Adult Mental Health Unit, Sligo University Hospital

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

ADULT MENTAL HEALTH UNIT, SLIGO UNIVERSITY HOSPITAL

Sligo, Co. Sligo

Date of Publication:
Tuesday 15 February 2022

ID Number: AC0287

2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care

Conditions Attached:
Yes

Most Recent Registration Date:
19 October 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Teresa Dykes, General Manager, Mental Health CHO1

Inspection Team:
Mary Connellan, Lead Inspector
Marianne Griffiths
Susan O'Neill

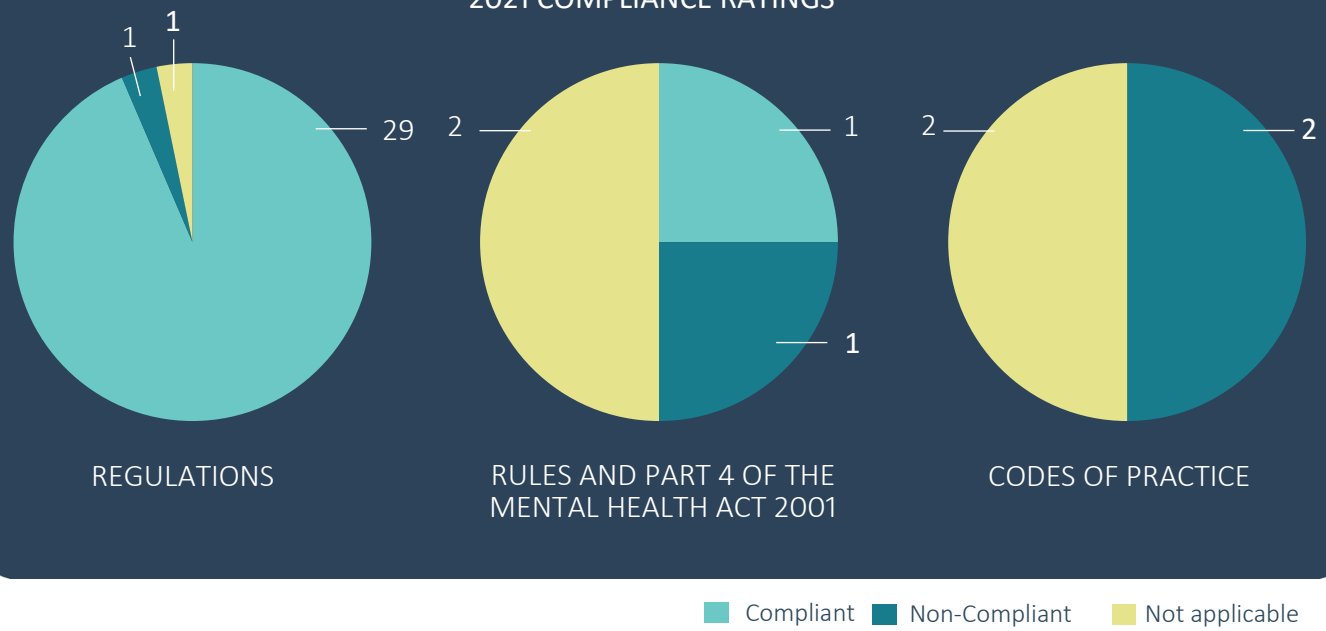
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
31 August – 3 September

Previous Inspection date:
17 – 20 November 2020

Inspection Type:
Announced Annual Inspection

2021 COMPLIANCE RATINGS

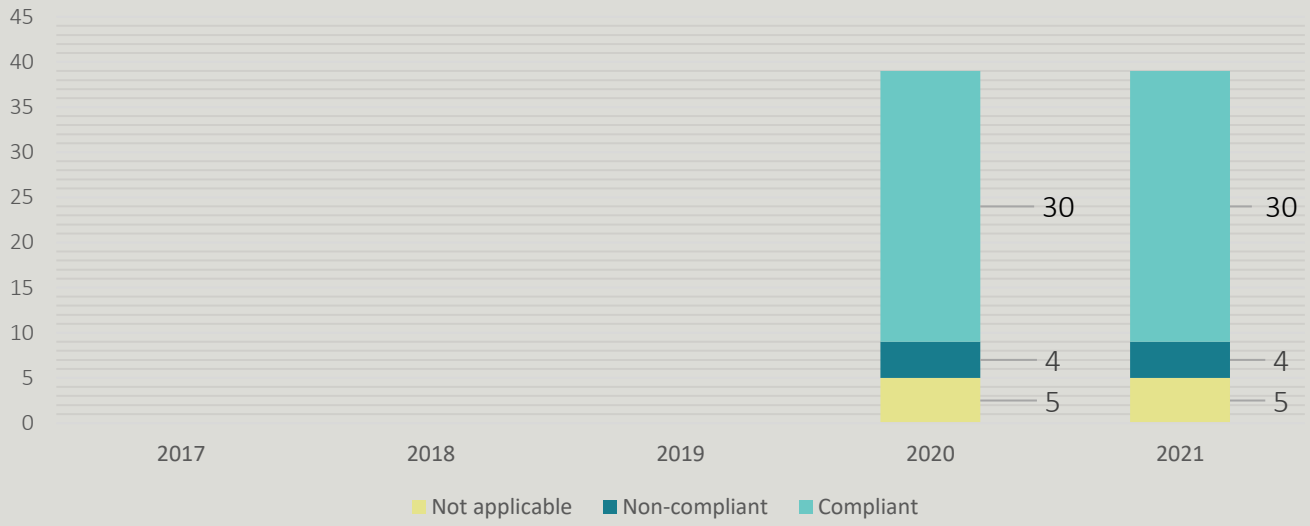


RATINGS SUMMARY 2017 – 2021

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

Please note: **The approved centre opened for the first time in 2020.**

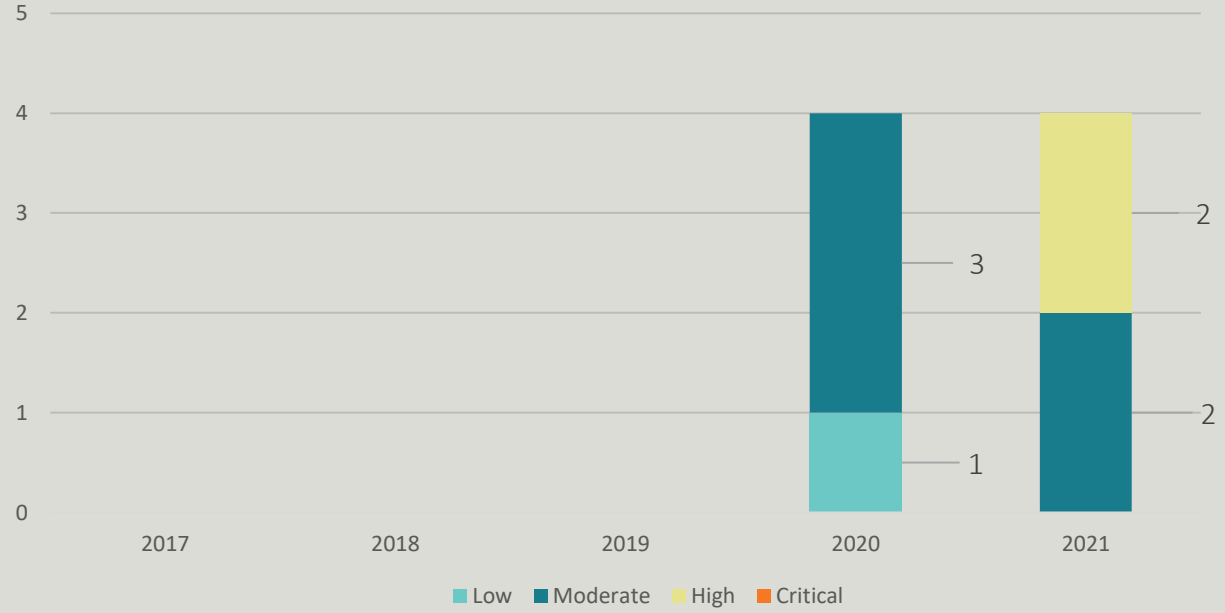
CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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.

Please note: **The approved centre opened for the first time in 2020.**

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2017 – 2021



Contents

1.0 Inspector of Mental Health Services – Review of Findings 6
Conditions to registration 6
2.0 Quality Initiatives 10
3.0 Overview of the Approved Centre 11
3.1 Description of approved centre 11
3.2 Governance 12
3.3 Reporting on the National Clinical Guidelines 13
4.0 Compliance 14
4.1 Non-compliant areas on this inspection 14
4.2 Areas that were not applicable on this inspection 14
5.0 Service-user Experience 15
5.1 Service-user feedback 15
5.2 Advocacy 16
6.0 Feedback Meeting 17
7.0 Inspection Findings – Regulations 18
8.0 Inspection Findings – Rules 52
9.0 Inspection Findings – Mental Health Act 2001 55
10.0 Inspection Findings – Codes of Practice 58
Appendix 1: Corrective and Preventative Action Plan 63
Appendix 2: Background to the inspection process 69

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 purpose built acute mental health unit on the grounds of Sligo University Hospital (SUH), which opened in October 2020. Five general adult community mental health sector teams, a Psychiatry of Old Age (POA) community team, a Rehabilitation and Recovery team and a Mental Health Intellectual Disability team had admitting rights to the approved centre. The service also had a liaison psychiatry team working directly in SUH.

Compliance Summary	2020	2021
% Compliance	88%	88%
Regulations Rated Excellent	N/A	N/A

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

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *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-*	All 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-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.	to staff training 26(4) have been deferred until 2022.
The approved centre was not in breach of Condition 1 and the approved centre was compliant with Regulation 26: Staffing at the time of inspection.	

Escalation and enforcement actions since last inspection

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

Escalation and enforcement actions since this inspection

There were no escalation or enforcement actions since this inspection.

Safety in the approved centre

We found that the approved centre 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.
- 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.

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 inadequate.

- Group themes included recovery through activity-gardening group, arts and crafts group, baking group and music group, independent living skills-breakfast group, lunch time group and Self Care group. Other groups included coping through the senses group-sensory integration and Action of inertia group. Occupational therapists also participated in three co-facilitated groups: Recovery care

plan group-with nursing, lifestyle redesign group-with pharmacy, Let's Get Active Group - with a Sports Partnership Qualified Facilitator.

- 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:

- Residents' individual care plans inspected were found to be inadequate.
- The registered medical practitioner did not complete a medical examination of the resident within three hours of the episode of physical restraint taking place.

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.

- Accommodation comprised of 25 single en suite bedrooms that were spacious and designed to afford safety and comfort for the 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.
- 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.

However, the approved centre was non-compliant with Section 4 of the Mental Health Act: Consent to Treatment.

Responsiveness to residents' needs

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

- The approved centre had two activity rooms with recreational supplies including television, Wii Console with games and controls, foosball table, table tennis table, jigsaws, board games, books and newspapers. There were three different types of exercise equipment in the main courtyard. There

was also a beauty room, a relaxation room, a quiet room, and a group room which could be used for recreational pursuits.

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

Governance of the approved centre

We found that there were adequate governance structures and processes in place.

- The approved centre was part of Community Healthcare Organization 1 (CHO 1) and was governed under the Sligo Leitrim Mental Health Service (SLMHS). There was an Area Management Mental Health committee for SLMHS which met monthly.
- There was a Quality and Risk committee that met monthly.
- There was a monthly business meeting specific to the approved centre chaired by the Assistant Director of Nursing. Along with a Policy & Procedure Group (PPG) and the Drugs and Therapeutic Committee, this committee reported to the Quality and Risk Committee monthly.
- The risk register was reviewed monthly at the business meeting and risks were escalated to the Quality and Risk committee and area management team as applicable. There was a strong emphasis on risk management.
- The Irish Advocacy Network (IAN) facilitated a weekly one-to-one session with residents. There was a recovery education facilitator who worked with residents in the approved centre one day a week. As part of the National Framework for Recovery and the CHO1 implementation plan, a recovery implementation officer was working with staff to measure their fidelity to recovery principles and practice.

COVID-19 response

Protocols to manage and decrease the risk of COVID-19 to residents were evident. Visiting was restricted but was facilitated on a pre-planned basis at the time of inspection. Infection prevention control measures were used and there was access to clinical personnel from this field.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. In partnership with Mental Health Ireland and the National Recovery Framework, CHO1 service had an implementation plan to develop, deliver and embed Recovery education and practices. A Recovery Education Facilitator had commenced and worked directly in the approved centre.

2. The purchasing and implementation of '*iAuditor*' which was *a* software package to support the efficient and timely completion of audits and the sharing of results. It aimed to provide visibility and insights to help raised safety and quality standards across an organization.

3. The *HSE Health Passport* communication tool had been introduced across the wider service. Commonly used in the intellectual disability services, this had been adapted for mental health and used mainly with residents and service users from the rehabilitation and recovery team.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was a purpose built acute mental health unit on the grounds of Sligo University Hospital (SUH). It had opened in October 2020. The Adult Mental Health Unit (AMUH) served a population of approximately 109,000 and included the counties of Sligo, Leitrim, West Cavan and South Donegal from the Pettigo/Laghey line. This encompassed five general adult community mental health sector teams, namely: South Leitrim, North Leitrim (including West Cavan and South Donegal), South and West Sligo, Sligo Town and North Sligo. There was one Psychiatry of Old Age (POA) community team, one Rehabilitation and Recovery team and one Mental Health Intellectual Disability team that had admitting rights to the approved centre. The service also had a liaison psychiatry team working directly in SUH. This service was part of the National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self- Harm and the National Clinical Programme for Eating Disorders. The service was also a pilot site for the National Clinical Programmes for Early Intervention Psychosis (EIP) and for Attention Deficit Hyperactivity Disorder (ADHD). Individually these programmes were under the directorship of consultant psychiatrist leads all who worked directly in or with the approved centre.

Accommodation comprised of 25 single en suite bedrooms that were spacious and designed to afford safety and comfort for the residents. There was a high dependency unit (HDU) and a seclusion suite. There was a dining room, day rooms, a quiet room, an occupational therapy room with a kitchen, a beauty room and two courtyard style gardens. Visits were facilitated in designated visitor rooms located in the reception area and separate from the accommodation and activity areas.

The approved centre adopted the in-reach model of care. The medical team, and the associated health and social care professionals from the respective sector teams attended the approved centre to provide care and treatment for their service users. Core clinical staff that worked directly in the approved centre included ward-based nursing staff, two occupational therapists, a pharmacist and visiting pharmacist technician. A recovery education facilitator worked in the approved centre one day a week.

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

Resident Profile	
Number of registered beds	***25***
Total number of residents	**23**
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	1
Number of patients on Section 26 leave for more than 2 weeks	1

3.2 Governance

The approved centre was part of Community Healthcare Organization 1 (CHO 1) and was governed under the Sligo Leitrim Mental Health Service (SLMHS). The wider Community Healthcare area included Donegal and Cavan/Monaghan. There was an Area Management Mental Health committee for SLMHS comprising of the General Manager/Registered Proprietor, Business Manager, Area Lead for Mental Health Engagement, Service User Representative, Area Director of Nursing, Mental Health Act Administrator, Executive Clinical Director and Heads of Discipline for health and social care professionals. This committee met monthly.

There was a Quality and Risk committee that met monthly. Chaired by the Area Director of Nursing and co-chaired by the Executive Clinical Director this group had representation from the various heads of discipline and included representatives from various committees.

There was a monthly business meeting specific to the approved centre chaired by the Assistant Director of Nursing. Membership comprised of medical personnel, health and social care professionals, mental health act administrator and members of the nursing team. All of these personnel worked directly in the approved centre. The local business manager and recovery implementation officer were also members. Agenda items included review of the risk register, maintenance, health and safety, infection prevention and control, COVID-19, restrictive practices, and compliance. The latter included audit and review. Along with a Policy & Procedure Group (PPG) and the Drugs and Therapeutic Committee, this committee reported to the Quality and Risk Committee monthly.

The person with responsibility for risk management was known by all staff. This role was supported by the heads of discipline and the risk advisor. The risk register was reviewed monthly at the business meeting and risks had been escalated to the Quality and Risk committee and area management team as applicable. There was a strong emphasis on risk management. Emergency response training was provided once weekly for staff working in the approved centre. This included fire training and the management of clinical emergency events. There was a culture of managing and reporting incidents which was evidenced in a review of the National Incident Report Forms (NIRF) which were part of the National Incident Management System (NIMS).

The clinical staff that worked directly in the approved centre comprised of nursing staff, two occupational therapists, a pharmacist and a visiting pharmacist technician. The various sector teams, i.e., medical and health and social care professionals provided an in-reach model for care and treatment. The assessed therapeutic needs of the residents were deemed to have been met, however, not all the health and social care professionals had resumed to pre-COVID-19 working in the approved centre. This was evidenced with the inspection of Individual Care Plans (ICP) where a number of meetings held documented nursing and medical staff in attendance only. Sessional one- to- one work with residents had been provided. Staff were supported through their respective line management with training, clinical supervision and professional development.

The Irish Advocacy Network (IAN) facilitated a weekly one-to-one session with residents. At the time of the inspection these meetings were held virtually using an audio-visual link with an electronic tablet. The advocacy service was enhanced by the presence of a recovery education facilitator who worked with residents in the approved centre one day a week. In consultation with residents, various groups had been

facilitated to include anger management, a group on individual care planning and a group on hope and recovery. As part of the National Framework for Recovery and the CHO1 implementation plan, a recovery implementation officer was working with staff using a Team Recovery Implementation Plan (TRIP). This is a self-assessment process by which service providers can measure their fidelity to recovery principles and practice, designed by implementing Recovery through organizational change.

In line with practices at Sligo University Hospital the approved centre adopted the Health Protection Surveillance Centre (HSPC) guidance for acute hospital settings. Protocols to manage and decrease the risk of COVID-19 to residents were evident. Visiting was restricted but was facilitated on a pre-planned basis at the time of inspection. Infection prevention control measures were used and there was access to clinical personnel from this field.

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:

Please note: **The approved centre opened for the first time in 2020.**

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019	2020		2021	
Regulation 15: Individual Care Plan		N/A		N/A		N/A	✓		✗	High
Part 4 of the Mental Health Act 2001: Consent To Treatment		N/A		N/A		N/A	✓		✗	High
Code of Practice on the Use of Physical Restraint		N/A		N/A		N/A	✓		✗	Moderate
Code of Practice on Admission Transfer and Discharge to and from the approved centre		N/A		N/A		N/A	✗	Low	✗	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 had not admitted any children 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 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 no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Four completed service user experience questionnaires were returned to the inspectors. No resident chose to speak with an inspector over the telephone during the inspection.

Of the four completed questionnaires, three indicated that each of these residents knew their multi-disciplinary team members, the remaining one indicated 'no' to this question. Two of four indicated that they knew who their keyworker was. Three respondents indicated that they knew what their care plan was, with two indicating they were 'always' involved in setting goals for their care plan, one indicated 'sometimes' and one left this section unanswered.

Three respondents indicated that they were 'always' able to discuss worries or concerns with a member of staff, the remaining one indicated 'sometimes' for this question. Two respondents indicated that there were enough activities during the day, two respondents indicated no. Three of four respondents indicated that they had space for privacy, and that they felt their privacy and dignity was respected.

On a scale of 1-10, with 1 being poor and 10 being excellent, two residents rated 10 out of 10 for their overall experience of care and treatment, one resident rated 9 and one resident rated 3.

5.2 Advocacy

The Inspectors received a report from the IAN representative. The approved centre had an advocacy service. A representative from the IAN was available to the approved centre on a weekly basis. This service was facilitated via audio-visual link using an electronic tablet during the COVID-19 pandemic.

Feedback from the IAN on behalf of the residents was that individuals liked and appreciated having a single room with en suite facilities. The building was described very positively, and residents stated that they liked the new facility. Residents had said that they were happy with the care and treatment, the food was good, and the occupational therapy was good. Specific groups were named as being enjoyable and these included a gardening group, mindfulness group, the exercise group and a baking group. Residents also commented positively on having the opportunity to discuss their medication with a pharmacist.

Areas for improvement suggested by residents to the IAN representative was that, for one resident, their room was noisy as it was located near the heating system. Residents commented that it was difficult to speak with a social worker. It was suggested that laundry facilities on site would be good as opposed to sending laundry out.

The inspector spoke with the Recovery Implementation Officer for CH0 1. This role had been developed by the HSE in partnership with Mental Health Ireland and had responsibility for implementing the National Framework for Recovery across the organization in a focussed and targeted way. An integral part of this role was the development of structures that put each residents' recovery at the centre of every interaction, intervention, and communication. A Recovery Education Facilitator who worked with the residents also represented the resident voice in the recovery educational sessions and training for all staff working within the approved centre.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Registered Proprietor representative
- Acting Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 1
- Recovery Implementation Officer
- Occupational Therapy Manager
- Risk Advisor
- Principal Psychology Manager
- Principal Social Worker

Apologies were received on behalf of the social work team leader and the mental health act administrator.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, and serving of food. Food was prepared and cooked in Sligo University Hospital and transported to the approved centre which was on the same site. Hygiene was maintained to support food safety requirements and residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and takes account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans.

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 written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in September 2020.

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

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. The approved centre had two activity rooms with recreational supplies. These included: television, Wii Console- with games and controls, foosball table, table tennis table, jigsaws, board games, books and newspapers. There were three different types of exercise equipment in the main courtyard. There was also a beauty room, a relaxation room, a quiet room, and a group room which could be used for recreational pursuits.

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. A priest chaplain visited the approved centre each week and contact details for other multifaith chaplains were available.

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 October 2020.

Visiting times were appropriate and reasonable, and the visiting process took account of COVID-19 precautions. Visits were by pre-arranged appointments only. Two separate visitors' rooms were 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. One of the two visiting rooms 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 relating to communication. The policy was last reviewed in September 2020.

Residents had access to Wi-Fi internet and the approved centre's cordless telephone phone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in March 2020. It included all policy regulation requirements including:

- 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.

No searches had taken place since the last inspection and the approved centre was inspected on the basis of policy only.

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 November 2020.

The clinical file of a resident who had died was inspected. The death of the resident was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodates the resident representatives, family, next of kin, and friends. All deaths of residents, including a resident transferred to a general hospital for care and treatment, 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

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

Four ICPs were only developed by medical and nursing staff and were not developed by all the relevant multi-disciplinary team (MDT) members following a comprehensive assessment within seven days of admission. One ICP did not identify appropriate goals for the resident, in this ICP goals were frequently documented as 'alleviate symptoms'. Five ICP's did not identify the specific resources required to provide the care and treatment, instead non-specific resources were documented in the term 'MDT'.

A multi-disciplinary team did not review or update individual care plans in three ICPs. Medical and nursing staff only reviewed ICP's. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances and goals; this was documented.

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

a) **Four individual care plans were not developed by the multi-disciplinary team following a comprehensive assessment within seven days of admission: these four individual care plans were developed by nursing and medical staff only.**
b) **One individual care plan did not identify appropriate goals for the resident.**
c) **Five individual care plans did not identify the resources required to provide the care and treatment.**
d) **A multi-disciplinary team did not review or update individual care plans in three individual care plans.**

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 residents, 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.

Social work and psychology were of service to the approved centre on an in-reach basis. At the time of the inspection there was no resident in the approved centre requiring psychology input. Social work staff met with residents on an individual basis only and did not undertake delivering group work. There were two full time occupational therapists assigned to the approved centre.

After being assessed by an occupational therapist, the resident was referred to specific groups that best met their needs. Group themes included recovery through activity-gardening group, arts and crafts group, baking group and music group, independent living skills-breakfast group, lunch time group and Self Care group. Other groups included coping through the senses group- sensory integration and Action of inertia group. Occupational therapists also participated in three co-facilitated groups: Recovery care plan group-with nursing, lifestyle redesign group-with pharmacy, Let's Get Active Group - with a Sports Partnership Qualified Facilitator.

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 an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in September 2020.

The clinical file of one resident who had been transferred in a planned situation was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer to a named individual, which included a resident transfer form and 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 medical emergencies policy. The policy was last reviewed in May 2020.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Residents received appropriate general health care interventions in line with individual care plans. A six-monthly general health assessment was inspected, in relation to the only resident who was in the approved centre for a period greater than six months.

This six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, nutritional status including diet and physical activity, and Body Mass-Index (BMI), weight and waist circumference. The resident did not wish to receive a dental health check. 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 written operational policy and procedures on the provision of information to residents. The policy was last reviewed in September 2020.

The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information is clearly and simply written. It contained details of housekeeping arrangement, 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 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.

Residents were provided with the details of their multi-disciplinary team (MDT). 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

Resident's privacy and dignity was appropriately respected at all times. The manner in which staff addressed and communicated with residents was respectful. 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.

Residents were facilitated to make private phone calls. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. 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

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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.

The lighting in the approved centre was sufficiently bright and positioned to facilitate reading and other activities. Ligature points were minimised to the lowest practicable level. The condition of the physical structure and the overall approved centre environment was 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. The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained.

The approved centre 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 compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in October 2020.

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

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to health and safety. The policy was last reviewed in November 2020.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the use of CCTV. The policy was last reviewed in November 2019. The policy included the purpose and function of using CCTV for observing residents in the approved centre.

There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. The approved centre's use of CCTV was also detailed in the resident information booklet. CCTV cameras used to observe residents were not capable 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 written staffing policy and procedures relating to the recruitment, selection, and Garda vetting requirements. The staffing policy was last reviewed in November 2019.

The number and skill mix of staffing were sufficient to meet resident needs. Staff employed in the approved centre included nursing staff, medical staff, two occupational therapists, a pharmacist, and a visiting pharmacy technician. Social work and psychology worked on an in-reach basis. A recovery education facilitator worked in the approved centre one day a week. Up to eight teams had admitting privileges to the approved centre. 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 (48)	48	100 %
Medical (26)	26	100 %
Occupational Therapist (2)	2	100 %
Social Worker (5)	5	100 %
Psychologist (2)	2	100 %

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in March 2020.

Residents' 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 was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It contained all 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 policies and procedures requiring a three-yearly review had been reviewed and updated as required.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process, including remote access to the tribunals. Staff attended Mental Health Tribunals and provided assistance as necessary when the patient required assistance to attend or participate in the process. Resources and facilities were provided by the approved centre to support patients in 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 on the complaints process. The policy was last reviewed in September 2020 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All oral and written complaints were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made.

Minor complaints were documented in the community minutes and all formal complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan (ICP). Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them, and this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in September 2020. The risk management policy addressed all requirements of the regulation.

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

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

Incidents were recorded and risk-rated in a standardised format, and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and

recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission and data returns in line with the MHC Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. The information provided was anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered 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 one condition 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 September 2020. 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 taking into account Rule 5.1 (direct observation). Residents in seclusion had access to adequate toilet and washing facilities. 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 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

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined.

There was no documented evidence present on the clinical file or on the Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent,* that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment.

A Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient and documented the following: Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, any supports provided to the patient in relation to the discussion and their decision-making, and any views expressed by the patient. The form 17 also included approval by a consultant psychiatrist and authorisation by a second consultant psychiatrist.

The Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* did not adequately document a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because in relation to one patient: A Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent:* did not document that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment.

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating **MODERATE**

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 September 2020. The policy covered:

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

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

Monitoring: The approved centre submitted an annual report to the Mental Health Commission on its use of physical restraint.

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

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

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. 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 registered medical practitioner did not complete a medical examination of the resident within three hours of the episode of restraint taking place. 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 non-compliant with this Code of Practice because the registered medical practitioner did not complete a medical examination of the resident within three hours of the episode of restraint taking place, 5.4.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge, each of which were reviewed in September 2020.

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

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, 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. There was a key-worker system in place. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, social and housing needs, work situation, education, and dietary requirements. 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. Family members were involved in the discharge process. A discharge plan was in place as part of the individual care plan. The discharge plan included an estimated date of discharge, documented communication with the relevant general practitioner, and a reference to early warning signs of relapse. A discharge meeting was held and this was attended by the resident, their key-worker, and relevant members of the multi-disciplinary team.

The pre-discharge assessment covered the resident's psychiatric and psychological needs, a current mental state examination, informational needs, and social and housing needs. The discharge was co-ordinated by the key worker. A preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was issued to relevant personnel within 14 days.

The discharge summary letter included details of diagnosis, medication, mental state at discharge, outstanding health and social issues, follow-up arrangements, and names and contact details of key

people for follow-up. The discharge summary did not include details of prognosis and it did not include risk issues such as signs of relapse.

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

a) **The discharge summary did not include details of the resident's prognosis, (38.4).**
b) **A discharge summary did not include risk issues such as signs of relapse, (38.4).**

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10002398		**Four individual care plans were not developed by the multi-disciplinary team following a comprehensive assessment within seven days of admission: these four individual care plans were developed by nursing and medical staff only.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The ECD and Nominee Proprietor have meet with key Line Managers of the AHP's attached to the AMHU SLMHS. A QIP has been agreed and will commence with the appointment of a Social Worker which has approval and is currently within the recruitment cycle. Input from Psychology deisgnated hours per week.	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic.	31/03/2022	Social Work Principal/Team Leader Principal Psychologist OT Manager
Preventative Action	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	02/12/2021	Psychology Social Work Compliance Manager
Reason ID : 10002399		**One individual care plan did not identify appropriate goals for the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Memo to all staff of the Approved Centre re appropriate identification of goals for ICPs. To be discussed at Business Group and Quality and Risk.	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	29/11/2021	Medical Staff Nursing OT Social Work Psychology Compliance Manager

Preventative Action	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	02/12/2021	Medical Staff Nursing OT Social Work Psychology Compliance Manager
Reason ID : 10002400		**Five individual care plans did not identify the resources required to provide the care and treatment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Memo to all staff of the Approved Centre re appropriate identification of resources for ICPs. To be discussed at Business Group and Quality and Risk.	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	01/12/2021	Medical Staff Nursing OT Social Work Psychology Compliance Manager
Preventative Action	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	01/12/2021	Medical Staff Nursing OT Social Work Psychology Compliance Manager
Reason ID : 10002401		**A multi-disciplinary team did not review or update individual care plans in three individual care plans.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Psychology- Correspondence to all staff re the importance of contributing to ICPs. QIP to be put in place regarding psychology staffing to ensure capacity to attend ICPs. To be discussed at Quality and Risk Group. Social Work- Mental health Social	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	31/03/2022	Psychology Social Work

	Worker not currently attached to a community team will commence taking referrals from AMHU. Meetings with clients will be via video link or telephone. Input in to care plan will be discussed with client and sent directly to AMHU for inclusion in client file. Permanent Mental Health Social Worker will be place in AMHU Sligo by end Q1 2022.				
Preventative Action	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	3 monthly auditing of ICPs. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	02/12/2021	Psychology Social Work Compliance Manager

Part 4 of the Mental Health Act 2001: Consent to Treatment					
Reason ID : 10002402		**In relation to one patient: A Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent: did not document that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	ECD will meet with all consultants to discuss need to assess and document the capacity to consent or refuse treatment of each patient admitted involuntarily for three months or more. Mental Health Act Administrator will give a presentation to all consultants in relation to this aspect of the Act.	6 monthly auditing of Part 4 of the Mental Health Act 2001: Consent to Treatment documentation to monitor compliance. Action plans will be discussed at the monthly Business group and shared with colleagues. ECD will share findings with Consultant Group.	Achievable and Realistic	31/01/2022	ECD All Consultants Compliance Manager
Preventative Action	6 monthly auditing of Part 4 of the Mental Health Act 2001: Consent to Treatment documentation to monitor compliance. Action plans will be discussed at the monthly Business group and shared with colleagues. ECD will share findings with Consultant Group.	6 monthly auditing of Part 4 of the Mental Health Act 2001: Consent to Treatment documentation to monitor compliance. Action plans will be discussed at the monthly Business group and shared with colleagues. ECD will share findings with Consultant Group.	Achievable and Realistic	31/01/2022	ECD All Consultants Compliance Manager

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10002397		**The registered medical practitioner did not complete a medical examination of the resident within three hours of the episode of restraint taking place, 5.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	ECD to send memo to NCHDs reminding them of the regulatory requirement to physically examine a resident within 3 hours of an episode of restraint taking place.	6 monthly auditing of Physical Restraint documentation to monitor compliance. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	01/12/2021	ECD All NCHDs
Preventative Action	6 monthly auditing of Physical Restraint documentation to monitor compliance	6 monthly auditing of Physical Restraint documentation to monitor compliance. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	02/12/2021	ECD All NCHDs Compliance Manager

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10002395		**The discharge summary did not include details of the resident's prognosis, (38.4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	PPPG group to review the discharge summary and amend to include mandatory section on prognosis.	Admission, Transfer and Discharge practises will be audited 6 monthly to ensure compliance. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	31/01/2022	ECD PPG
Preventative Action	3 yearly review of policy to ensure compliance with Code of Practise for Admission, Transfer and Discharge	Admission, Transfer and Discharge practises will be audited 6 monthly to ensure compliance. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	03/12/2021	ECD PPG
Reason ID : 10002396		**A discharge summary did not include risk issues such as signs of relapse, (38.4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	PPPG group to review the discharge summary and amend to include mandatory section on risk issues and signs of relapse.	Admission, Transfer and Discharge practises will be audited 6 monthly to ensure compliance. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	31/01/2022	ECD PPG
Preventative Action	3 yearly review of policy to ensure compliance with Code of Practise for Admission, Transfer and Discharge.	Admission, Transfer and Discharge practices will be audited 6 monthly to ensure compliance. Action plans will be discussed at the monthly Business group and shared with colleagues.	Achievable and Realistic	03/12/2021	ECD PPG

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.

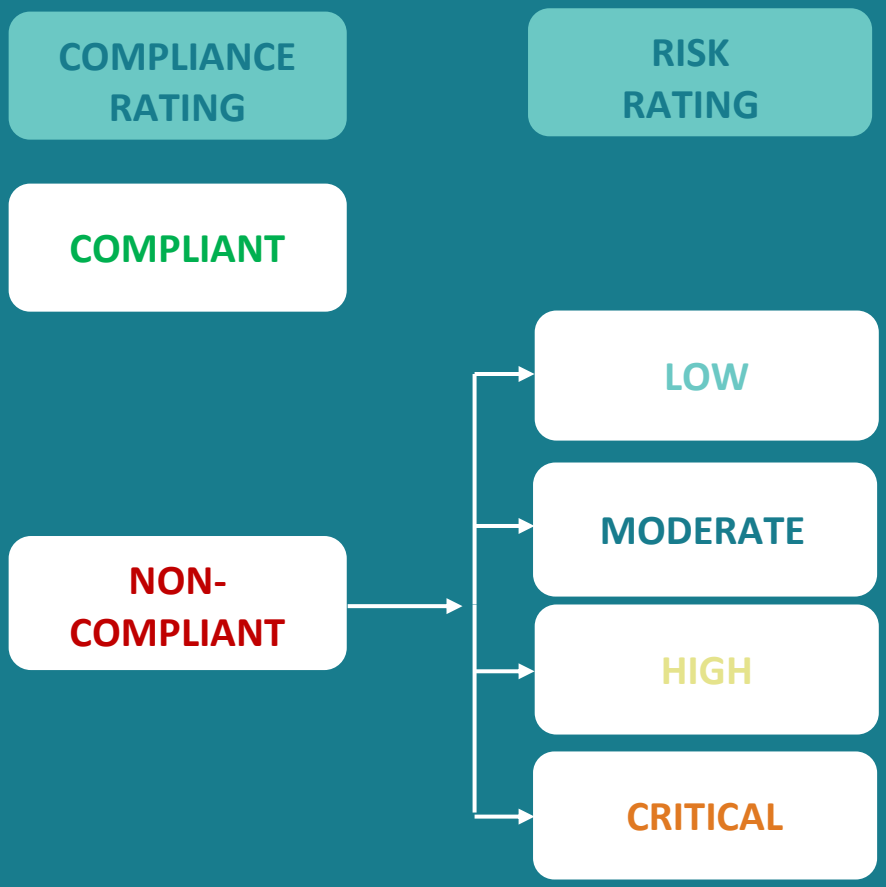
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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