Deer Lodge

mhc
coimisiún meabhair - shláinte
mental health commission

Annual Inspection
Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

DEER LODGE

Deer Lodge, St. Margaret's Road, Killarney, Co. Kerry

Date of Publication:
Monday 21 February 2022

ID Number: AC0159

2021 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
11 July 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Hugh Scully, Acting General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
Susan O'Neill, Lead Inspector
Sarah Jones

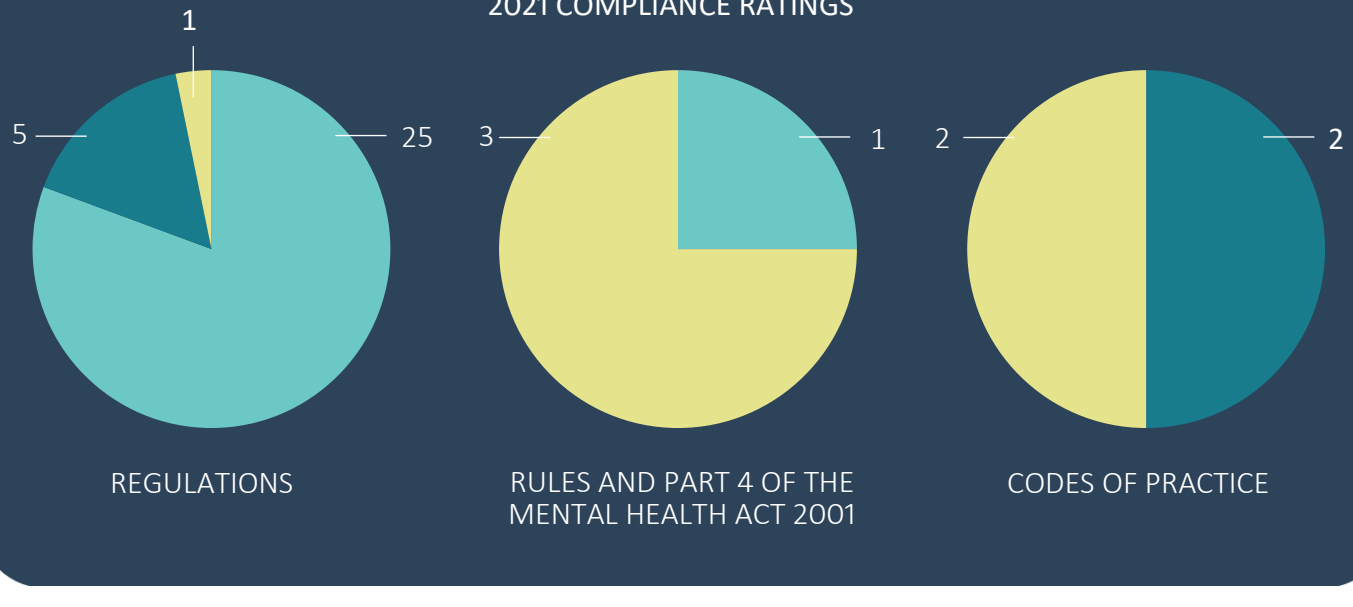
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
5 October – 8 October 2021

Previous Inspection date:
6 – 9 October 2020

Inspection Type:
Announced Annual Inspection

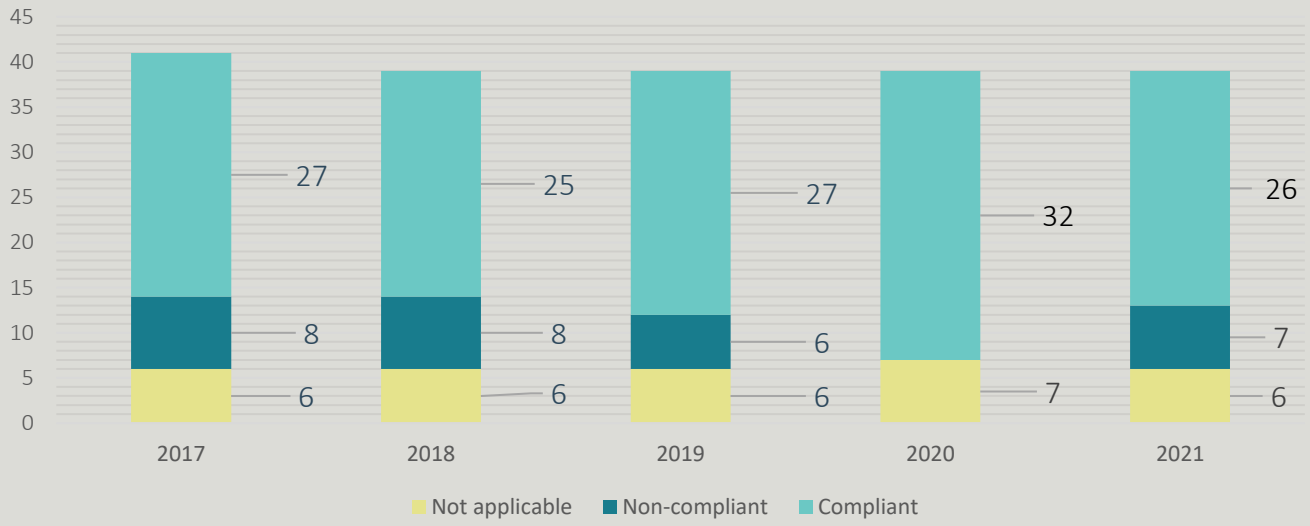
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

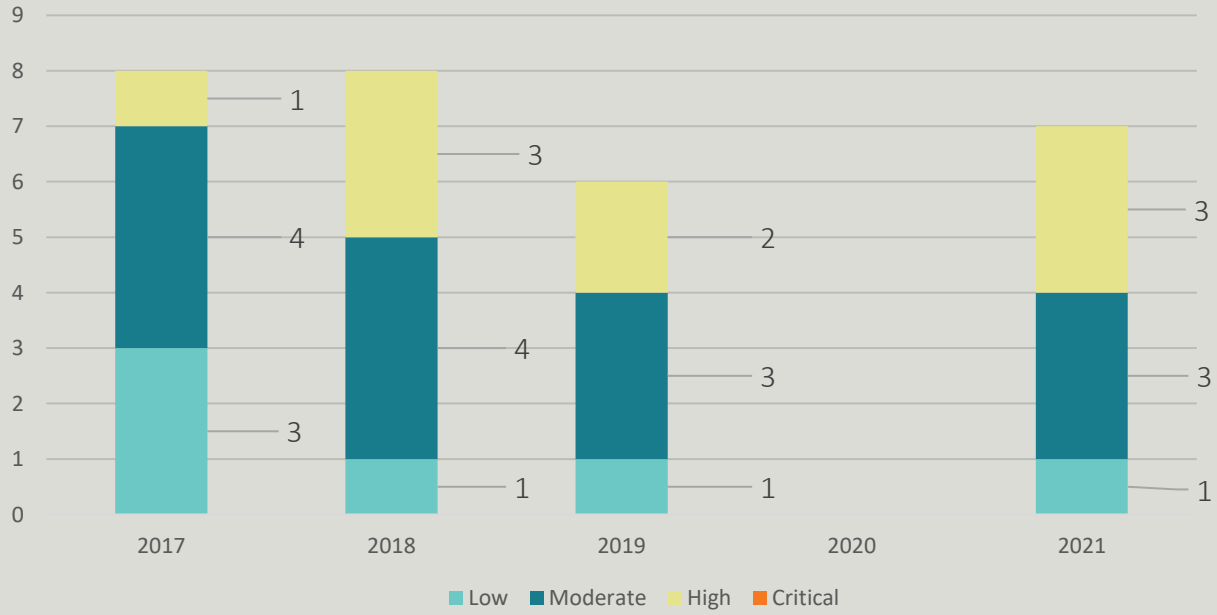
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 6
Conditions to registration 6
2.0 Quality Initiatives 10
3.0 Overview of the Approved Centre 11
3.1 Description of approved centre 11
3.2 Governance 11
3.3 Reporting on the National Clinical Guidelines 13
4.0 Compliance 14
4.1 Non-compliant areas on this inspection 14
4.2 Areas that were not applicable on this inspection 14
5.0 Service-user Experience 16
5.1 Service-user feedback 16
5.2 Advocacy 17
6.0 Feedback Meeting 18
7.0 Inspection Findings – Regulations 19
8.0 Inspection Findings – Rules 52
9.0 Inspection Findings – Mental Health Act 2001 53
10.0 Inspection Findings – Codes of Practice 56
Appendix 1: Corrective and Preventative Action Plan 61
Appendix 2: Background to the inspection process 68

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

The approved centre was a purpose-built, residential Mental Health Recovery Unit in Killarney, County Kerry. It provided continuing mental health care, psychiatry of later life, mental health rehabilitation and mental health care for people with an intellectual disability. The approved centre consisted of four houses: Mountain View, River View, Wood View and Lake View. The approved centre had two multi-disciplinary teams, specialising in Rehabilitation and Recovery (Mountain View/River View Units) and Psychiatry of Later Life (Wood View/Lake View Units).

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	77%	76%	82%	100%	79%
Regulations Rated Excellent	3	11	10	N/A	N/A

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

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 26(4) and 26(5): Staffing the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are*	Health care staff were trained in the Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and

up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission	Codes. Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.
The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.	

Escalation and enforcement actions since last inspection

There were no escalation and enforcement actions since last 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.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- There was an appropriately qualified staff member on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

Appropriate care and treatment of residents

We found that staff did not adequately provide therapeutic activities and physical health monitoring appropriate to needs of residents.

- The individual care plans inspected were not of a satisfactory standard.
- A reduction in occupational therapy resources impacted on the service's ability to meet all residents occupational therapy needs. Only referrals, based on resident needs that were deemed urgent, were assessed and treated, while all other referrals, where needs were deemed non-urgent, were not.
- The required six-monthly monitoring of residents' physical health was not fully comprehensive in the cases inspected.

Respect for residents' privacy, dignity and autonomy

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

- All residents had single en suite bedrooms.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- 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 apart from some areas that required painting.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

Responsiveness to residents' needs

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

- Recreational activities included walks, newspaper readings, bingo, relaxation group, gardening group, board games, cards, puzzles, tv, mindfulness colouring, quizzes, outings on the bus, jigsaws, knitting, arts and crafts, and books. 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.
- Peer advocacy services were available.

Governance of the approved centre

There was a robust governance structure and processes in place.

- The approved centre was part of Cork Kerry Community Healthcare and was governed under the Kerry Mental Health Services. A local business meeting (Deer Lodge Management Meeting) convened

approximately every six to eight weeks and was attended by heads of discipline. Agendas items included quality initiatives, complaints, risk issues, incidents, and training issues.

- A risk register for Deer Lodge was maintained by local management and included corporate, health and safety, and structural risks. The register was reviewed regularly at the local Deer Lodge Management Meeting. Incidents arising in Deer Lodge were reviewed at the local management team meeting.
- Resident engagement in governance and quality improvement processes were facilitated throughout the service.
- The approved centre was dedicated to improving service quality. A Quality and Patient Safety Committee for the Kerry region convened every six weeks.
- A local Compliance Group meeting at Deer Lodge convened on a regular basis to discuss matters relating to regulatory compliance issues.
- A programme of audit was implemented by the multi-disciplinary team throughout the service. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre.

COVID-19 response

COVID-19 was a standing agenda item for both the Deer Lodge local business meeting and the Cork Kerry Mental Health Management Team Strategic Meeting and issues arising were actively managed. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Development of a library facility in Mountain view Unit.

2. Development of an exercise room in Mountain view Unit.

3. Development of a movie area in one of the therapeutic group rooms.

4. Acquisition of new garden furniture for outdoor areas.

5. Implementation of the MECC (Make Every Contact Count) training programme for staff. This programme provided health professionals with knowledge and skills to support residents during routine contact. Residents were encouraged to make healthier lifestyle choices to help prevent and manage chronic diseases.

6. Designation and training of an Infection Prevention Control nurse.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was a purpose-built, residential Mental Health Recovery Unit. The unit opened in 2017, and was located on St. Margaret's Road in Killarney, County Kerry. The approved centre was registered with the Mental Health Commission for the provision of continuing mental health care, psychiatry of later life, mental health rehabilitation and mental health care for people with an intellectual disability.

The approved centre consisted of four 'households': Mountain View, River View, Wood View and Lake View. All were connected through a central thoroughfare that featured an entrance, foyer, communal area, therapy areas, prayer room, activity rooms and other facilities including a hair salon. Within each of the four households, each resident had their own en suite bedroom, and additionally, residents had access to a sitting room, dining room, quiet room, kitchenette and an internal landscaped garden area.

The approved centre had two multi-disciplinary teams, specialising in Rehabilitation and Recovery (Mountain View / River View Units) and Psychiatry of Later Life (Wood View / Lake View Units).

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

Resident Profile	
Number of registered beds	***40***
Total number of residents	**37**
Number of detained patients	5
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	31
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Cork Kerry Community Healthcare and was governed under the Kerry Mental Health Services. The Cork Kerry Mental Health Management Team Strategic Meeting convened monthly and was attended by relevant Heads of Discipline and Service. The meeting minutes evidenced discussion of key topics such as quality and patient safety, complaints arising, human resources, staff training, risk issues, regulatory compliance issues, and operational issues. A local business meeting (Deer Lodge Management Meeting) convened approximately every six to eight weeks and was attended by heads of discipline or a designated representative. Agendas items included quality initiatives, complaints, risk issues, incidents, and training issues.

The majority of heads of discipline had received training in risk management procedures. A risk register for Deer Lodge was maintained by local management and included corporate, health and safety, and structural risks. The register was kept up-to-date and reviewed regularly at the local Deer Lodge Management Meeting. Relevant risks were escalated to the executive risk register, which in turn, was reviewed at the Cork Kerry Mental Health Management Team Strategic Meeting. Incidents arising in Deer Lodge were reviewed at the local management team meeting.

Two multi-disciplinary teams, specialising in Psychiatry of Old Age (POLL) and Rehabilitation and Recovery admitted to the approved centre. The teams had an adequate skill mix of staff which included medical, nursing, and health and social care disciplines. However, the staffing levels for medical and occupational therapy disciplines were not optimal. At the time of the inspection, occupational therapy services were provided on an in-reach basis to the approved centre. Two staff grade occupational therapists based within the community Rehabilitation and Recovery team and POLL team attended the approved centre one day per week to provide services. This represented a significant resource reduction compared to previous staffing levels which consisted of one full time senior grade occupational therapist based in the approved centre. The resource deficit had existed since April 2021 and efforts to secure temporary backfill for the post were unsuccessful. The reduction in staffing resources impacted on the service's ability to meet all residents occupational therapy needs in the approved centre. While funding for a six-month temporary contract had been secured, at the time of inspection, the process for post recruitment had not commenced. This issue had been raised at the Cork Kerry Mental Health Management Team Strategic Meeting and entered on the local risk register for the approved centre.

The rehabilitation and recovery medical consultant post had been vacant since the end of June 2021. At the time of inspection, a locum consultant had been recruited and attended the approved centre one day per week. Service provision was further supplemented through additional hours provided by two other consultants working within Kerry Mental Health services. While service levels were not optimal, service user identified needs were met. This issue had been raised at the Cork Kerry Mental Health Management Team Strategic Meeting and documented in the local and executive risk registers. Interviews for the consultant post were scheduled for November 2021. There were three vacant posts arising in the discipline of nursing, however, staffing levels were effectively managed through overtime usage. Interviews for these posts were due to take place within four weeks of the inspection.

Resident engagement in governance and quality improvement processes were facilitated throughout the service. The Area Lead for Mental Health Engagement attended the Mental Health Management Team Strategic Meeting and provided feedback to the management team. Within the approved centre, regular resident community meetings, suggestion boxes, service user surveys, annual focus groups, engagement with group planning, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Irish Advocacy Network contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre.

The approved centre was dedicated to improving service quality. A Quality and Patient Safety Committee for the Kerry region convened every six weeks. Agenda items indicated active review and planning regarding several areas which underpin service improvement and quality; these included a review

of the risk register, serious incident reviews and recommendations, clinical audit results and quality improvement plans. A local Compliance Group meeting at Deer Lodge also convened on a regular basis to discuss matters relating to regulatory compliance issues. The progression and development of various quality initiatives in the approved centre was also a standing agenda item at the local business meeting. A programme of audit was implemented by the multi-disciplinary team throughout the service. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre.

COVID-19 was a standing agenda item for both the Deer Lodge local business meeting and the Cork Kerry Mental Health Management Team Strategic Meeting and issues arising were actively managed. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 15: Individual Care Plan	✓		✓		✓		✓		✗	High
Regulation 16: Therapeutic Programmes and Activities	✗	Low	✗	High	✓		✓		✗	High
Regulation 19: General Health	✓		✗	Moderate	✓		✓		✗	Moderate
Regulation 22: Premises	✓		✓		✓		✓		✗	Low
Regulation 26: Staffing	✗	High	✗	High	✗	High	✓		✗	High
Code of Practice on the use of Physical Restraint in Approved Centres	✗	Moderate	✗	High	✓		✓		✗	Moderate
Code of Practice for the Admission, Transfer and Discharge to and from an Approved Centre	✗	Moderate	✗	Moderate	✗	High	✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.

Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- 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.

Six residents spoke with members of the inspection team. Residents reported that the approved centre was very homely and clean. The meals provided were of good quality with daily choice. Residents were complimentary to staff, stating that staff were approachable and had a nice demeanour. In general, the residents were aware of their individual care plans (ICP) and received copies of their ICPs. All the residents engaged in the recreational and therapeutic activities and spoke positively about them. Three of the residents commented on the reduced access to the occupational therapy service, noting that it would be better to have an occupational therapist based within the approved centre again.

Service user questionnaires were completed by 22 residents. The following feedback was provided in the questionnaire responses.

- Twenty-one residents were happy with how staff talked to them.
- Twenty-one residents had space for privacy and felt their privacy and dignity was respected at all times.
- Twenty residents felt safe in the approved centre.
- Eighteen respondents understood their ICP.
- Sixteen respondents indicated that they were always involved in the ICP goal setting.
- Sixteen residents indicted that upon arrival to the approved centre, a member of staff did explain what was happening in a way that they could understand.
- Thirteen residents indicated that they always received information about their diagnosis
- Thirteen residents knew who their keyworker was.

- Sixteen residents knew the members of their multi-disciplinary team.
- Thirteen residents indicated that they always felt able to discuss worries or concerns with a staff member.
- Sixteen residents indicated that there were enough activities during the day.
- Seventeen residents indicated that they always felt able to give feedback to staff and to make a complaint.
- Specific comments documented within the questionnaires included a desire for more community outings, more trips to the shops, and more variety on the menus.

5.2 Advocacy

The approved centre had an advocacy service. The inspectors did not receive a report from the IAN representative.

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:

- Acting Occupational Therapy Manager
- Acting Area Director of Nursing
- Acting Assistant Director of Nursing
- Clinical Nurse Manager Grade 2 (four in attendance)
- Executive Clinical Director
- Complaints Officer/Area Administrator
- Dietitian
- Psychologist
- Registered Proprietor nominee

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

Each resident was readily identifiable by staff when receiving medication, health care, and other services. At least two appropriate resident identifiers were used, which included resident name, date of birth, medical record number, address, and photograph. The identifiers, detailed in each resident's clinical file, were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior for 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 choices within the approved centre. Food was properly prepared and comprised of servings from different food groups as per the Food Pyramid. Residents received at least two choices for meals. Residents always had sufficient supplies of safe and fresh drinking water. The needs of residents identified as having special nutritional and dietary requirements were assessed, addressed, and documented 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 appropriate and adequate catering equipment. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. All food was prepared at St Columbanus Hospital, a community hospital located in Killarney, and was delivered to Deer Lodge daily.

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 did not wear nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with emergency personal clothing that was appropriate and considered their preferences, dignity, bodily integrity, and religious and cultural practices.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in September 2020. Residents could bring in personal property and possessions on admission, and these were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP).

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a range of recreational activities appropriate to the resident group profile during the week and at the weekend. Activities included walks, newspaper readings, bingo, relaxation group, gardening group, board games, cards, puzzles, tv, mindfulness colouring, quizzes, outings on the bus, jigsaws, knitting, arts and crafts, and books.

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 priest visited the approved centre by request. There was a prayer room in the approved centre for residents to use for prayer, spirituality and as a quiet area.

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

There was a written policy and procedures in relation to visits. The policy was last reviewed in September 2020. Visiting times were appropriate and reasonable. There was a designated visiting room available where private visits could take place, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during these visits. The visiting room was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to resident communication. The communication policy was last reviewed in September 2020. Residents had access to postal mail, telephone, and the Internet via Wi-Fi. There were no restrictions on residents' communication at the time of the inspection. The senior staff member only examined incoming and outgoing resident communication based on risk assessment - if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy in relation to the implementation of resident searches. The policy was last reviewed in September 2020.

The policy addressed all the requirements of the regulation, including the following:

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

There were no searches undertaken since the last inspection, and for this reason, compliance was assessed on the basis of policy alone.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to caring for residents who are dying. The policy was last reviewed in September 2020. The clinical file of a resident who had been cared for while dying in the approved centre was inspected. The end-of-life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs, as documented in the relevant individual care plan. Religious and cultural practices were respected, as were the privacy and dignity of the resident, who was cared for in a single en suite bedroom.

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

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

Two of five ICPs inspected, were not developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. Three of the ICPs did not identify appropriate and specific goals for the resident, instead inappropriate and vague goals were identified, using terminology such as 'baking, and 'ensure stable mental state'.

Five ICPs did not fully identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. One ICP did not identify the resources required to provide the care and treatment.

The ICP was reviewed by the MDT in consultation with the resident at least every six months. ICPs were updated by the MDT following review, as indicated by the residents' changing needs, condition, circumstances and goals.

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

a) **Two individual care plans were not developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission.**
b) **Three individual care plans did not identify appropriate goals for the resident.**
c) **Five individual care plans did not fully identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.**
d) **One individual care plan did not identify the resources required to provide the care and treatment.**

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

The approved centre had access to a range of therapeutic services including occupational therapy, psychology, and social work services. These services were based within the community mental health teams and respective health and social care professionals visited the approved centre as required. Residents were mostly seen on an individual basis. There was one occupational therapy led group session per week facilitated on both the Psychiatry of Later Life (POLL) and the Rehabilitation and Recovery Units. Group themes included art therapy, baking, and relaxation.

Since the previous inspection, there had been a reduction in the occupational therapy service provision available to the approved centre. Previous staffing levels consisted of one full time senior grade occupational therapist based in the approved centre, however, since April 2021, this resource was replaced by two staff grade occupational therapists. Both therapists, based within the community mental health teams, attended the approved centre one day per week to provide services within the Rehabilitation and Recovery and POLL units. The reduction in resources impacted on the service's ability to meet all residents occupational therapy needs. Referrals, based on resident needs that were deemed urgent, were assessed and treated only. All other referrals, where needs were deemed non-urgent, were not attended to. Upon inspection, in the case of one resident, specific psychosocial needs, deemed as non-urgent, were not met. As a result, the service provided for this resident was not directed towards restoring and maintaining the optimal level of psychosocial functioning.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

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

a) **The registered proprietor did not ensure that each resident had access to an appropriate range of therapeutic services and programmes as the specific occupational therapy needs of one resident were not met, 16(1).**

b) **The registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of psychosocial functioning of residents due to reduced occupational therapy resource provision to the approved centre, 16(2).**

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in place in relation to the transfer of residents. The policy was last reviewed September 2020. The clinical file of one resident who had been transferred from the approved centre in non-emergency circumstances was examined. Full and complete written information about the resident was transferred to the receiving hospital. The transfer documentation included a transfer form, and a letter of referral including a list of current medication.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy and procedures, which included emergency procedures. The policy was last reviewed in July 2020. The approved centre had an emergency resuscitation trolley and staff always had access to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs but within a six-month timeframe.

Three clinical files of residents who had been in the approved centre for more than six months were inspected. All three residents had received a six-monthly general health check, however, this was not adequately completed. Waist circumference was not documented in three of the general health checks. Blood pressure was not documented in one of the general health checks. Body Mass Index (BMI) was not documented in two of the general health checks. In all cases, dental health, smoking status, family history and nutritional status were reviewed and documented. Residents on antipsychotic medication received an annual assessment of glucose regulation, blood lipids, prolactin levels, and an electrocardiogram heart function test. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes according to age and gender.

The approved centre was non-compliant with this regulation because the six-monthly general health assessments for three of the residents were not completed comprehensively:

a) **Three general health assessments did not record the residents' waist circumference, 19(1)(b).**
b) **One general health assessment did not record the resident's blood pressure, 19(1)(b).**
c) **Two general health assessments did not record the residents' body mass index, 19(1)(b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a policy and procedures in relation to the provision of information to residents. The policy was last reviewed September 2020.

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

Residents were provided with written and verbal information on their diagnosis. Medication information sheets as well as verbal information were provided in a format appropriate to residents' 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

The general behaviour of staff and the manner in which staff interacted with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs.

Each resident was in a room on their own with an en suite attached and their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls. All bathrooms, showers, and toilets had locks on the inside of the door unless there was an identified risk to a resident.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

The lighting in the approved centre was sufficiently bright and positioned to facilitate reading and other activities. Ligature points were minimised to the lowest practicable level. In general, the approved centre was maintained in a good state of repair both externally and internally however, the internal premises were not maintained in good decorative condition throughout. There were marks and chipped paintwork observed on the walls of both the Psychiatry of Later Life (POLL) units.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained. The approved centre was clean, hygienic, and free from offensive odours. Suitable furnishings were provided to support resident independence and comfort. There was at least one assisted toilet per floor. Assisted devices and equipment such as ceiling hoists and wheelchairs were provided to address resident needs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure the premises was maintained in a good decorative condition. Several walls were marked and damaged with chipped paintwork in both Psychiatry of Later Life Units, 22 (1)(a).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in September 2020.

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

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently, where there was a significant change in the resident's care or condition, and this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy, and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in September 2020.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in relation to the recruitment, selection and Garda vetting requirements. The policy was last reviewed in September 2020. An appropriately qualified staff member was on duty at all times, and this was documented. The numbers and skill mix of staffing were insufficient to meet resident occupational therapy needs.

Two multi-disciplinary teams, specialising in Psychiatry of Old Age (POLL) and Rehabilitation and Recovery admitted to the approved centre. Multidisciplinary teams included psychiatry, nursing, occupational therapy, psychology, and social work staff. However, the staffing levels for medical and occupational therapy disciplines were not optimal. At the time of the inspection, occupational therapy services were provided on an in-reach basis to the approved centre. Two staff grade occupational therapists based within the community Rehabilitation and Recovery team and the POLL team attended the approved centre one day per week to provide services. This represented a significant resource reduction compared to previous staffing levels, which consisted of one full time senior grade occupational therapist based in the approved centre. This service resource deficit had existed since April 2021. The reduction in resources impacted on the service's ability to meet all residents occupational therapy needs in the approved centre.

The rehabilitation and recovery medical consultant post had been vacant since the end of June 2021. At the time of inspection, a locum consultant had been recruited and attended the approved centre one day per week. Service provision was further supplemented through additional hours provided by two other consultants working within Kerry Mental Health services. While service levels were not optimal, service user identified needs were met.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre. Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.

The following table shows the number of staff trained in the Mental Health Act 2001 and the percentage of staff trained in each discipline.

Staff Training Table		
Profession	**Mental Health Act 2001**	
Nursing (42)	42	100%
Medical (6)	6	100%
Occupational Therapist (2)	2	100%
Social Worker (2)	2	100%
Psychologist (3)	3	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the number of occupational therapy staff were appropriate to the assessed needs of residents. Not all residents' occupational therapy needs were met due to the limitation in occupational therapy staffing resources in the approved centre, 26 (2).

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 two written operational policies and procedures in relation to the creation of, access to, retention of and destruction of records. The policies were each last reviewed in September 2020. All residents' records were secure, up to date, in good order, with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements.

Resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained to a logical sequence. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented and up-to-date hard copy register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 to the Mental Health Act 2001.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

The operating policies and procedures required by the regulations were reviewed within the required three-year time frame.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Resources and facilities were also provided by the approved centre to support patients in accessing Mental Health Tribunals remotely. Staff attended Mental Health Tribunals, and where required, provided residents with the necessary assistance to attend or participate in the process.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. The complaints procedure was provided to residents and their representatives in an information booklet at admission or soon after. The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All oral and written complaints were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made.

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There were a comprehensive risk management policy and emergency plan in place. The risk management policy was last reviewed in September 2020. The risk management policy and emergency plan addressed all requirements.

The person with responsibility for risk was identified and known by all staff. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk management policy was implemented throughout the approved centre. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Corporate, health and safety, and clinical risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Multi-disciplinary teams (MDT) were involved in the development, implementation, and review of individual risk management processes. Individual risk assessments were completed prior to physical restraint episodes, in conjunction with medication requirements or administration, and at resident admission, transfer and discharge.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated and recorded in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team (MDT), and a record was maintained of clinical reviews and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There

was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

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 one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment and that the patient was unable to consent. A Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient and documented the following:

- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the patient in relation to the discussion and their decision-making.
- The specific names of medications prescribed to the patient.

- The form 17 also included approval by a consultant psychiatrist and authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in August 2020. The policy covered:

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

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

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

Evidence of Implementation: The clinical file of one resident who had been physically restrained was inspected. The clinical documentation did not provide adequate rationale for the undertaking of the physical restraint episode. As a result, it was unclear that physical restraint was only used in rare, exceptional circumstances and in the best interests of the resident, where the resident posed an immediate threat of serious harm to self or others. There was no documentation within the clinical file to show that physical restraint was used after all alternative interventions to manage the resident's unsafe behaviour had been exhausted.

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident's next of kin were informed about the physical restraint. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered health professional, and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the resident within three hours after the start of the episode of physical restraint.

The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. This episode of physical restraint was not reviewed by members of multi-disciplinary team (MDT) and documented in clinical file no later than two working days after the episode. The resident was afforded

the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **There was no documented evidence in the clinical file to indicate that physical restraint was used in rare, exceptional circumstances and in the best interests of the resident, where the resident posed an immediate threat of serious harm to self or others, (1.1).**
b) **There was no documented evidence in the clinical file to indicate that all alternative interventions to manage resident's unsafe behaviour had been considered prior to using physical restraint, (1.2).**
c) **The episode of physical restraint was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file no later than two working days after the episode, (9.3).**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. All policies were reviewed in September 2020 and combined, included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a keyworker. An admission assessment had been completed. The resident's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination.

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

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

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to relevant healthcare professionals within three days. A comprehensive discharge summary letter was not issued within 14 days of the resident's discharge from the approved centre. A timely follow up appointment took place.

The approved centre was non-compliant with this Code of Practice because a comprehensive discharge summary letter was not completed and issued within 14 days of the resident's discharge from the approved centre, 38.3 (b).

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 16: Therapeutic Services and Programmes

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 19: General Health

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 22: Premises

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 26: Staffing

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Code of Practice on the Use of Physical Restraint in Approved Centres
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10002407		**A comprehensive discharge summary letter was not completed and issued within 14 days of the resident's discharge from the approved centre, 38.3 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	ECD to contact to all Consultants reminding them that discharge letter needs to be done even when patient is being discharged to Consultant's own team.	Audit	Achievable	20/01/2022	ECD
Preventative Action	ECD to contact to all Consultants reminding them that discharge letter needs to be done even when patient is being discharged to Consultant's own team.	Audit	Achievable	20/01/2022	ECD

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.

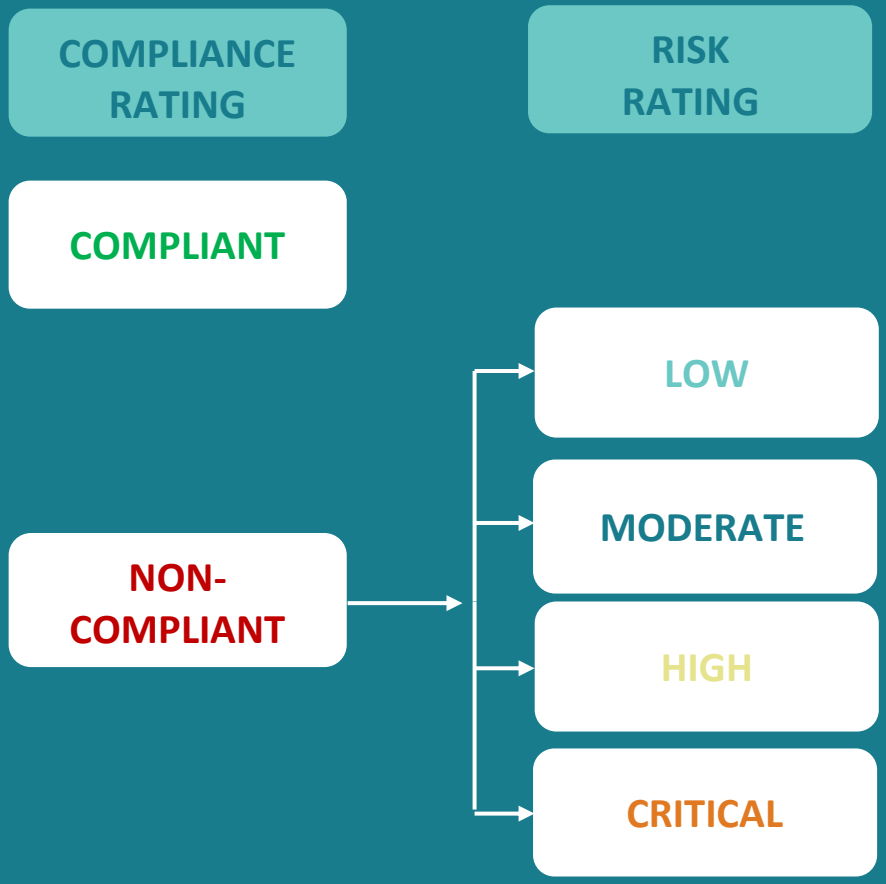
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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