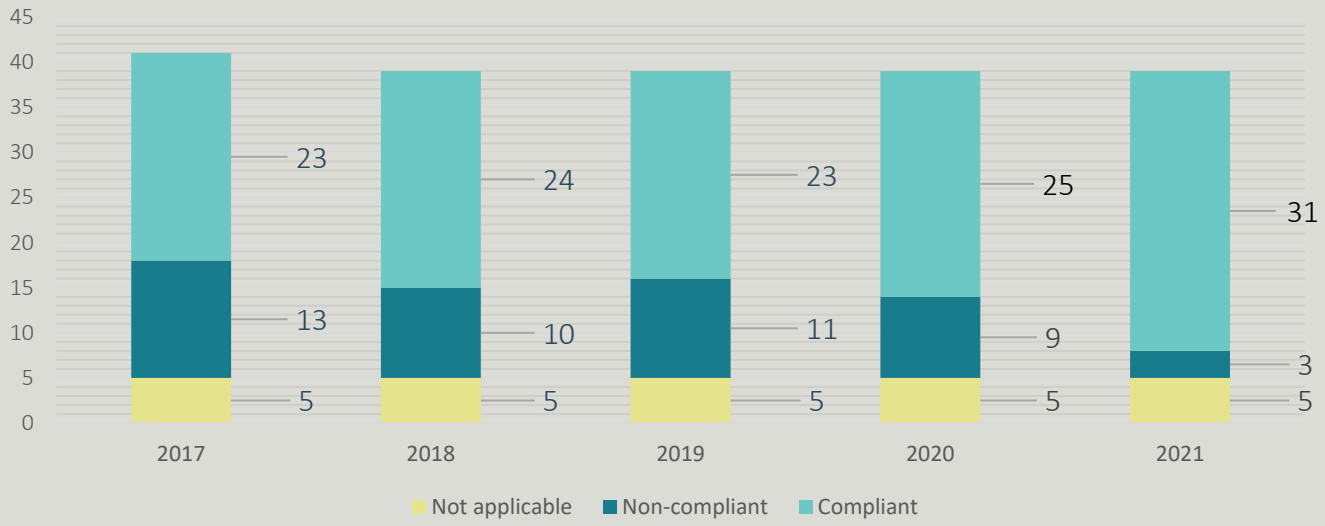
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2017 – 2021

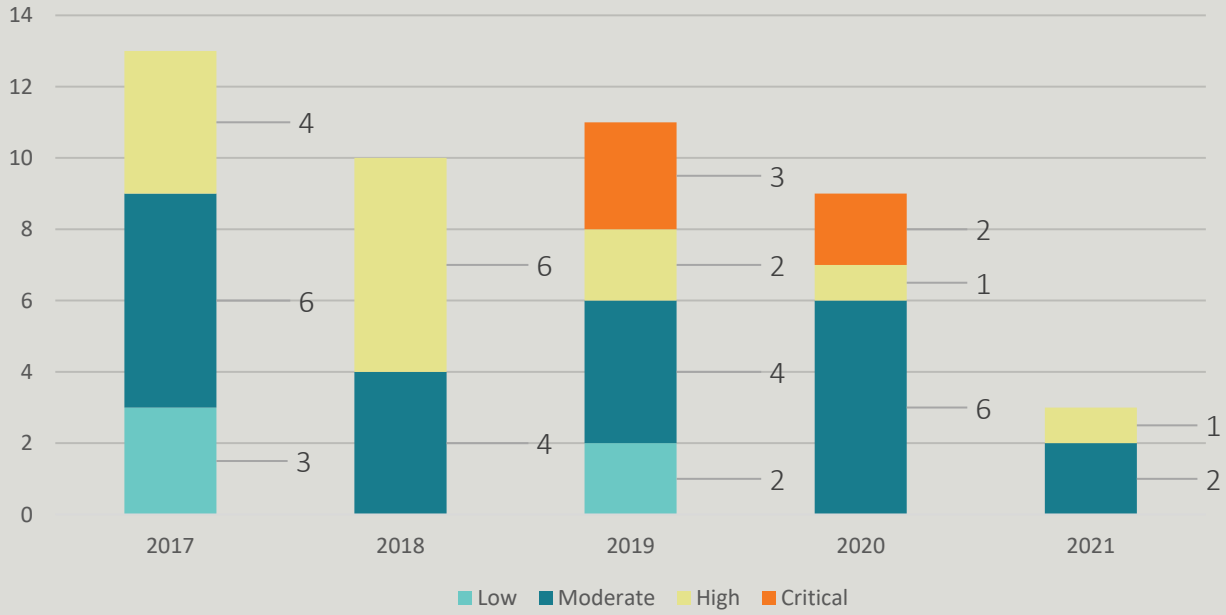
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

Carraig Mór was an 18-bed Psychiatric Intensive Care Unit (PICU) in Shanakiel, Cork, which opened in 2002. However, since May 2021, the facility has an operational capacity of 10 beds by agreement with the Mental Health Commission. The approved centre operated on a 24–hour basis as a psychiatric intensive care unit (PICU) for Cork city and county.

Referrals to this service predominantly came from the following services: St. Michael's Adult Mental Health Unit; Mercy University Hospital; South Lee Adult Mental Health Unit; Cork University Hospital; St. Stephen's Hospital, Glanmire; Centre for Mental Health Care and Recovery, Bantry General Hospital; Central Mental Hospital; Dublin and Cork Prison Services or from the Flexible Assertive Community Treatment (FACT) team. There was one multi-disciplinary team (MDT) for the approved centre.

Plans have been submitted by the Service in relation to a planned major refurbishment of the Carraig Mór Centre. The costed and time bound plan for further refurbishment work will provide for a new entrance, enlarged communal spaces and 18 single bedrooms when completed. In the interim period of refurbishment, bed capacity will further reduce in line with the roll-out of works.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	64%	71%	68%	74%	91%
Regulations Rated Excellent	5	10	12	N/A	N/A

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

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 22: Premises, the approved centre shall implement the costed, funded and time-bound plan to reconfigure the approved centre received in accordance with plans submitted on 17 February 2021, 7 May 2021, and 10 May 2021. All works must be completed by 30 November 2022. The approved centre shall provide regular updates on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.*	The approved centre has submitted a plan and updates with regard to reconfiguring the approved centre.
The approved centre was in not in breach of Condition 1 and the approved centre was non-compliant with Regulation 22: Premise at the time of inspection.	
Condition 2: *To ensure adherence to Regulation 22: Premises and Regulation 32: Risk Management, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs of residents.* *This plan shall address all issues of concern and take all necessary actions identified in the:* • *Fire Safety Risk Assessment (submitted 28 April 2021)* • *Ligature Audit Review & Action Plan (submitted 28 April 2021)* • *Health and Safety Report (submitted 7 May 2021)* *The approved centre shall provide regular updates to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.*	The approved centre has submitted a plan and updates with regard to the approved centre and work is ongoing.

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 with Regulation 26 at the time of inspection.	
Condition 4: *To ensure adherence to Regulation 27: Maintenance of Records, the approved centre shall audit their records and reports on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.*	The approved centre provided audit reports to the Commission. The inspectors found the clinical documentation was difficult to read due to the illegibility of handwritten notes and clinical files were not consistently kept in good order, loose pages were present in one of the files inspected.
The approved centre was not in breach of Condition 4 and the approved centre was non-compliant with Regulation 27: Maintenance of Records at the time of inspection.	
Condition 5: *The approved centre shall, as of Friday 14 May 2021, reduce its occupancy from 18 to 10 residents. On commencement of Phase 1 of construction works, as referenced in the plans submitted by the HSE on 17 February 2021, 7 May 2021 and 10 May 2021, the approved centre shall reduce its occupancy to 8 residents. On commencement of Phase 2 of construction works as referenced in the plans submitted by the HSE on 17 February 2021, 7 May 2021 and 10 May 2021, the approved centre shall reduce its occupancy to 6 residents. The approved centre shall not increase its occupancy from 6 residents until such time as the construction works outlined above have been completed in compliance with Regulation 21: Privacy, Regulation 22: Premises and Regulation 32: Risk Management.*	The occupancy at the time of inspection was 10 residents.
The approved centre was not in breach of Condition 5 at the time of inspection.	

Escalation and enforcement actions since last inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice	23 October 2020	Failure to implement a programme of routine maintenance attached to the registration of the approved centre and non-compliance with Regulation 21: Privacy and Regulation 22: Premises.	Regulatory Compliance Meeting on 9 April 2021.
Regulatory Compliance Meeting	25 November 2020	The approved centre's continued non-compliance with Regulations 21 and 22, continued critical risk and failure to address the concerns in the correspondence of 6 and 16 November 2020, the Commission requested a Regulatory Compliance Meeting to afford the service an opportunity to present its plans to address ongoing concerns.	Approved centre was operational at 10 ward beds.
Immediate Action Notice	10 March 2021	The Commission required a response to address serious concerns about the arrangements in place to ensure the safety of residents.	Plan to renovate the approved centre submitted and accepted by the Commission.

Safety in the approved centre

We found that the approved centre mostly operated safe practices which reduced risk of harm and that effective systems were in place to safeguard patients.

- 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.
- Intensive fire training has been undertaken. It was noted that a total of 65 staff were trained in Fire Safety which included evacuation procedures during February, March, and April 2021. This was supported by monthly reviews and updates of fire safety procedures in line with ongoing and planned building works.
- CCTV had eliminated blind spots.

However, ligature points were not minimised to the lowest practicable level. While refurbishment works were ongoing at the time of the inspection and some ligature minimisation works had been completed, other identified ligature risks were still present.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to needs of residents, but individual care plans were unsatisfactory.

- There was an extensive range of therapeutic services and programmes delivered by the social worker, nurses, psychologist, and occupational therapy. This included groups such as: Animal Assisted Therapy, Mind Gym, Healthy Lifestyle Workshop, Self Care, Cognitive Maintenance and Stimulation, Managing Stress and Distress, Planning for the Future, Strengthening Relationships, Connecting with Calmness, and Coping with COVID-19.
- The occupational therapist was a trained physiotherapist and had input into providing information to residents on walking, cardiovascular health, and aerobic activities.
- 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.

However:

- The development of individual care plans was not satisfactory: Four individual care plans did not identify the care and treatment required to meet the goals identified, four individual care plans did not identify appropriate goals for the resident and five individual care plans did not identify the resources required to provide the care and treatment.

- The clinical documentation was difficult to read due to the illegibility of handwritten notes and clinical files were not consistently kept in good order, loose pages were present in one of the files inspected.

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.

- 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.
- The approved centre was compliant with the Rules Governing the Use of Seclusion and with the Code of Practice on the Use of Physical Restraint.

Responsiveness to residents' needs

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

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend.
- The information booklet was clearly and simply written.
- Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

There were governance structures and processes in place.

- Carraig Mór Psychiatric Intensive Care Unit (PICU) was part of the Cork North Mental Health Services and the wider Cork Kerry Mental Health Community Healthcare Services (Area 4). Carraig Mór was governed by the Carraig Mór Local Management Team (LMT) which reported to the Head of Service.
- The Policy, Procedure, Protocol and Guideline Group (PPPGG) provided a multi-disciplinary approach to policy development, review, approval, and dissemination.
- Audit was central to implementing continuous quality improvement and control processes. Audit findings were discussed within the Audit Committee and the findings were shared with the relevant committees.
- There were timely updates of the Risk Register at the Review of the Risk Register and Incident meeting. Risks were also discussed at the LMT meeting where the Risk Register was a standing item. The Area Risk Register which was held at Head of Service level.
- All incidents were reviewed by the Risk Register and Incidents Committee. Incident reports with trends and analysis were provided on a quarterly basis by the Quality and Patient Safety (QPS) Department, and which were discussed at the Local Management Team meetings.
- The Centre has been actively pursuing strategies to reduce restrictive practices and has initiated a committee who will work closely with National Mental Health on achieving the actions identified within the MHC Seclusion and Restraint Reduction Strategy. Carraig Mór Centre has been chosen as an initial pilot site for this initiative for Community Healthcare Area 4.

COVID-19 response

Public health protocols were followed.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Garden areas were modified to enable fuller access and walkways for both male and female residents.

2. The Centre had improved resident safety with the provision of two automated external defibrillators (AEDs) within the centre, one in each ward area.

3. The Centre had improved vision lines in enhancing patient safety within the centre through the provision of more comprehensive internal closed circuit television.

4. A Healthy Lifestyles Committee to promote healthy lifestyles opportunities for residents had been established.

5. Carraig Mór had been selected as a pilot site to explore how reductions in restrictive practices can be achieved in line with actions identified within the MHC Seclusion and Restraint Reduction Strategy.

6. A Coping with COVID-19 Workshop was developed and delivered to residents.

7. A Pilot Lead for the establishment of a regular weekly clinic for Animal Assisted Activities (AAA) had contributed to a University College Cork evaluation of the residents and staff experiences of Animal Assisted Therapy (AAT) within a Psychiatric intensive care Unit (PICU).

8. A Registered Nurse Tutor position had been introduced across all adult mental health services including the Carraig Mór Centre. This will enable the standardisation of Training Logs, monitoring of the uptake of mandatory training and provide specialist post registration training in key areas such as: mental health assessment; risk assessment and individual care planning development.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Carraig Mór was an 18-bed Psychiatric Intensive Care Unit (PICU) in Shanakiel, Cork, which opened in 2002. However, since May 2021 the facility has an operational capacity of 10 beds by agreement with the Mental Health Commission. Although not specifically referenced, the gender mix of these beds was usually comprised of either seven male and three female beds or six male and four female beds, this was due to the configuration of facilities currently available.

The centre comprised of two floors with resident accommodation on the ground floor and facilities for activities and therapies on the first floor. The unit consisted of a male observation ward, a female observation ward, and one single room. The approved centre operated on a 24 –hour basis as a psychiatric intensive care unit (PICU) for Cork city and county. At the time of inspection, there were three females and six male residents, of whom six were detained under the Mental Health Act, 2001.

Referrals to this service predominantly came from the following services: St. Michael's Adult Mental Health Unit; Mercy University Hospital; South Lee Adult Mental Health Unit; Cork University Hospital; St. Stephen's Hospital, Glanmire; Centre for Mental Health Care and Recovery, Bantry General Hospital; Central Mental Hospital; Dublin and Cork Prison Services or from the Flexible Assertive Community Treatment (FACT) team. There was one multi-disciplinary team (MDT) for the approved centre.

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

Resident Profile	
Number of registered beds	***10***
Total number of residents	**9**
Number of detained patients	6
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Carraig Mór Psychiatric Intensive Care Unit (PICU) was part of the Cork North Mental Health Services and the wider Cork Kerry Mental Health Community Healthcare Services (Area 4). Carraig Mór was governed by the Carraig Mór Local Management Team (LMT) which reported to the Head of Service. This team met monthly and reviewed the work and activities of the numerous sub-committees and working groups which reported to them. These included the Audit Committee, Policy Committee, Risk Register and Incidents

Committee and Consultant Group, as well as a Health and Safety Committee. There was also a bi-monthly Clinical Nurse Manager meeting which dealt with the management of nursing resources, training and audit activities and provided a two-way communication link to the Local Management Team.

The Policy, Procedure, Protocol and Guideline Group (PPPGG) provided a multi-disciplinary approach to policy development, review, approval and dissemination. There was an established culture of implementing quality improvement audit tools to monitor and evaluate standards of care. Audit was central to implementing continuous quality improvement and control processes. A key driver in this process was the ECD/CD of the Centre. Audit findings were discussed within the Audit Committee and the findings were shared with the relevant committees. Both policy development and review of the audit programme were undertaken by the multi-disciplinary team and continued throughout the year despite the many ongoing operational challenges.

There was clear evidence of at least monthly review with timely updates of the Risk Register at the Review of the Risk Register and Incident meeting. Risks were also discussed at the LMT meeting where the Risk Register was a standing item. Any risk which was not able to be managed at unit level was escalated to the Area Risk Register which was held at Head of Service level. Risk Management training was provided by the QPS department. Upon initial impact of the COVID-19 crisis, a management team convened daily to manage the unprecedented challenges to all services. As the crisis progressed, and specific management processes were implemented, the meeting frequency has reduced.

Although the approved centre's registered proprietor held overall responsibility for the risk management process, the person nominated within the risk management policy with overall responsibility for risk management was the Assistant Director of Nursing (ADON) in Carraig Mór. Whilst this person might be a risk owner for identified clinical risks, they may be more accurately be ascribed as the risk co-ordinator or action owner, especially for the non- clinical risks identified within the risk assessments. The Centre has been actively pursuing strategies to reduce restrictive practices and has initiated a committee who will work closely with National Mental Health on achieving the actions identified within the MHC Seclusion and Restraint Reduction Strategy. Carraig Mór Centre has been chosen as an initial pilot site for this initiative for Community Healthcare Area 4.

All incidents were reviewed by the Risk Register and Incidents Committee. Incident reports with trends and analysis were provided on a quarterly basis by the Quality and Patient Safety (QPS) Department, and which were discussed at the Local Management Team meetings. There was clear adherence to established procedures following the death of a resident. The Centre had instigated a timely and appropriate medical response to the sudden death. Notifications to the Gardai, Coroner and MHC were undertaken. This was followed by an MDT review and a Serious Incident Management Team review. The service was currently awaiting publication of an independent review panel of this death. It was noted that a number of support strategies had also been implemented to support the bereaved family and to the other residents and staff.

Following the death of this resident whilst in Carraig Mór, an announced focused inspection of the approved centre followed. This focused inspection by the Inspector, Dr Susan Finnerty on the 12 March 2021, identified a number of immediate specific measures and enforcement actions which related to the unsuitability of the premises at the time of the person's death. These have largely been remedied and the specific actions

undertaken included: immediate actions to install a more comprehensive CCTV within the Centre; as well as a new fire alarm system including sensors and new fire panels.

Also, in response to MHC enforcement actions and discussions, the Centre has had its bed complement reduced from 18 beds to 10 beds since May 2021. The Centre was also required to implement an immediate programme of maintenance to ensure that the premises were safe and met the needs of residents. This included a fire safety risk assessment, a health and safety report and a ligature audit review and action plan.

Subsequently, additional plans have been submitted by the Service in relation to a planned major refurbishment of the Carraig Mór Centre. The costed and time bound plan for further refurbishment work will provide for a new entrance, enlarged communal spaces and 18 single bedrooms when completed. In the interim period of refurbishment, bed capacity will further reduce in line with the roll-out of works.

In support of MHC Registration Condition 3, intensive fire training has been undertaken. It was noted that a total of 65 staff were trained in Fire Safety which included evacuation procedures during Feb/March/April 2021. This was supported by monthly reviews and updates of fire safety procedures in line with ongoing and planned building works.

Recruitment and retention were ongoing, and it was recognised by a number of heads of discipline that there currently is improved capacity to engage more fully with residents because of the reduced numbers of residents. This was also recognised in the Irish Advocacy Network report 2021. Heads of discipline also identified a desire to plan for the fullest human resources compliment of healthcare disciplines in seeking to deliver the highest quality service when the resident numbers increase to their full compliment. Whilst there were nursing vacancies, further nurse staffing posts have been approved. There was a full medical staff compliment within the Centre.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 15: Individual Care Plans	✓		✓		✗	Moderate	✗	Moderate	✗	High
Regulation 22: Premises	✗	High	✗	High	✗	Critical	✗	Critical	✗	Moderate
Regulation 27: Maintenance of Records	✗	Moderate	✗	High	✗	High	✗	Moderate	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

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

5.0 Service-user Experience

5.1 Service-user feedback

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

- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

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

Resident feedback is an essential component of the inspection process. However, within the current climate the inspection team sought to reduce the risk of COVID -19 to residents. As a result, residents were offered the opportunity to speak with an Inspector over the phone as an alternative. Residents were also provided with feedback questionnaires. However, as one resident wished to speak with us, we facilitated this on site adopting physical distancing and through the use of facemasks.

Four completed resident feedback questionnaires were returned to the inspection team which were complimentary of staff and positive about their care. A report from the Irish Advocacy Network was also submitted and included the following comments:

- As admissions were down the staff had extra time to be with the inpatients and this helped a lot.
- The relaxation of some COVID-19 precautions allowed the residents to be taken on trips out in the bus to places like Gougane Barra and picnics were supplied from the kitchen and clients were taken for tea on their way back.
- Tribunals have been quite confusing for a number of people. Some Tribunals were held on zoom, some on the phone, some solicitors gave a consultation on the phone but there was no consistency and clients reported being suspicious of who they were talking to on the phone at times. Some clients report not getting the Form 8 from their solicitor after their Tribunal.

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 Clinic Director (ECD) / Clinical Director (CD)
- Head of Services
- Consultant Psychiatrist
- Area Administrator
- Principal Psychologist
- Occupational Therapy
- Principal Social Worker
- Senior Psychologist
- Administration Officer

Nursing Representatives did not attend the feedback meeting due to ongoing industrial action.
The Area Lead for Mental Health Engagement was on leave.

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.

In relation to clarity sought by the inspection team regarding resident feedback to Regulation 30 - Mental Health Tribunals: specific to the communication methods between each patient and their solicitor. The Clinical Director advised that all methods of communication are made available to patients in Carraig Mór to facilitate patient / solicitor communication prior to Tribunals (i.e., telephone and video conferencing). The ECD/CD responded that they would like this issue to go back to the Mental Health Commission, that on-site, face to face tribunals are necessary due to resident concerns, and the fact that the team cannot control the platforms of communication.

The ECD/CD requested clarity on Regulation 21-Privacy in relation to the monitor privacy shield and possible suggested repositioning of large CCTV screen in nurse's station, and also further clarification of missing elements within the admission assessment.

In relation to Regulation 15 – Individual Care Plans (ICP), the ECD/CD referred to the service's ICP training and adherence to the HSE document: Writing a Person-centred Individual Care Plan Guidance Document, *A guide to support HSE Mental Health Services staff with the Mental Health Act 2001 (Approved Centres) Regulations 2006, Regulation 15, Individual Care Plan.* Both the ECD/CD and Consultant Psychiatrist for the Centre requested clarity on what exact requirements the MHC was looking for in relation to ICPs.

The ECD and CD also noted that in previous inspections, (and in the MHC ICP Audit document) it was made clear that the ICP was to reflect client goals within the ICP. This was also stated within the ICP audit.

The ECD and CD highlighted that goals were for the resident as opposed to goals for the MDT and that goals for the treating team are not accepted, e.g., 'Monitor for non-compliance with medication'.

The ECD/CD and Consultant Psychiatrist sought clarification as to whether the full plan of care is requested or if it the ICP was only to reflect Client Goals. The Mental Health Commission response presented at the Carraig Mór feedback meeting requested that the ICP reflect the full plan of care for each resident.

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

A minimum of two resident identifiers appropriate to the resident group profile were used. The identifiers, detailed in each resident's clinical file, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food options. Food was properly prepared and comprised of portions from different food groups as per the Food Pyramid. Residents were provided with at least two choices for meals, and they had sufficient supplies of safe and fresh drinking water in easily accessible locations throughout the approved centre. The needs of residents identified as having special nutritional and dietary requirements were assessed where necessary and addressed in residents' individual care plans. Residents had access to a dietitian if required.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

There was appropriate and sufficient catering equipment, crockery, and cutlery which suited the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with appropriate emergency personal clothing that considered their preferences, dignity, bodily integrity, and religious and cultural practices. The emergency clothing stock was available from central stores.

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 detailing the processes for managing residents' personal property and possessions. The policy was last reviewed in April 2019.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP).

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. A recreational day trip was in progress during this inspection.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2020. At the time of the inspection generic COVID-19 restrictions and safety protocols were implemented in relation to visitors. Private visits were permitted to take place in a separate visitor room unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting areas was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on communication. The policy was last reviewed in May 2021. Residents had access to postal mail, fax, and Internet including e-mail.

Individual risk assessments were undertaken for all residents, in relation to any risks associated with their external communication and this was documented in the individual care plan. A senior staff member only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on searches. The policy was last reviewed in October 2019. The policy addressed all of the requirements of the regulation, including the following:

- 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 and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file of one resident who was searched was inspected. The resident's consent was sought and documented, prior to the search taking place. General written consent was sought for routine environmental searches. A written record was kept of all environmental searches. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during the search and why. There was a minimum of two clinical staff in attendance when the search was being conducted. The search was implemented with due regard to the resident's dignity and privacy. One of the staff members who conducted the search was of the same gender as the resident being searched.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in place which covered the protocols in place for end of life care. The policy was last reviewed in April 2019.

One resident died suddenly in the approved centre since the last inspection, and their clinical file was inspected. The sudden death was managed in accordance with the residents religious and cultural practices with dignity and propriety, and in a way that accommodated the resident, representatives, family, next of kin and friends. All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). All ICPs were each recorded in the one composite set of documentation. Five ICPs were inspected. The ICPs included allocated sections for goals, treatment, care, resources required, and for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not integrated with progress notes. Each ICP was developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

Four out of five ICPs did not identify appropriate goals for the resident. Four out of five ICPs did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Five out of five ICP's did not identify the resources required to provide the care and treatment. A multi-disciplinary team reviewed and updated individual care plans in five ICPs.

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

a) **Four individual care plans did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment, 15.**
b) **Four individual care plans did not identify appropriate goals for the resident, 15.**
c) **Five individual care plans did not identify the resources required to provide the care and treatment, 15.**

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 needs of the resident population, as documented in the residents' individual care plans (ICPs). The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

The approved centre had input from each of the following three disciplines who delivered one to one work with residents - psychology, nursing, and occupational therapists. These three disciplines ran groups such as: Animal Assisted Therapy, Mind Gym, Healthy Lifestyle Workshop, Self Care, Cognitive Maintenance and Stimulation, Managing Stress and Distress, Planning for the Future, Strengthening Relationships, Connecting with Calmness, and Coping with COVID-19.

Occupational therapists ran groups which focused on leisure interests and the Model of Human Occupation informed the content of the leisure interest groups such as baking, cooking, independent living skills, social skills, and recovery through activities as well as self-care groups. Education was delivered around healthy eating.

The occupational therapist was also a trained physiotherapist and had input into providing information to residents on walking, cardiovascular health, and aerobic activities. Occupational therapists were essential to community access programmes such as trips out. Residents received assistance on preparing for discharge, communication, motivation, and interpersonal interactions. The nurse therapist organised community bus trips to places including Killarney. The Nurse Therapist worked with occupational therapists and psychologists on delivering group activities on craftwork and individual care plan workshops. There were also weekend therapies including a relaxation group.

The social worker delivered only individual work at the time of the inspection. Topics covered included items such as housing, homelessness, child protection, family support and behavioural family therapy, and income and medical card applications. The social worker had placed a particular focus on family support and the improvement of relationships for the residents. The social worker also facilitated video calls with family.

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 was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the transfer of residents. The policy was last reviewed in October 2019. The clinical file of one resident who had been transferred from the approved centre, in a planned transfer situation was examined. Full, complete, and relevant written information about the resident accompanied the resident upon transfer, to a named individual in the receiving hospital when they moved there. The transfer documentation included a letter of referral including a list of current medication and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for responding to medical emergencies and in relation to general health. The policy was last reviewed in April 2019. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator, (AED). One AED was located on the Male Ward and one AED was located on the Female Ward.

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Residents received appropriate general health care interventions in line with individual care plans. Six-monthly general health assessments were inspected, in relation to three residents who were in the approved centre for a period greater than six months. These six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, diet, physical activity, a medication review, and Body Mass-Index (BMI), weight and waist circumference.

The files of one resident on antipsychotic medication was inspected. The resident received an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG) heart function test. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes according to age and gender, including breast check, retina check for diabetics, cervical screening, and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a policy and procedures detailing the process around the provision of information to residents. The policy was last reviewed in October 2019.

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

Residents were provided with written and verbal information on diagnosis, unless, in the treating psychiatrist's view, the provision of such information might be damaging to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to residents' and family's needs. 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

Resident's privacy and dignity was appropriately respected at all times. The manner in which staff spoke with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Where a resident shared a room the bed screening ensured that their privacy was not compromised. Communal areas were adequately sized in the context of the reduced numbers of residents.

Residents were facilitated to make private phone calls. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. CCTV monitor screens within the nursing station had a bespoke screen protector fitted that ensured the privacy of images displayed. All bathrooms, showers, and toilets had locks on the inside of the door unless there was an identified risk to a resident.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was adequately lit, heated, and ventilated. Appropriate signage and sensory aids were provided to help residents orientation needs. Hazards were minimised. There was a sufficient number of toilets and showers for residents in the approved centre. Resident bedrooms were appropriately sized to address resident needs. Residents had access to sufficient indoor and outdoor space including communal rooms and two gardens.

The lighting in the approved centre had been entirely replaced and refitted and residents had new individual overhead bed lights. The new lighting in communal rooms was sufficiently bright and positioned to facilitate reading and other activities.

Ligature points were not minimised to the lowest practicable level. While refurbishment works were ongoing at the time of the inspection and some ligature minimisation works had been completed, other identified ligature risks were still present at the time of the inspection.

The approved centre was kept in a good state of repair inside and outside. It was clean, hygienic, and free from offensive odours. Suitable furnishings were provided to support resident independence and comfort. There was at least one assisted toilet per floor. Assisted devices and equipment were provided to address resident needs.

The approved centre was non-compliant with this regulation because not all ligatures were minimised to the lowest practicable level based on risk assessment, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in April 2021.

Each resident had an MPAR, and five of these were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: medications administered, allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, date of discontinuation for each medication, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases.

All entries in the MPARs were readable. 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, and this was documented in the clinical file. When a resident's medication was withheld a record was kept, and the justification was documented in the MPAR and in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

Medication dispensed or supplied to the resident was stored securely in a locked storage unit unless it required refrigeration. Scheduled 2 and 3 controlled drugs were locked in a separate locked cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a safety statement and operating procedures relating to the health and safety of residents, staff, and visitors. The Site/Service Safety Statement (SSSS) was last reviewed in January 2021.

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 policy and procedures in relation to the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in May 2021.

There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe residents were incapable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre's use of CCTV.

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 staffing policy and procedures in place in relation to the recruitment, selection and Garda vetting requirements. The policy was last reviewed in June 2021.

Resident beds were reduced in the approved centre from 18 to 10 residents. The number and skill mix of staffing were sufficient to meet resident needs. The approved centre had a dedicated multi-disciplinary team. This included psychiatry, nursing, occupational therapy, psychology, and social work staff. The number and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times, and this was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022. The following is a table showing the numbers and percentages of staff trained in the Mental Health Act 2001.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (58)	58	100%
Medical (5)	5	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

NON-COMPLIANT

Risk Rating **MODERATE**

(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 policies and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in April 2021. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre. All residents' records were physically stored together and appropriately secured in a safe place throughout the approved centre.

Not all records were maintained in a manner so as to ensure accuracy and ease of retrieval. The handwriting contained on some clinical documentation was difficult to read due to the illegibility of handwritten notes. Files were not consistently kept in good order; loose pages were present in one of the files inspected. One admission physical health assessment record was incomplete – it was missing the resident's name and medical record number on the document. This file also contained incomplete sections.

Resident records were developed and maintained in a logical sequence, and records were reflective of the resident' current status and the care and treatment being provided.

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

a) **Not all records were maintained in a manner so as to ensure accuracy and ease of retrieval. The handwriting contained on some clinical documentation was difficult to read due to the illegibility of handwritten notes, 27 (1).**
b) **Files were not consistently kept in good order; loose pages were present in one of the files inspected, 27 (1).**
c) **One admission physical health assessment record was incomplete – it was missing the resident's name and medical record number on the document. This file also contained incomplete sections, 27 (1).**

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 an electronic register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 of the Mental Health Act 2001.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All fifteen operating policies and procedures required by the regulations were all reviewed within the required three-year time frame, having due regard to any recommendations made by the Inspector or the Commission.

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in February 2020. It included the process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre. There was a nominated individual responsible for dealing with all complaints available in the approved centre.

The complaints procedure and the nominated person’s contact details were publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints were handled promptly, appropriately, and sensitively. The nominated person maintained a record of all complaints relating to the approved centre. Any resident who had made a complaint was not adversely affected by reason of the complaint having been made. All complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded, these records were in addition to and distinct from a resident’s individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or 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

There was a comprehensive written policy in relation to risk management and incident management processes. The policy was last reviewed in March 2021. The policy included all of the policy related regulation requirements, including:

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

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

Clinical and corporate risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Health and safety risks were identified, assessed, reported, treated, monitored, and recorded

in the risk register. Individual risk assessments were completed prior to episodes of resident seclusion and physical restraint and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration.

Incidents were risk-rated in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk reviewed incidents for any trends or patterns occurring in the service.

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre was adequately insured against accidents and injury to residents. The approved centre's insurance certificate and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered 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 conditions relating to the certificate of registration attached to it, which was displayed prominently.

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, which was last reviewed in August 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.

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

Evidence of Implementation: Seclusion facilities were furnished and maintained to ensure respect for resident dignity and privacy, as far as practicable and taking into account Rule 5.1 (direct observation). Residents in seclusion had access to adequate toilet and washing facilities, with an en suite toilet attached to the seclusion room. All furniture and fittings were of a design and quality so as not to endanger patient safety. The seclusion room was not used as a bedroom.

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

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

seclusion, unless detrimental to resident. The resident was informed of the ending of an episode of seclusion and cultural awareness and gender sensitivity was demonstrated.

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

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

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 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. Following administration of medication for a continuous period of three months, there was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment in which each of the residents consented to being treated. In both patient cases, there was a written record of consent, with the following:

- The name of the medications prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient – including the nature and purpose of the medications, the effects of medications, including risks and benefits and any views expressed by the patient and any supports provided to the patient in relation to the discussion and their decision-making.

The approved centre was compliant with this regulation.

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

Monitoring: The annual report on the use of physical restraint was submitted to the approved centre.

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

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident's next of kin were not informed about the physical restraint and the explanation for not informing them was documented in the clinical file.

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

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

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in June 2019, the transfer policy was last reviewed in October 2019, and the discharge policy was last reviewed in April 2021. All policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, and current mental health state. The resident received a full physical examination.

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

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

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to primary care on the day after discharge. A comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, and names and contact details of key people for follow-up.

The discharge summary also included risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan	
Reason ID : 10002309	**Four individual care plans did not identify appropriate goals for the resident, 15.**
The approved centre did not provide an acceptable Corrective and Preventative Action Plan (CAPA) within the required timeframe. The approved centre will be required to provide an acceptable CAPA and the Commission will follow up in relation to same and will escalate accordingly.	

Regulation 22: Premises					
Reason ID: 10002312	**Not all ligatures were minimised to the lowest practicable level based on risk assessment, 22(3).**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature reducing works have continues since Inspection including, changing out radiators, installation of new wardrobes, improvements to existing curtain rails and replacement of TV units	Regular updates from maintenance department. Ongoing site meetings with Estates Department and Design team.	Achievable and on going	17/01/2022	Maintenance Department, design team and estates
Preventative Action	1. Reduced ligature furnishings and fittings to be incorporated into larger capital project. 2. Increased CCTV in corridor areas. 3.Reduced bed capacity reflective of each phase of works until larger capital project is complete.	1.All new fixtures, fittings and furniture specifications will be anti-ligature in design with appropriate certification to ensure compliance. Bi-weekly site meetings to review works reports and plan for future works. 2.Additional CCTV in place. 3.Bed reduction capacity in place.	1.Achievable and ongoing 2.Achieved 3.Achieved and ongoing	31/03/2022	1.Estates function, Design team with Service input. 2.ADON 3.Registered Proprietor

Regulation 27: Maintenance of Records					
Reason ID : 10002316	**Files were not consistently kept in good order; loose pages were present in one of the files inspected, 27 (1). Not all records were maintained in a manner so as to ensure accuracy and ease of retrieval. The handwriting contained on some clinical documentation was difficult to read due to the illegibility of handwritten notes, 27 (1). One admission physical health assessment record was incomplete – it was missing the resident's name and medical record number on the document. This file also contained incomplete sections, 27 (1).**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1.The 2 loose pages in the 1 file identified during the inspection were secured. All staff informed to secure any loose pages that they observe when using the clinical files. 2.Admin support has reviewed clinical files to ensure they are in good order, well maintained and organised to ensure ease of retrieval. 3.Staff informed to consider the legibility of their hand writing, to consider using block capitals were necessary. Any issue indentified during an audit pertaining to legibility to be followed up by the	1-4. Monthly auditing of the maintenance of records. Audit submitted to the Mental health Commission and results also reviewed at the Audit committee meeting	Achieved with ongoing monitoring	17/11/2021	1-4 - CD, Administration staff member, All MDT members

	relevant staff members line manager. 4.The 2 patient identifiers that were found to have been omitted were inputted.				
Preventative Action	1.Admin support to review files on a weekly basis, to ensure they are in good order, well maintained and organised to ensure ease of retrieval. 2.A clinical file index sheet, which will clearly identify what documents are to be filed in each section of the clinical files is underdevelopment. This sheet will also stipulate what documents and time lines for documents to be carried forward to new clinical files when they are being volumised . 3.A memo was circulated to all NCHD's, specifying that all aspects of physical health exams	1 & 2. Monthly auditing of the maintenance of records in place. 3. Regular auditing of the maintenance of records in place. Regular auditing of the code of practice for Admission. Results of both are presented, discussed and disseminated to staff members via the audit committee	1.Achieved with ongoing monitoring 2.Ongoing works and awaiting final draft of new document with implementation date 01/12/2021. 3.Achieved with ongoing monitoring	01/12/2021	1.Administration staff member. 2. Administration staff member, CNM3 3.CD

	are completed. In circumstance where the physical exam or aspects of the physical exam cant not be completed, it is to be clearly identified alongside; the reason(s) why it could not be completed and a plan to follow up on it.				

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.

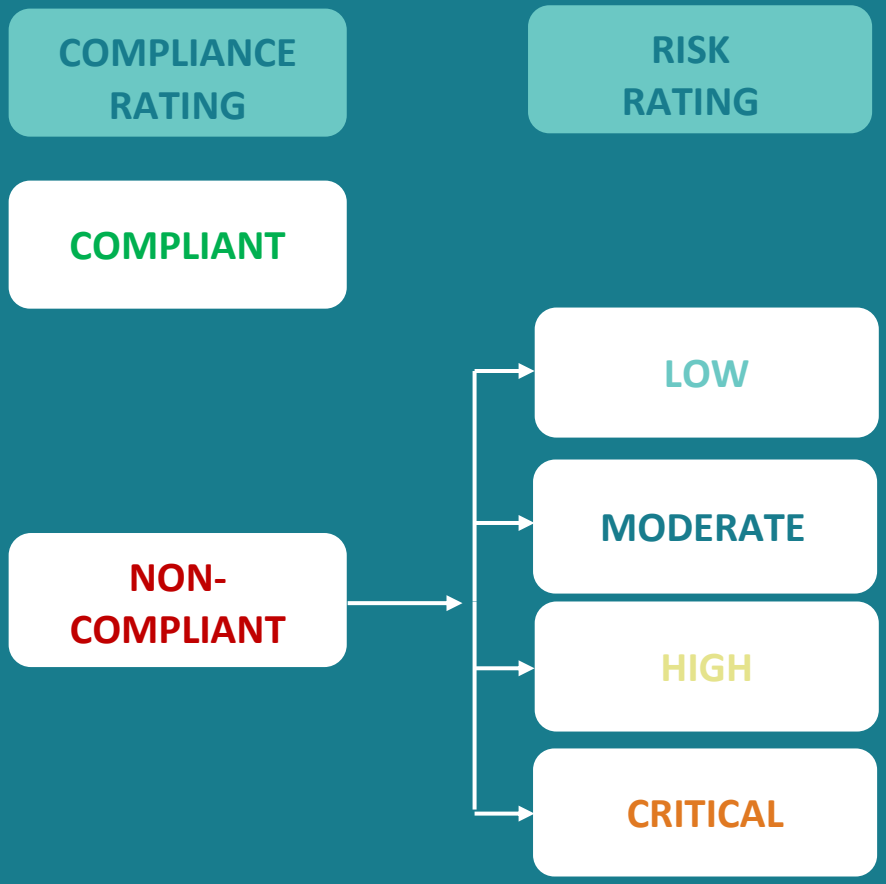
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation, and interview to assess compliance with the requirements.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