St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre

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mental health commission

Annual Inspection
Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

ST BRIDGET'S WARD & ST MARIE GORETTI'S WARD, CLUAIN LIR CARE CENTRE

St Mary's Campus, Longford Road, Mullingar, Co. Westmeath

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

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care / Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Conditions Attached:
None

Most Recent Registration Date:
31 May 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Martina Lennon, General Manager, Mental Health Services

Inspection Team:
Marianne Griffiths, Lead Inspector
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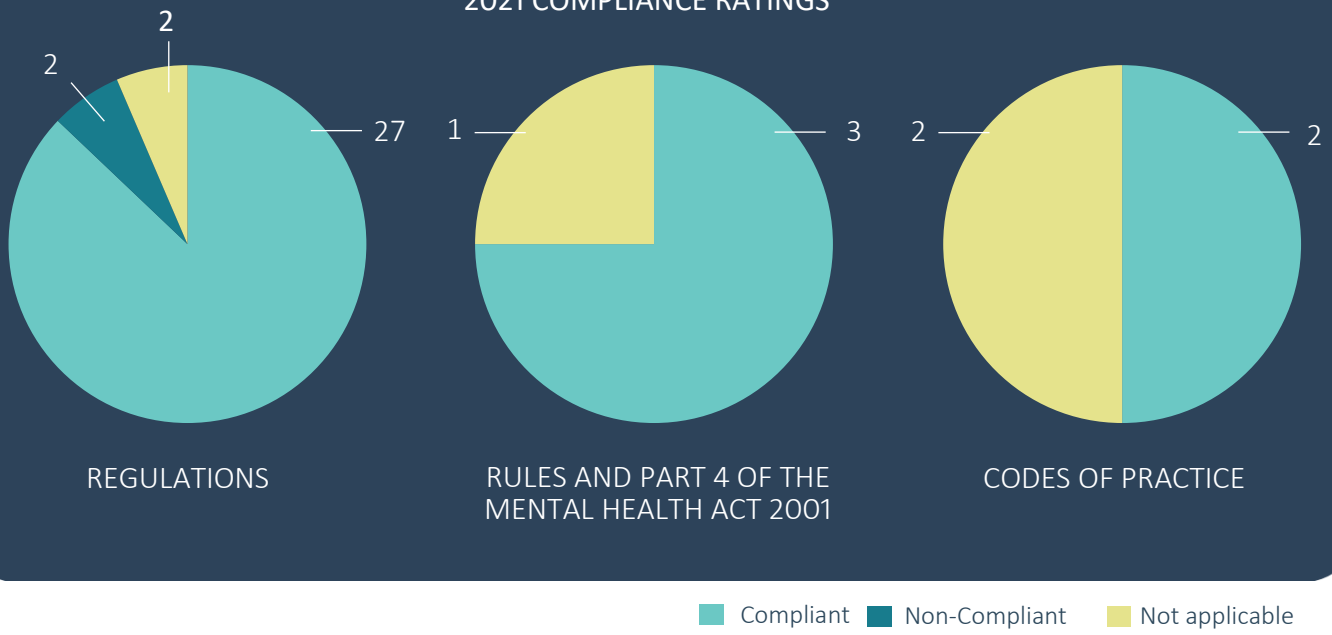
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
7 – 10 September 2021

Previous Inspection date:
10 – 13 November 2020

Inspection Type:
Announced Annual Inspection

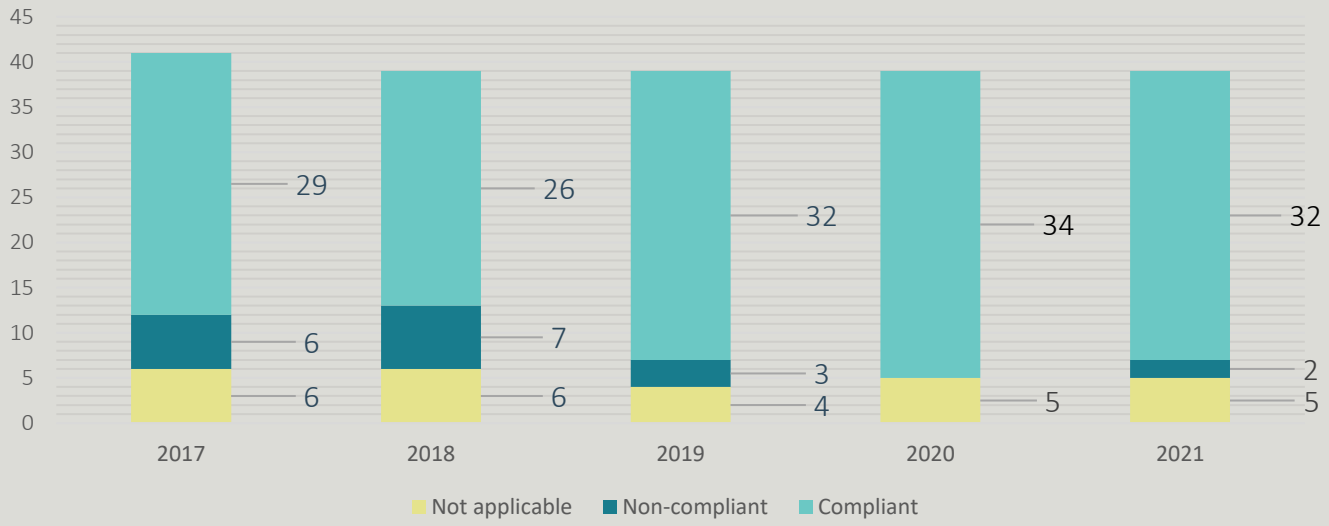
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

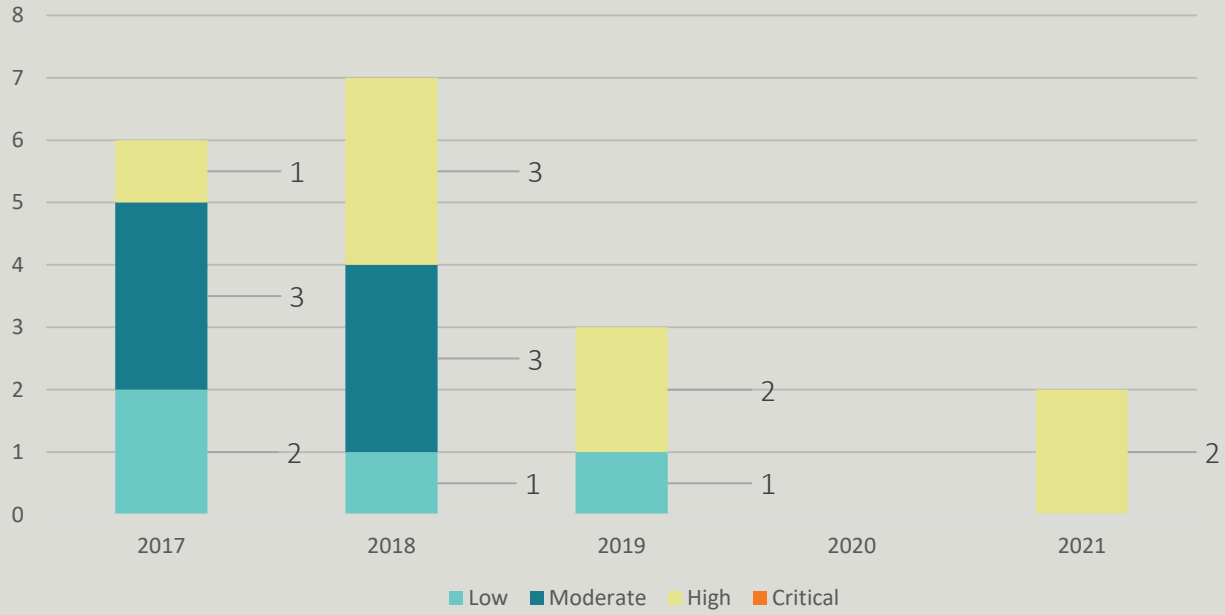
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2017 – 2021



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

The approved centre, opened in 2012, was located on the grounds of St. Mary's Care Centre and was located in a two-storey building. The approved centre provided care and treatment for long stay and continuing mental health care residents and acute admission for psychiatry of later life. Eight teams had admitting rights to the approved centre. While the approved centre was registered for 42 residents, the capacity had been temporarily reduced to 36 as a result of COVID-19 restrictions so that all residents could be accommodated in single, en suite rooms.

The building was shared with old age care facilities which were located in two units similar in layout to the approved centre. Shared facilities included: the central reception, a church, and catering facilities and therapy facilities. However, residents from Cluain Lir had limited access to therapy facilities due to an ongoing lack of clarity as to their entitlement to use these rooms. Access to a large therapy room was only permitted two days per week and the approved centre did not have a dedicated Tribunal Room**.** Residents could not access the external garden space at the back of the large therapy room.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	83%	79%	91%	100%	91%
Regulations Rated Excellent	4	6	18	N/A	N/A

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

Conditions to registration

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

Escalation and enforcement actions since last inspection

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

Escalation and enforcement actions since this inspection

There were no escalation and 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.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However, the risk associated with slates falling from an adjacent HSE building into the Cluain Lir garden, meant that residents of the approved centre did not have full or free access to the garden at the time of the inspection.

Appropriate care and treatment of residents

We found that therapeutic activities were not provided which were appropriate to meet the needs of residents.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.

- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

However:

- The programme of activities was predominantly recreational and there were insufficient recovery oriented therapeutic programmes provided by appropriately qualified professionals. This programme was led by the nursing staff and was not multi-disciplinary in its delivery.
- There was only limited access to therapeutic spaces including the occupational therapy kitchen, the snoezelen room and the therapies room.

Respect for residents' privacy, dignity and autonomy

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

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

Responsiveness to residents' needs

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

- Recreational activities provided included: Bingo, aromatherapy, nail treatments, hand massage, garden walks, word wheels, soft balls, current affairs groups, a foot spa, beauty therapy, relaxation, arts and crafts. Movie night took place on a weekly basis and some residents chose to undertake activities including knitting. The approved centre provided access to recreational activities on weekdays and during the weekend.

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

Governance of the approved centre

- The Cluain Lir Care Centre was part of the Laois Offaly, Longford, Westmeath, Louth Meath Community Health Organisation (CHO). The Catchment Area team comprised of the Heads of Discipline as well as other senior managers from the wider CHO area.
- Local governance processes were also in place and included The Clinical Governance committee which had a set agenda which included: the results of audits completed, Mental Health Commission inspection report findings and specific areas of clinical care such as ensuring access to general health requirements such as dental care for residents.
- The approved centre had a multi-disciplinary group tasked with reducing restrictive practices within the approved centre.
- The Quality and Patient Safety meetings reviewed the risk register each month. Incidents were reviewed with action documented as applicable. If relevant, decisions were made as to the appropriateness of convening a Serious Incident Management Team to review issues of particular concern. Complaints and Health & Safety matters were also discussed at this meeting.
- The approved centre had a robust risk management process in place.
- There was a culture of promoting continuous quality within the approved centre. Audits were completed to identify areas of potential improvement. Clinical information was of a high quality and resident information was stored securely at all times.
- The Area Lead for Mental Health Engagement Lead was invited to attend the monthly community meetings, the Restrictive Practice Group and the management team meetings. The OT department gathered information from residents about their preferences with regard to OT activities.

COVID-19 response

COVID-19 contingency planning included the allocation of isolation corridors on both wards. Residents were required to isolate after admission or following a period of time spent in a general hospital. Staff used the space within the approved centre to minimize the risk of the spread of COVID-19. Infection control guidelines were followed in order to further reduce the risk posed by COVID-19.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A “Festival in a van” social inclusion concert was arranged for residents of both wards. This service was provided by Creative Ireland and Westmeath County Council. This provided live entertainment and a social outlet for residents which also adhered to social distancing requirements.

2. New smart TV’s had been procured for both wards to aid with online activities, this allowed for interactive engagement and provided appropriate online entertainment to the resident cohort.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the grounds of St. Mary's Care Centre which was situated across the road from the Regional Hospital Mullingar. The approved centre was opened in 2012 and was located in a two-storey building. St Bridget's Ward was located on the ground floor and St. Marie Goretti's Ward on the first floor. The building was shared with old age care facilities which were located in two units similar in layout to the approved centre. Shared facilities included: the central reception, a church, and catering facilities. Therapy facilities were also shared, however residents from Cluain Lir had limited access to therapy facilities due to an ongoing lack of clarity as to their entitlement to use these rooms. Access to a large therapy room was only permitted two days per week and the approved centre did not have a dedicated Tribunal Room. Residents could not access the external garden space at the back of the large therapy room.

The approved centre provided care and treatment for long stay and continuing mental health care residents and acute admission for psychiatry of later life residents undergoing assessment of needs. In total eight teams had admitting rights to the approved centre. Any of the Westmeath or Longford community teams could admit to the facility. Staff from the Psychiatry of Old Age team provided therapies within each unit. Community teams provided care and treatment to residents after they had been discharged.

While the approved centre was registered for 42 residents (22 in St. Bridget's and 20 in St. Marie Goretti's) the capacity had been temporarily reduced to 36 as a result of COVID-19 restrictions so that all residents could be accommodated in single, en suite rooms.

Residents from St. Brigid's Ward had access to a large external garden and to an internal garden space. The residents of St. Marie Goretti Ward did not have an equivalent space, instead they accessed the large downstairs garden by using a lift and going through St. Brigid's dormitory corridor and dining room. At the time of the inspection, access to the main garden was limited due to the risk of slates falling from an adjacent building.

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

Resident Profile	
Number of registered beds	***42***
Total number of residents	**29**
Number of detained patients	2
Number of wards of court	8
Number of children	0
Number of residents in the approved centre for more than 6 months	20
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The Cluain Lir Care Centre was part of the Laois Offaly, Longford, Westmeath, Louth Meath Community Health Organisation (CHO). The approved centre operated within this wider structure in terms of meetings and risk management processes. Local governance processes were also in place. The three main meetings at which Cluain Lir was represented included: the clinical governance meeting, the Catchment Area Meeting and the Quality and Patient Safety meeting. Each of these meeting took place on a monthly basis and ensured oversight of the approved centre as well as the wider service including Cluain Lir.

The Clinical Governance meetings had a set agenda which included: the results of audits completed, Mental Health Commission inspection report findings and specific areas of clinical care such as ensuring access to general health requirements such as dental care for residents. Best practice guidelines, matters relating to the premises and challenges relating to the recruitment of an occupational therapist were each documented within these minutes.

The Catchment Area team comprised of the Heads of Discipline as well as other senior managers from the wider CHO area. Issues relating to the service were discussed at these meetings. These included: mandatory staff training and the ongoing difficulties that the Cluain Lir St Brigid's and Marie Goretti staff and residents were experiencing in terms of accessing suitable therapeutic space. Similarly, these minutes contained a documented discussion about the risk associated with the falling slates from a building adjacent to the Cluain Lir garden and a proposed solution to this risk. The approved centre had a multi-disiciplinery group tasked with reducing restrictive practices within the approved centre.

The Quality and Patient Safety meetings reviewed the risk register each month. There was also a review of the potential risk issues facing the Cluain Lir approved centre at each meeting. Incidents were reviewed with action documented as applicable. If relevant, decisions were made as to the appropriateness of convening a Serious Incident Management Team to review issues of particular concern. Complaints and Health & Safety matters were also discussed at this meeting.

The approved centre had a robust risk management process in place. The Heads of Discipline each acknowledged the risks facing their respective departments. The medical, nursing, OT and social work disciplines each identified staff recruitment and retention as their main risk. The fact that there was no dedicated social worker employed specifically for the Cluain Lir residents in the approved centre were particular concerns for the social work department. Access to training was highlighted by the nursing and psychology departments with concerns raised over the approved centre reliance on HSE-Land online training. Other risks (identified by the medical team) included inadequate shared space for Mental Health Tribunals and off ward therapeutic activities and the risks posed by the ongoing COVID-19 pandemic.

As identified risks, staffing and staff resources provided a challenge to the approved centre. Staff from the in-reach teams attended the approved centre if a specific identified need arose for the resident however this did not happen often, and it was predominantly the social worker and psychologist from the Psychiatry of Later Life team who worked with the Later Life in-patients and attended the ICP meetings. In the case of

occupational therapy, a full time OT had recently commenced working in Cluain Lir. This post had been vacant for the four months between May and September 2021, resulting in unmet resident needs.

The multi-disciplinary team, although functioning well in terms of their individual disciplines, appeared to be challenged in delivering integrated, multi-disciplinary therapeutic groups within the approved centre. This was evident from the lack of interdisciplinary working in providing therapeutic groups to the residents of Cluain Lir and the reliance on nursing therapies at the time of the inspection. Supervision arrangements were in line with the requirements of the various disciplines and included aspects of performance appraisal for staff.

The Area Lead for Mental Health Engagement had been redeployed from this role during the COVID-19 pandemic. They had recently returned to the role. The Area Lead for Mental Health Engagement acted as a supported residents to access the Irish Advocacy Network and to recruit an advocate relevant to their specific need.

There was a culture of promoting continuous quality within the approved centre. Strategic goals identified by the Heads of Discipline included: 100% compliance with the Mental Health Commission Judgement Support Framework and 100% staffing in line with Vision for Change (nursing), to maintain best practice and mandatory training as well as possible through the pandemic (medical), and to strengthen and develop the existing work of the Social Workers in their individual clinical teams across the region (social work). The Heads of Discipline also sought to ensure appropriate psychological supports were provided for clients of the psychology service and to provide a high equity, effective and equitable occupational therapy (OT) service to the clients of the approved centre. Audits were completed to identify areas of potential improvement. Clinical information was of a high quality and resident information was stored securely at all times.

The approved centre promoted service user engagement in various manners. The Area Lead for Mental Health Engagement Lead was invited to attend the monthly community meetings, the Restrictive Practice Group and the management team meetings. The OT department gathered information from residents about their preferences with regard to OT activities. COVID-19 contingency planning included the allocation of isolation corridors on both wards. Residents were required to isolate after admission or following a period of time spent in a general hospital. Staff used the space within the approved centre to minimize the risk of the spread of COVID-19. Infection control guidelines were followed in order to further reduce the risk posed by COVID-19.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 16: Therapeutic Services	✓		✓		✓		✓		✗	High
Regulation 22: Premises	✓		✗	Low	✓		✓		✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As no voluntary resident had received ECT since the last inspection, this Code of Practice was non-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.

No resident chose to speak with the inspectors during the inspection. 17 completed questionnaires were returned to the inspection team. All respondents stated that they had space for privacy and 16 indicated that they felt their privacy and dignity were always respected, with one respondent stating 'sometimes.' 15 respondents stated that there were enough activities to do during the day, with two ticking the 'no' box for this question. Six respondents indicated that they did not know what their individual care plan was; eleven respondents understood what their individual care plan was. In responses to the question, 'How often are you able to discuss worries or concerns with a member of staff as soon as you need to?' 12 residents stated 'always,' four ticked the 'sometimes' box and one respondent did not have worries or concerns. 15 residents felt that they could communicate freely with family and friends with two stating 'no' when asked.

Comments included: 'the music is great, 'the food is ok' and 'the staff are good.' Two residents of Marie Goretti ward stated that they would like direct access to a garden.

5.2 Advocacy

The approved centre had an advocacy service. The Inspectors received a report from the Irish Advocacy Network (IAN) representative who received the feedback from service users. This report contained the following information:

- The food was lovely.
- Nice to have a modern private bedroom with an en suite.
- Nursing staff were very helpful.
- The garden in St. Bridget's ward was lovely.
- Resident report to enjoy the mindfulness & art groups.

Further comments made by the IAN representative were:

- The lack of continuity of an occupational therapist meant that residents felt that they were disadvantaged in receiving OT services.
- Residents found it hard to be nursed in isolation for two weeks after coming from the general hospital.

6.0 Feedback Meeting

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

- Clinical Director
- Registered Proprietor
- Administrator
- Business Manager
- Mental Health Act Administrator
- Area Lead for Mental Health Engagement
- Psychology Manager
- Occupational Therapy Manager
- Social Work Manager
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Consultant Psychiatrist
- Non Consultant Hospital Doctor
- Senior Social Worker

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. The attendees reiterated the difficulties in accessing appropriate therapeutic space within the approved centre and those encountered in terms of the recruitment of an occupational therapist.

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. 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 and a source of safe, fresh drinking water was available at all times 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, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing, if required, that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. At the time of inspection, no residents were wearing nightclothes during the day as indicated by their individual care plan.

There was a laundry service for residents provided by the approved centre.

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 safekeeping of all personal property and possessions.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in March 2020.

Residents' 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 by their ICP and in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities provided included: Bingo, aromatherapy, nail treatments, hand massage, garden walks, word wheels, soft balls, current affairs groups, a foot spa (for one individual), beauty therapy, relaxation, arts and crafts. Movie night took place on a weekly basis and some residents chose to undertake activities including knitting.

The approved centre facilitated structured recreational activities on weekdays and during the weekend.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits, which were last reviewed in July 2021.

At the time of the inspection, visits to the approved centre were curtailed and in line with infection control measures and public health guidance. Outside of these restrictions reasonable times were identified during which a resident could receive visits and reasonable steps had been taken to ensure the safety of residents and visitors. As all residents had single room accommodation, visits could take place in the residents' bedrooms. A separate visitors' room or visiting area was provided where residents could meet visitors in private. The visitors' room was suitable for children visiting a resident.

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, which were last reviewed in August 2019.

Residents had access to a mail, email, internet, and telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. There were two iPad's with Wi-Fi to facilitate further communication with family members during COVID-19 pandemic.

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. This was not applicable to any resident at the time of inspection.

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 July 2021.

The policy included all requirements related to:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- Carrying out searches with the consent of a resident.
- Carrying out searches in the absence of consent.
- The finding of illicit substances during a search.

No searches had been carried out in the approved centre since the previous inspection. Therefore, this regulation was inspected on the policy requirement 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 number of written operational policies and protocols for care of residents who were dying, all of which were last reviewed in July 2021.

The clinical file of a resident who had died was inspected. The death was managed in accordance with the resident's religious and cultural practices, with dignity and propriety and in a way that accommodated the resident's family, and next of kin.

The end of life care provided was appropriate to residents' physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, as were the privacy and dignity of the resident. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care.

All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT every three months, in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

(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

A number of health and social care professionals worked with the Psychiatry of Later Life team within the approved centre; these included; an occupational therapist, a social worker and a psychologist. The team also included medical staff. The nursing team within the approved centre engaged in the delivery of nurse lead therapies with the residents.

The therapeutic services and programmes were not consistently appropriate to meet the residents' needs. The ICP of one resident had been identified as lacking required OT involvement for a number of months over the course of the summer when the occupational therapy post had been vacant.

Individual therapeutic services were delivered to residents following clinical assessments. However, the approved centre's therapeutic services and programmes were not directed towards restoring and maintaining optimum levels of physical and psychosocial functioning due to the fact that the programme of activities was predominantly recreational and there were insufficient recovery oriented therapeutic programmes provided by appropriately qualified professionals. This programme was led by the nursing staff and was not multi-disciplinary in its delivery.

Limited access to therapeutic spaces including the occupational therapy kitchen, the snoezelen room and the therapies room also meant that the approved centre therapeutic services and programmes were not directed towards restoring and maintaining optimum levels of physical and psychosocial functioning. While there was a therapies room within Cluain Lir that was available to the residents, it was only accessible two days a week.

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

a) **The therapeutic services and programmes were not consistently appropriate to meet the residents' needs. The individual care plan of one resident had been identified as lacking required occupational therapy involvement for a number of months, 16 (1).**
b) **The approved centre's therapeutic services and programmes were not directed towards restoring and maintaining optimum levels of physical and psychosocial functioning due to the fact there were insufficient recovery oriented therapeutic programmes facilitated by appropriately qualified professionals, 16 (2).**

c) **Limited access to therapeutic spaces including the occupational therapy kitchen, the Snoezelen room and the therapy room also meant that the approved centre therapeutic services and programmes were not directed towards restoring and maintaining optimum levels of physical and psychosocial functioning, 16 (1).**

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The clinical file of one resident who had been transferred 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, that contained a list of current medications and a resident transfer form.

In the case of this emergency transfer, communications between the approved centre and the receiving facility were documented and followed up with a written referral.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy and a policy for responding to medical emergencies. The Medical Emergency policy was last reviewed in March 2020.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Three clinical files were examined in relation to provision of general health services. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans. General health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The clinical files of three residents who had been in the approved centre over six months were reviewed. The six monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, body mass-index and weight. For residents on anti-psychotic medication there had been an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG).

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 March 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 was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and residents' rights.

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

Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Residents were called by their preferred name, and the general demeanour of staff and the way in which they addressed and communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs and sought the resident's permission before entering their bedrooms, as appropriate.

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.

Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre, and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics and the lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces.

Hazards were not consistently minimised in the approved centre. The risk associated with slates falling from an adjacent HSE building into the Cluain Lir garden, meant that residents of the approved centre did not have full or free access to the garden at the time of the inspection. Ligature points were minimized to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43 degrees Celsius. Current national infection control guidelines were followed.

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

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

The approved centre was non-compliant with this regulation because the overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff & visitors. Access to the garden for the residents has been significantly curtailed because of structural risks posed by an adjacent HSE building, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, six 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 signature of the medical practitioner for each entry.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition: this was documented in the clinical file. Directions to crush medication were only accepted from the resident's medical practitioner with a documented reason as to why contained in the residents' ICP.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as 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 written operational policies and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last approved August 2019. An addendum in relation to COVID-19 had been added to the policy. Each ward had its own Safety Statement that had been reviewed and updated annually as required.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to staffing. The policy which was last reviewed in July 2019, included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

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. The Psychiatry of Older Age team provided the multi-disciplinary input into the approved centre. This included medical, nursing, occupational therapy, social work, and psychology staff.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

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

Staff Training Table		
Profession	Mental Health Act 2001	
Nursing (31)	31	100%
Medical (29)	29	100%
Occupational Therapist (7)	7	100%
Social Worker (6)	6	100%
Psychologist (6)	6	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 relating the creation of, access to, retention off and destruction of records. The policy was last reviewed in July 2019.

Resident records were secure, up-to-date, and in good order, and were physically stored together in a secure office. 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 maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Documentation of inspections relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All 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 to support the Mental Health Tribunal process including adequate resources to support the process. Staff were available to attend Mental Health Tribunals when a patient required assistance to attend or participate in the process. The resources and facilities were provided by the approved centre to support patients accessing Mental Health Tribunals remotely.

The approved centre was compliant with this regulation

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission or soon thereafter. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented and actioned appropriately. All complaints (that were not minor) 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). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management as well as a Safety Statement. The policy was last reviewed in March 2019.

The risk management policy and associated safety statement addressed all policy requirements, including:

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

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 and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were completed in conjunction with medication requirements or administration, and resident transfer and discharge. Individual risk assessments were also completed 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, with the information provided 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 by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently at the approved centre reception.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also 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.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

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

- The storage of Dantrolene.
- The management of cardiac arrest.

Training and Education: All staff involved in ECT had been trained in line with best international practice. Similarly, all staff involved in ECT had appropriate training in Basic Life Support techniques documented.

Evidence of Implementation: Staff from the Regional Midlands General Hospital delivered ECT to Cluain Lir residents as required. ECT took place in theatre facilities located in the general hospital. Patients of Cluain Lir were escorted to the General Hospital by a staff member from Cluain Lir in order to receive ECT treatment.

The clinical record of one involuntary patient receiving ECT was reviewed. The patient had been assessed as not having capacity to provide consent and a Form 16 was documented. A detailed medical history and full physical assessment was completed with the resident prior to the commencement of the programme of ECT. The patient was informed of their right to access an advocate of their choosing at any stage. A cognitive assessment was completed before each programme of ECT and ongoing monitoring of the patient's cognitive status was carried out over the course of the treatment.

A full and completed ECT record was maintained for each session including: the session number, laterality, the dose (prescribed and administered) and the duration and quality of the seizure. Post ECT assessments were contained within the clinical file.

The ECT register was completed as required.

The approved centre was compliant with this rule.

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Evidence of Implementation: The approved centre had a written operational policy and procedures relating to the use of mechanical restraint. The policy was last updated in September 2020.

Mechanical restraint was only used for the enduring risk of harm to the self or others, or used to address an identified clinical need. Mechanical restraint was used only when less restrictive alternatives were unsuitable. Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of the consultant psychiatrist or by the duty consultant psychiatrist acting on his or her behalf.

The clinical file of one patient who had been mechanically restrained was reviewed on inspection. The clinical file contained a contemporaneous record which specified the following: there was an enduring risk of harm to the self or others; less restrictive alternatives were implemented without success; the type of mechanical restraint; the situation in which mechanical restraint was being applied; the duration of the restraint; the duration of the order; and the review date.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of a patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment. The patient was assessed as being unable to consent to the continued administration of medication. Treatment was approved and authorised by two consultant psychiatrists pursuant to the procedure set out in *Form 17: Administration of Medicine for more than 3 Months Involuntary Patient (Adult)- Unable to Consent.*

The Form 17 contained the name of the medications prescribed and a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medication(s). It contained details of the discussion with the patient, including: the nature and purpose of the medication(s); the effects of the medication(s) including any risks and benefits; and any views expressed by the patient; any supports provided to the patient in relation to the discussion and their decision-making.

The approved centre was compliant with Part 4 of the Mental Health Act 2001.

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: The clinical file of a resident that had been physically restrained was examined on inspection. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Completed clinical practice forms had been placed in the resident's clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. A key-worker system was in place. The admission was on the basis of a mental illness or mental disorder. The resident had 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, 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. The discharge plan included an estimated date of discharge, as well as a follow-up plan and a reference to early warning signs of relapse. A discharge meeting was held and attended by the resident, their key worker, and relevant members of the multi-disciplinary team (MDT).

A discharge assessment was completed: it addressed the resident's psychiatric and psychological needs, a current mental state examination, a comprehensive risk assessment, and a risk management plan. There

was appropriate MDT input into discharge planning. A preliminary discharge summary was issued within three days. A comprehensive discharge summary had been issued within fourteen days.

The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues and follow- up arrangements. Risk issues had also been included. A timely follow up appointment had been arranged.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10002403		**The therapeutic services and programmes were not consistently appropriate to meet the residents' needs. The individual care plan of one resident had been identified as lacking required occupational therapy involvement for a number of months, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Regrade existing basic grade OT to Senior grade OT (approval granted by Head of Service)	Track process of application	Yes if suitable candidate is available	31/03/2022	OT Manager
Preventative Action	Senior OT Community providing urgent assessments and advice	Monitored by OT Manager	Yes	03/12/2021	OT Manager
Reason ID : 10002404		**The approved centre's therapeutic services and programmes were not directed towards restoring and maintaining optimum levels of physical and psychosocial functioning due to the fact there were insufficient recovery oriented therapeutic programmes facilitated by appropriately qualified professionals, 16 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Regrade existing basic grade OT to Senior grade OT (Approved by Head of Service)	OT Manager to track process of application	Yes if suitable candidate is available	31/03/2022	OT Manager
Preventative Action	Senior OT Community providing urgent assessments and advice	Monitor by OT Manager	Yes	03/12/2021	OT Manager
Reason ID : 10002405		**Limited access to therapeutic spaces including the occupational therapy kitchen, the Snoezelen room and the therapy room also meant that the approved centre therapeutic services and programmes were not directed towards restoring and maintaining optimum levels of physical and psychosocial functioning, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Provide additional space for therapeutic areas Remove the current multisensory room and provide one extra multipurpose area for therapies Kitchenette now available for use on a bookable basis Funding has been	3 monthly audit of space usage	Yes	31/01/2022	ADON

	made available to create a multisensory area on each ward				
Preventative Action	The multisensory room is now repurposed to a 2nd therapy room which is bookable The kitchenette is available on a bookable basis and available for OT assessments The larger therapeutic space is available on Thurs/Fridays for group work	3 monthly audit of usage space	Yes	03/12/2021	ADON

Regulation 22: Premises	
Reason ID : 10002406	**The overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff & visitors. Access to the garden for the residents has been significantly curtailed because of structural risks posed by an adjacent HSE building, 22(3).**
The approved centre did not provide acceptable Corrective and Preventative Action Plan (CAPA) within the required timeframe. The approved centre will be required to provide an acceptable CAPA and the Commission will follow up in relation to same and will escalate accordingly.	

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.

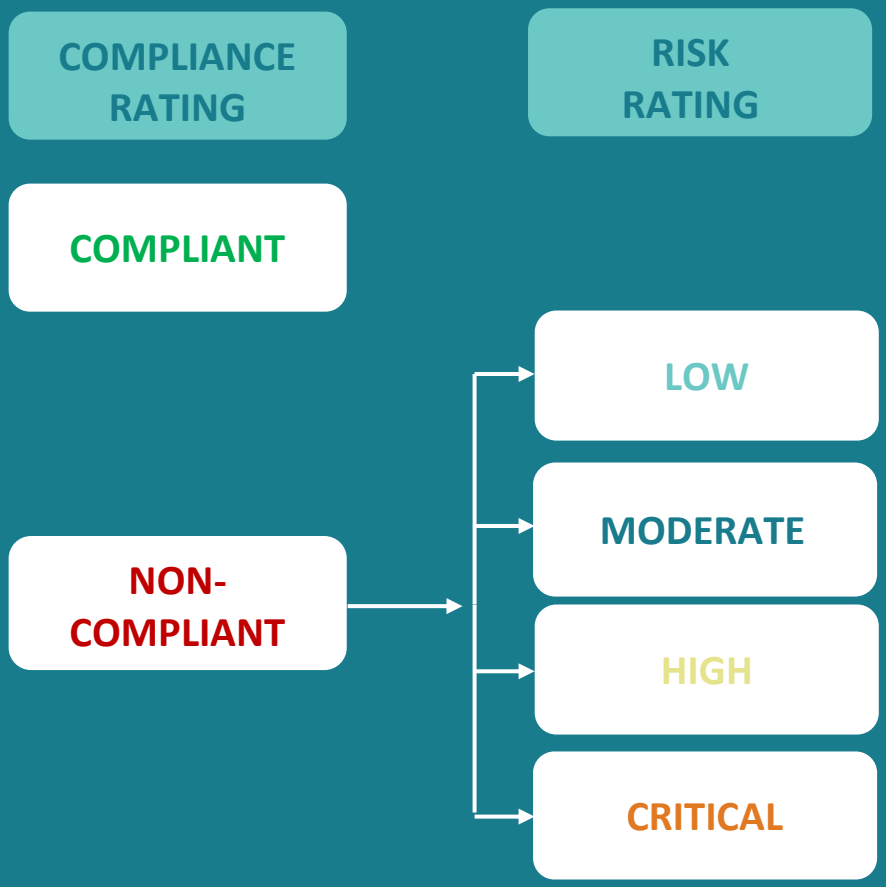
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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