St Gabriel's Ward, St Canice's Hospital

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coimisiún meabhair - shláinte
mental health commission

Annual Inspection
Report 2021

Promoting Quality Safety and Human Rights in Mental Health

ST GABRIEL'S WARD, ST CANICE'S HOSPITAL

St Gabriel's Ward, St Canice's Hospital
Dublin Road, Kilkenny

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

Approved Centre Type:
Continuing Mental Health Care / Long Stay
Psychiatry of Later Life

Conditions Attached:
None

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, Acting Head of Services, CHO 5 Mental Health Services

Inspection Team:
Carol Brennan – Forsyth, Lead Inspector
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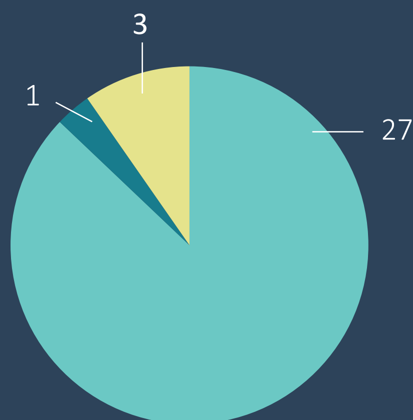
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
29 June – 2 July 2021

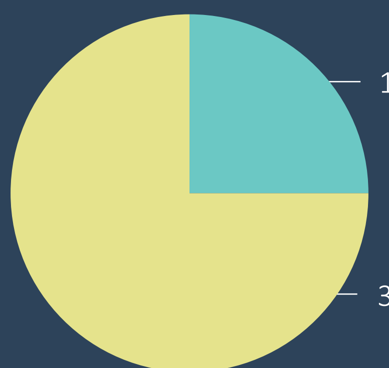
Previous Inspection date:
4 – 7 August 2020

Inspection Type:
Announced Annual Inspection

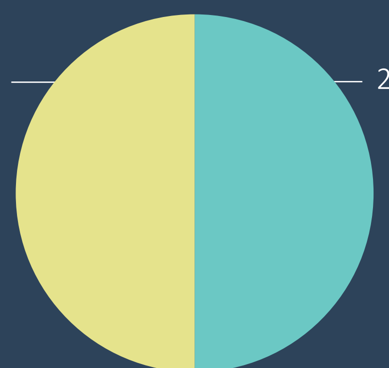
2021 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



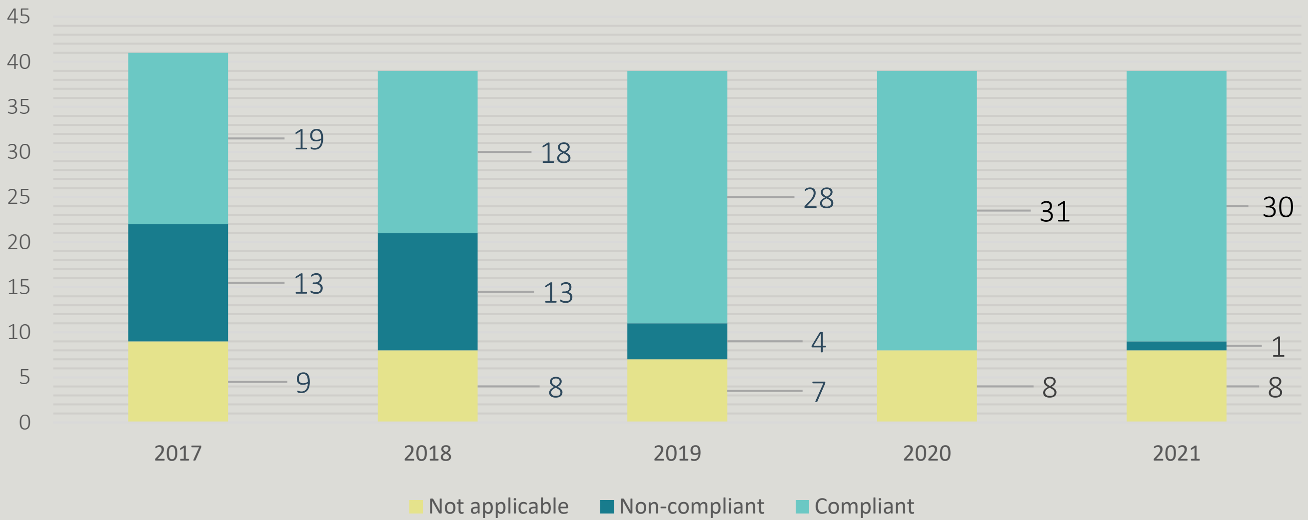
CODES OF PRACTICE

Compliant · Non-Compliant · Not applicable

RATINGS SUMMARY 2017 – 2021

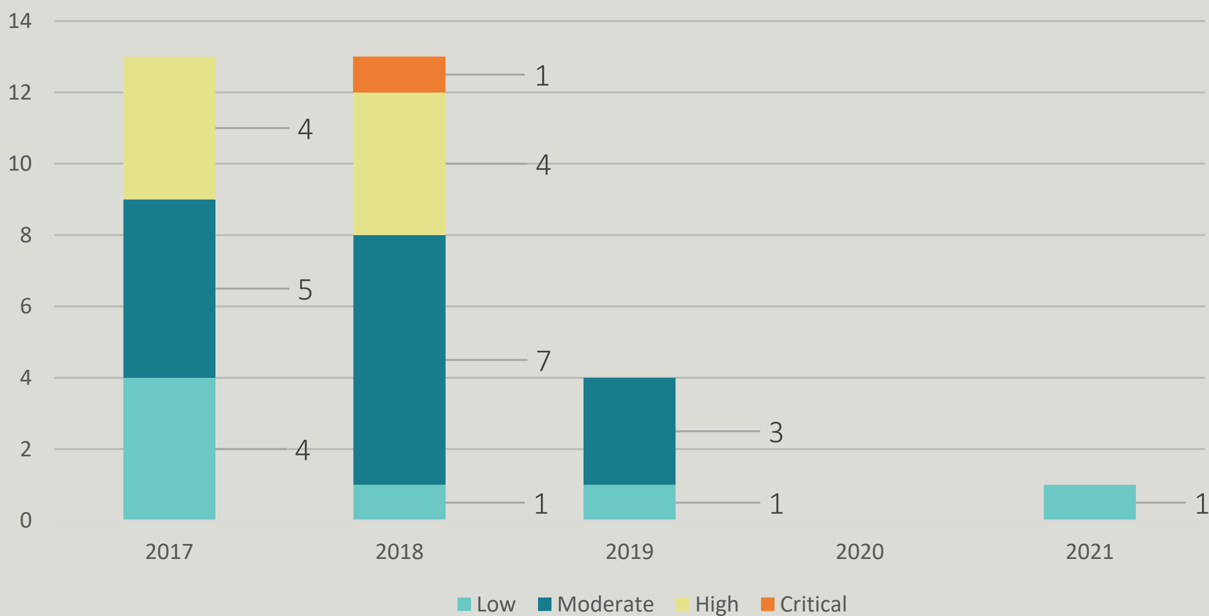
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2017 – 2021



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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

The approved centre was a 20-bed facility, built in the 1980 and located on the grounds of St. Canice's Hospital in Kilkenny. It accommodated residents under the Psychiatry of Later Life and continuing care team. The approved centre was dementia friendly and there are a number of initiatives that improved care and treatment for elderly people.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	59%	58%	88%	100%	97%
Regulations Rated Excellent	0	2	13	N/A	N/A

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

Conditions to registration

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

Escalation and enforcement actions since last inspection

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

Safety in the approved centre

We found that in the main, the approved centre operated safe practices which reduced risk of harm and that effective systems were in place to safeguard patients, but fire safety procedures required attention.

- 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.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However, there were no records of any fire evacuations being carried out in the approved centre. The report on Fire Safety for the approved centre was last updated in January 2012; it contained out of date information regarding bed capacity.

Appropriate care and treatment of residents

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

- The approved centre had a dedicated occupational therapist and part-time social worker. Residents had access to a psychologist by referral.
- The therapeutic timetable included the following: mindful melodies; therapeutic gardening; chair based exercises; music therapy; multi-sensory programmes; nature based social interactions; art therapy; and, orientation therapy.
- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident and their families as far as possible. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- 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.
- The approved centre introduced a booklet entitled 'Remembering Yesterday Living Today: Getting to know me in my own unique way'. This booklet was used as a tool for the resident and their families to explore and present the resident's lifespan and life experiences through therapeutic reminiscence.

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 apart from the lack of en suite single rooms for all residents.

- 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 mostly 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.

However:

- There were minor maintenance issues to be addressed.
- Some of the sleeping accommodation was in two or three-bed rooms with toilet and en suite shower facilities. At the time of inspection there were no plans to provide residents with single room accommodation.

Responsiveness to residents' needs

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

- Recreational activities included walking groups; chair based exercises; community outings; gardening; arts and crafts; music; games; and, TV. The approved centre provided access to recreational activities on weekdays and during the weekend.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

- The approved centre was part of South East Community Healthcare Organisation and was governed by the executive team from Carlow/ Kilkenny/South Tipperary team. The local Quality and Patient Safety Committee (QPSC) met monthly and issues arising from these meetings were then tabled at the Quality and Safety Executive Committee (QSEC), which met monthly.
- The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed.
- Clinical audits were undertaken by staff.
- Responsibilities regarding risk were allocated at management level and throughout the approved centre and recorded in the risk register. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF).
- The Area Lead for Mental Health Engagement had engaged a representative (family member) from the local Mental Health Forum in Kilkenny to be involved in St Gabriel's Ward on behalf of the residents. The representative had been attending the local QPSC meetings.

COVID-19 response

- Due to COVID-19 restrictions, the approved centre had engaged remotely with Alzheimer's Society Ireland to bring programmes to residents such as 'Bringing Joy' and 'Mindful Memories'.
- The residents had access to video calls during the COVID-19 restrictions to promote visual communication between residents and their families.
- The approved centre had purchased smart TVs for residents in isolation due to COVID-19. Activity Packs have been developed which included ideas for activities whilst in isolation.
- St Gabriel's Ward had been reconfigured into three zones to protect residents during the COVID-19 pandemic. Zone A, which was a general ward area, Zone B, a cocoon area to protect vulnerable residents and an isolation area.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Due to COVID-19 restrictions the approved centre had engaged remotely with Alzheimer's Society, Ireland to bring programmes to residents such as 'Bringing Joy' and 'Mindful Memories'.

2. The approved centre ensured that resident's had access to video calls during the COVID-19 restrictions to promote visual communication between residents and their families. This was a joint initiative between the social work and the occupational therapy departments.

3. The approved centre had purchased smart TVs for residents in isolation due to COVID-19. Activity Packs have been developed which included ideas for activities whilst in isolation.

4. The approved centre introduced a booklet entitled 'Remembering Yesterday Living Today: Getting to know me in my own unique way'. This booklet was used as a tool for the resident and their families to explore and present the resident's lifespan and life experiences through therapeutic reminiscence.

5. Residents had access to a new social work service for residents and their families in St Gabriel's Ward.

6. Nursing staff had commenced a Falls Prevention Group in October 2020 to explore and engage national policy regarding falls prevention in the approved centre.

7. A Public Innovation Funding grant had been secured to incorporate a dementia-friendly garden to maximise the outdoor space for residents and their families.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey, brick façade building erected in the 1980s. The community mental health teams were co-located in separate facilities within the building. There were plans in place for the community mental health teams to move to a new premises which would free up space for the approved centre to incorporate a new occupational therapy area, an extended palliative care area and reconfiguring of the nurses office and the residents day room.

The approved centre comprised a central nurses' office, sitting room, and day area with bedroom accommodation located on an adjacent corridor. Sleeping accommodation was in single, two or three-bed rooms with toilet and shower facilities en suite. St Gabriel's Ward had been reconfigured into three zones to protect residents during the COVID-19 pandemic. Zone B, which was a general ward area, Zone A, a cocoon area to protect vulnerable residents and an isolation area. The approved centre accommodated residents for acute or continuing care under the Psychiatry of Later Life team.

Residents had access to a large secure garden area under supervision. There were plans in place to renovate the garden and to provide residents and their families with a dementia-friendly garden space. At the time of inspection there were no plans to provide residents with single room accommodation. Overall, the unit was bright and clean and had a calm, dementia-friendly focus.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**15**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	8
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of South East Community Healthcare Organisation which was divided into two executive management teams (EMT) namely Carlow/Kilkenny/South Tipperary and Waterford/Wexford. St. Gabriel's ward was governed by the executive team from Carlow/ Kilkenny/South Tipperary team. The monthly EMT meetings consisted of heads of discipline, the head of service, and the service manager. An

Operational Team Meeting at senior management level met to discuss issues regarding the COVID-19 pandemic the frequency of these meetings were determined by changes to public health guidelines. The local Quality and Patient Safety Committee (QPSC) met monthly and issues arising from these meetings were then tabled at the Quality and Safety Executive Committee (QSEC), which met monthly. Minutes from these meetings were provided to the inspection team.

The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed. Clinical audits were furnished to the inspection team where applicable.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre and recorded in the risk register. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF). The approved centre had an Emergency Plan and a COVID-19 Prevention and Outbreak Plan.

At the time of inspection, the numbers and skill mix of clinical staff had increased to meet the residents' needs during the pandemic for both day and night duty. The approved centre had a dedicated occupational therapist and part-time social worker. Residents had access to a psychologist by referral.

The Area Lead for Mental Health Engagement had engaged a representative (family member) from the local Mental Health Forum in Kilkenny to be involved in St Gabriel's Ward on behalf of the residents. The representative had been attending the local QPSC meetings.

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 22: Premises	✗	High	✓		✓		✓		✗	Low

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.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The inspection team received two service user experience questionnaire (completed by family members) and spoke with two family members over the phone. Feedback suggested residents/families were involved in goal setting for their Individual Care Plans where possible. Respondents said they were able to discuss worries or concerns with members of staff. Respondents were very happy with the staff and the care and treatment received by their relatives. Respondents felt there were enough activities for their family members during the day. One respondent was happy that the staff had assisted them to stay in contact with their family member during the level 5 restrictions. On a scale of 1-10, (1 being poor and 10 being excellent) the approved centre received a 9 and a 10 rating.

5.2 Advocacy

The Inspectors did not receive a report from the IAN representative at the time of inspection.

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:

- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager III
- Principal Psychologist
- Occupational Therapists x 2
- Principal Social Worker
- Head of Service
- General Manager
- Service Manager
- Compliance Officer
- Risk Advisor
- Area Lead for Mental Health Engagement
- Mental Health Act Administrator
- Support Service Manager

Apologies:

- Executive Clinical Director
- Occupational Therapy Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. In this regard, the approved centre used stickers and photographs to identify residents; the stickers included resident names, date of birth and medical record numbers. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. In addition, residents had at least two choices for meals. A source of safe, fresh drinking water was available to residents as there was a water dispenser in the day room. Drinks were also offered at regular intervals throughout the day. Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. A Malnutrition Universal Screening Tool (MUST) was completed on every resident; specialised diets were accommodated, and dietitian services were organised on referral.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. There was also a fund for individualised clothing if an unplanned admission required new clothing. Residents changed out of their nightclothes during daytime hours unless specified otherwise in their individual care plans (ICPs).

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2021.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them; spacious wardrobes and lockers were allocated to each resident. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions; the checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. In addition, residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP and in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. The residents had access to a variety of recreational activities. Examples included the following: walking groups; chair based exercises; community outings; gardening; arts and crafts; music; games; and, TV. The approved centre provided access to recreational activities on weekdays and during the weekend.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. Due to COVID-19 precautions, residents could access church services virtually.

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 August 2019.

Visiting times were appropriate and reasonable; at the time of inspection, there were three visiting time slots per day. A separate visitors' room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Visiting also took place in the garden area. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting room was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in February 2021.

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

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in June 2021. It included all requirements related to:

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

There had been no searches in the approved centre since the last inspection.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

The clinical file of one resident who had died in the approved centre was examined on inspection. The death was managed in accordance with the resident’s 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 as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. Due to COVID-19 precautions, residents were split into two distinct zones, A and B, based on risk assessment. The therapeutic timetable included the following: mindful melodies; therapeutic gardening; chair based exercises; music therapy; multi-sensory programmes; nature based social interactions; art therapy; and, orientation therapy. Prior to the COVID-19 pandemic, external therapeutic service providers attended the approved centre; it was hoped at the time of inspection that these sessions would recommence as soon as possible. Additionally, many of the therapeutic sessions took place on a 1:1 basis due to the resident cohort.

The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. 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. This was done where possible and in line with COVID-19 Public Health Guidelines.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in September 2019.

The clinical file of one resident who had been transferred from the approved centre was examined. Full and complete written information regarding the resident was transferred when they moved from the approved centre. This Information was sent in advance to a named individual and included a resident transfer form and a letter of referral that contained a list of current medications.

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 general health policy and procedures, which included emergency procedures. The policy was last reviewed in April 2021.

The approved centre had an Automated External Defibrillator which was available to all staff. It did not have an emergency trolley; in the case of a medical emergency it was the process to call 999. There was a first aid kit onsite available to all staff. Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. At a minimum, the six-monthly general health assessment documented the following: physical examination; family and personal history; Body Mass Index (BMI), weight, and waist circumference; blood pressure; smoking status; nutritional status, including diet, physical activity, and sedentary lifestyle; and, dental health.

For residents on antipsychotic medication, there was an annual assessment of the following, unless more regular review was indicated by physical examination: glucose regulation; blood lipids; electrocardiogram (ECG); and, prolactin. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including but not limited to Breast check, retina check (diabetics only), and bowel screening. Additionally, the medication review, which was per prescriber guidelines, was integrated into the six-monthly review.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Residents were called by their preferred name, and the general demeanour of staff indicated respect. The manner in which staff addressed and communicated with residents was appropriate, as was staff appearance and dress. Staff displayed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate. All bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to the resident. Where residents shared a room, bed screening ensured that their privacy was not compromised.

All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass 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. Additionally, residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space, and appropriately sized communal room were provided. There was suitable and sufficient heating in the approved centre, both in bedrooms and in day areas. Rooms were ventilated, and private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. The lighting in communal rooms suited the needs of residents and staff; it was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. In addition, minimisation of ligature points was to the lowest practicable level, based on a risk assessment.

However, the approved centre was not kept in a good state of repair internally. On the inspection walkabout, scratches were observed on radiators in one bedroom. Furthermore, some paint was chipped on the wall of the relaxation room. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment; records were maintained. Painting of the approved centre took place on a three yearly cycle; therefore, paintwork was not due until 2022. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Current national infection control guidelines were followed; there was a new Assistant Director of Nursing (ADON) post for infection control, education, training, and audits.

There was a sufficient number of toilets and showers for residents in the approved centre. Residents had access to an assisted toilet. The approved centre had a designated sluice room and a designated cleaning

room, as appropriate. All resident bedrooms were appropriately sized to address resident needs. The approved centre provided suitable furnishings to support resident independence and comfort. Additionally, the approved centre provided assisted devices and equipment to address resident needs. However, there was a lack or storage space in the approved centre which meant that hoists were stored in the main bathroom in the Cocoon Zone (Zone A). This indicated that the physical structure was not 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. At the time of inspection there were plans to refurbish parts of the building, these plans included swapping the nurses station and the day room so as the residents day room could look out to the garden. Plans also included extending the approved centre into the community health area to provide more space for an activities room and a larger palliative care area. There were no plans to provide single-room accommodation for the residents.

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

a) **The approved centre was not consistently maintained in good decorative condition. There were scratches on a radiator in one bedroom, some paint was chipped on the relaxation room wall, 22 (1) a.**
b) **There was a lack of storage space in the approved centre which meant that hoists were stored in the main bathroom in the Cocoon Zone (Zone A). This indicated that the physical structure was not 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, 22 (3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in October 2018 and included:

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

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

All entries in MPARs were legible. Medication was reviewed and rewritten at least six-monthly or more frequently where there was a significant change in the resident's care or condition; this was documented in the clinical file. When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file. Directions to crush medication was only accepted from the resident's medical practitioner. The medical practitioner provided a documented reason as to why the medication was to be crushed. The pharmacist was consulted about the type of preparation to be used. Additionally, the medical practitioner documented in the MPAR that the medication was to be crushed.

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 to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as a refrigerator. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further safety.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on staffing. The policy was last reviewed in March 2019.

The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times. This was documented. The approved centre had one multi-disciplinary team. The disciplines included psychiatry, nursing, occupational therapy and social work staff. Residents had access to a dietitian and speech and language therapist when required. There was a dedicated occupational therapist and social worker in the approved centre. Residents had access to psychology by referral via the principal psychologist.

An appropriately qualified staff member was on duty and in charge at all times; this was documented. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulations (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (16)	16	100%
Medical (2)	2	100%
Occupational Therapist (1)	1	100%
Social Worker (1)	1	100%

Psychologist (0)	0	0%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in June 2021. The policy included:

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

Resident records were secure, up-to-date, and in good order. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in June 2021 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. The approved centre maintained a minor complaints log. There were no outstanding complaints at the time of inspection. Processes were in place for making, handling and investigating complaints. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in July 2019. The approved centre also had a COVID-19 addendum which was approved in July 2020. The risk management policy and associated safety statement addressed all requirements.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. The risk management procedures actively reduced identified risks to the lowest practicable level. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with relevant legislation

Clinical risks were identified, assessed, treated, reported, and monitored; clinical risks were documented in the risk register as appropriate. Health and safety risks were documented in the risk register, as appropriate. Structural risks, including ligature points, were removed or effectively mitigated; there was a low risk due to the resident cohort. Corporate risks were identified, assessed, treated, reported, and monitored by the approved centre; corporate risks were documented in the risk register. The approved centre implemented a plan to reduce risks to the residents while any works in the premises were ongoing.

Individual risk assessments were completed prior to and during the following: physical restraint; mechanical restraint; at admission to identify individual risk factors; resident transfer; resident discharge; and, in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with no conditions to registration attached. The certificate was displayed prominently at the entrance of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

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

Evidence of Implementation: The clinical file of one resident who was mechanically restrained was reviewed on inspection. Mechanical restraint was undertaken due to the enduring risk of harm to the self or others and was only used to address an identified clinical need. Mechanical restraint was used only when less restrictive alternatives were deemed unsuitable. Additionally, mechanical restraint was ordered by a registered medical practitioner under the supervision of the consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf; the prescription for mechanical restraint was observed on inspection and was updated every three months.

The clinical file contained a contemporaneous record that specified the following: there was an enduring risk of harm to the self or others; less restrictive alternatives were implemented without success; the type of mechanical restraint; the situation in which mechanical restraint was to be applied; the duration of the restraint; the duration of the order; and the review date.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated August 2020. It addressed the following:

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

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

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

Evidence of Implementation: One episode of physical restraint was reviewed on inspection. Physical restraint (PR) was used in rare, exceptional circumstances and was in the best interests of the resident, where the resident posed immediate threat of serious harm to the self or others. PR was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered. PR was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using PR. PR was initiated by a registered medical practitioner (RMP) or a registered nurse (RN), or by other members of the multi-disciplinary team (MDT) in accordance with the policy on PR. 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 as soon as was practicable; this was recorded in the clinical file.

The RMP completed a medical examination of the resident (physical examination) no later than three hours after the start of an episode of PR. The order for PR lasted a maximum of 30 minutes, and the episode of PR was recorded in the clinical file. The Clinical practice form (CPF) was completed by the person initiating and ordering the use of PR no later than three hours after the episode. The CPF was signed by the CP within 24 hours. The resident was informed of the reasons for, likely duration of, and circumstances leading to discontinuation of PR unless the information may be prejudicial to the resident's mental health, well-being, or emotional condition. As soon as practicable, and with the resident's consent, or where the resident lacked the capacity and could not consent, the resident's next of kin or representative was informed of the use of PR and a record of the communication was placed in the clinical file.

Staff were aware of relevant considerations in the individual care plan pertaining to the resident's requirements and needs in relation to the use of PR. Where practicable, a same sex staff member was present at all times during the episode of PR. The resident was afforded the opportunity to discuss the episode with members of the MDT involved in their care as soon as practicable. The completed CPF was placed in the resident's clinical file. Each episode of PR was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

Transfer: The transfer policy, which was last reviewed in September 2019, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in June 2021, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed on inspection. The discharge plan included the estimated date of discharge and documented communication with the relevant general practitioner, primary care team, or Community Mental Health

Team. The discharge meeting was attended by the resident, the key worker, relevant members of the multi-disciplinary team, and family member or advocate, where appropriate and with the consent of the resident. The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and, informational needs. Discharge was coordinated by the key worker. The preliminary discharge summary was sent to the general practitioner within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and, risk issues such as signs of relapse. The family member, carer, or advocate was involved in the discharge process, where appropriate.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 22: Premises					
Reason ID : 10002273		**The approved centre was not consistently maintained in good decorative condition. There were scratches on a radiator in one bedroom, some paint was chipped on the relaxation room wall, 22 (1) a.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Scratches on a bedroom radiator and paint chipping on the relaxation room wall have been reported to Technical Services. Painting works will be complete week ending 5th November 2021 . Painting requirements outside of the maintenance schedule will be notified to Technical Services on the Arantico system.	Walk through review	Achievable and realistic	05/11/2021	Technical Services.
Preventative Action	A 3 year preventative maintenance and decorative programme is in place. The painting schedule for Gabriel's Ward is 2022 . We are considering options to protect the radiators from damage by moving beds in the longterm.	Walk through review	Achievable and realistic	05/11/2021	Technical Services
Reason ID : 10002274		**There was a lack of storage space in the approved centre which meant that hoists were stored in the main bathroom in the Cocoon Zone (Zone A). This indicated that the physical structure was not 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, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The issue related to two hoists. Both can now be safely stored in the respective	Walk through review	Achievable	04/10/2021	ADON + Technical Services

	service users accommodation. Reconfiguration of room space has allowed this to happen.				
Preventative Action	Design plans are developed to extend the area of St Gabriel's Ward. A dedicated equipment storage space is included in these design plans.	Design plans.	Achievable	31/03/2023	Technical Services

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.

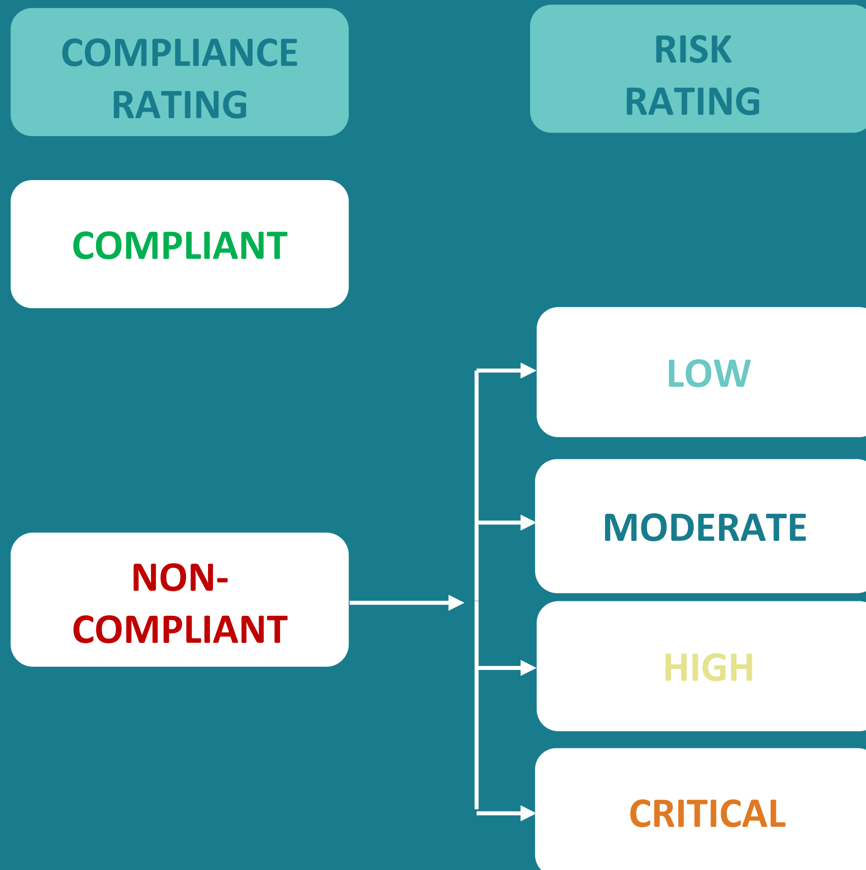
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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