Sliabh Mis Mental Health Admission Unit, University Hospital Kerry

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

SLIABH MIS MENTAL HEALTH ADMISSION UNIT, UNIVERSITY HOSPITAL KERRY

Sliabh Mis Mental Health Admission Unit, University Hospital Kerry, Rathass, Tralee, Co Kerry

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2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

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

Inspection Team:
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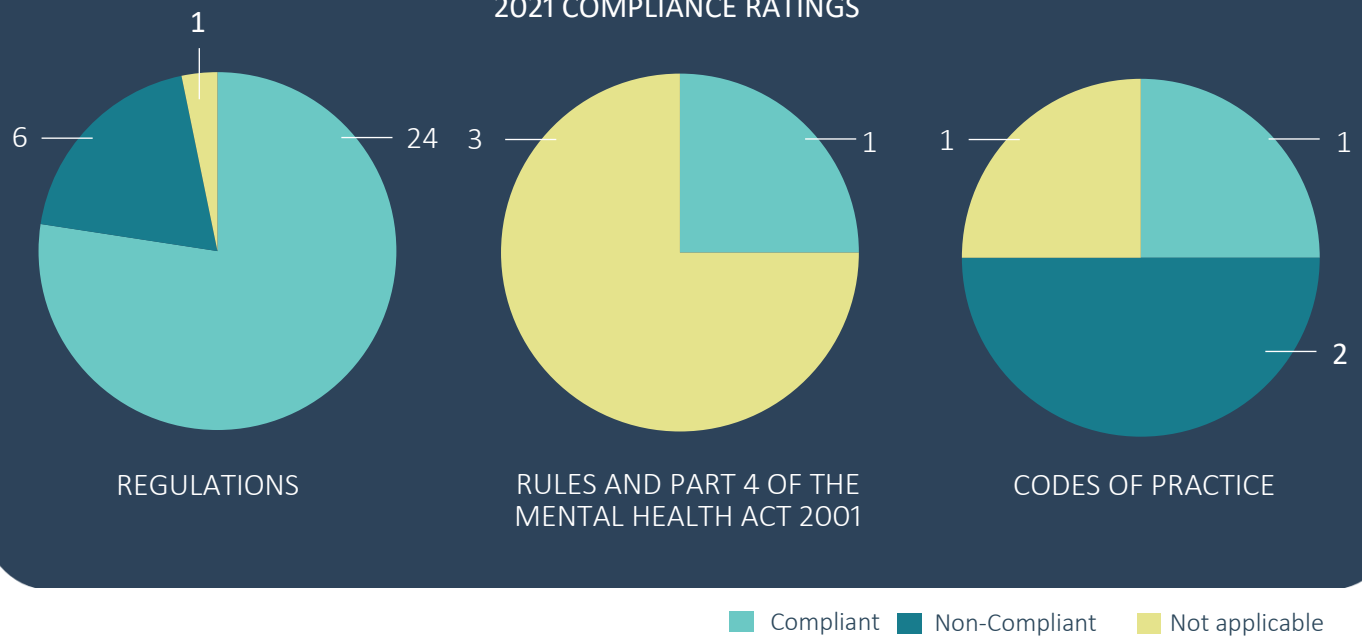
Inspection Date:
21 – 24 September 2021

Previous Inspection date:
6 – 9 October 2020

Inspection Type:
Announced Annual Inspection

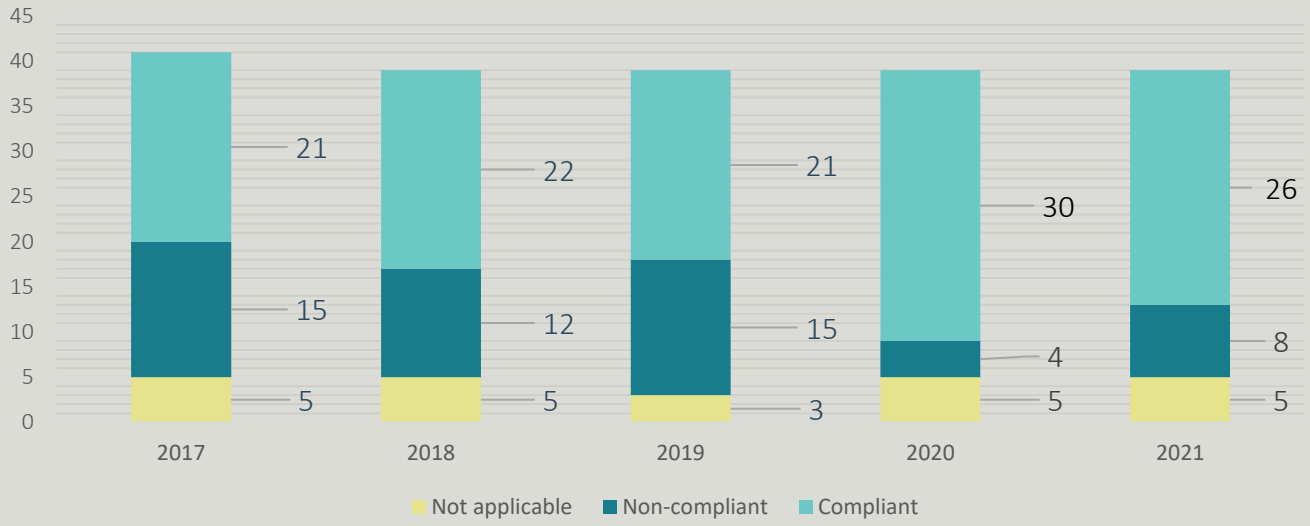
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

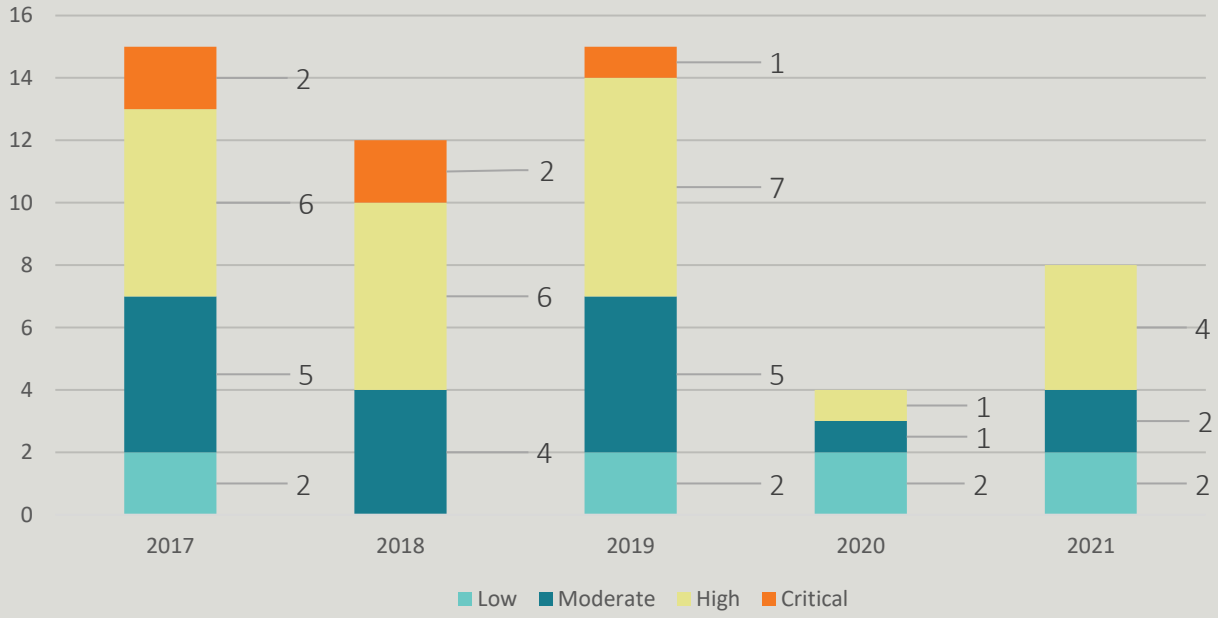
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

The approved centre had 34 beds and was located on the ground floor of University Hospital Kerry. The approved centre consisted of three wards: Reask ward was an acute ward and Valentia a sub-acute Ward, both with 15 beds each. Brandon Ward was a four bedded high observation unit.

The approved centre had one designated multi-disciplinary team, and the Psychiatry of Later Life team.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	59%	65%	58%	88%	76%
Regulations Rated Excellent	0	0	0	N/A	N/A

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

Conditions to registration

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

Conditions	Findings
Condition 1: To ensure adherence to Regulation 26(4) and 26(5): Staffing the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The	Health care staff were trained in the Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes. Due to COVID-19 Pandemic, the inspection

approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.	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 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 the previous inspection.

Escalation and enforcement actions since this inspection

There were no escalation and enforcement actions since this inspection.

Safety in the approved centre

We found that the approved centre mainly operated safe practices which reduced risk of harm and that effective systems were in place to safeguard patients. However, there were outstanding fire safety issues.

- Individual risk assessments were completed at admission to identify residents' individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of nursing staff were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However, fire drills had not taken place. The closing mechanism of the clinical nurse management office fire door was broken causing the fire door to remain ajar. The office door formed a sub compartment to the corridor which was a compartment to contain fire and a fire exit pathway. This issue had not been resolved since it was reported seven months previously.

Appropriate care and treatment of residents

We found that existing staff provided therapeutic activities and physical health monitoring appropriate to needs of residents, but occupational therapy input was missing.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The social worker offered individual sessions for assessed needs and the psychologist facilitated two group sessions weekly alongside individual sessions as required. The clinical nurse specialist (CNS) coordinated the timetable when they were on duty, however the CNS groups were not facilitated when the CNS was not on duty. Groups facilitated by the CNS included relaxation sessions, walking groups, exercises and educational groups.
- Residents' general health needs were monitored and assessed as indicated by the residents' specific needs.

However, non-urgent assessed needs for occupational therapy could not be met as the approved centre did not have access to a designated occupational therapist.

Respect for residents' privacy, dignity and autonomy

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

- The sleeping accommodation on Reask Ward and Valentia Ward consisted of three, four bedded dormitories, with three single en suite bedrooms each. Brandon Ward had four single en suite bedrooms.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside the door.
- Residents were facilitated to make private phone calls.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Noticeboards did not display resident names or other identifiable information.
- Staff treated and communicated with residents in a respectful manner.
- The approved centre was compliant with the Rules Governing the Use of Seclusion.

However:

- There was paint damage, holes in walls, damaged ceiling tiles which were all outstanding for 10 months. Several wall corners were damaged and dented due to collision impacts to the walls. A request was sent into the maintenance department seven months prior to the time of inspection for protective aluminium covers to be fitted which had not been progressed or completed.
- The CCTV monitors were viewable from open access nurses' stations desks on a corridor outside the dormitory rooms on both Reask and Valentia wards within the approved centre. This was not resolved since the 2020 inspection.

Responsiveness to residents' needs

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

- Activities included a walking group, bingo, movies, television, exercise groups and quizzes. Residents also had access to self-directed activities such as reading, movies, television and utilising the garden space.
- The approved centre provided access to recreational activities on weekdays and during the weekend.
- There was a choice of food at mealtimes.
- 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 sufficient private space as well as areas for socialisation.

Governance of the approved centre

- The approved centre was part of Cork Kerry Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 4. The approved centre was governed under the Kerry Mental Health Services through the Kerry Mental Health Management team. The Area Lead for Mental Health Engagement attended these meetings.
- The approved centre management meeting which met every five weeks was a multi-disciplinary team forum to discuss local operational issues such as risk management; patient safety issues; compliance; health and safety and compliments and complaints. A Bed Management meeting was held twice per week.
- There was a standardised process for the management of risks and incidents.
- An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre.
- Within the approved centre, resident was facilitated through regular community meetings, suggestion boxes and with the complaints process. Formal complaints were reviewed at the Kerry Mental Health Service Management team meeting.
- There was a commitment to improving quality. Performance was measured through the continual review of key performance indicators; comments, compliments and complaints; incident reports and audit findings. The inspection highlighted non-compliances in the approved centre increased from the previous year. The 2020 inspection noted four non-compliances which increased to eight non-compliances during this inspection period.

However, the risk management procedures did not actively reduce identified risks to the lowest practicable level of risk as there was a lack of fire drills and a faulty closer on a fire door to a sub fire compartment. High risk issues, such as sourcing a Senior grade Occupational Therapist and the CCTV monitors which were identified during the previous inspection in 2020 had not been addressed.

COVID-19 response

The risk of COVID-19 was actively managed through the approved centre's risk management processes.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- The Social Work Department reconfigured to match the service need of Sliabh Mis during the COVID-19 pandemic. There was now one full time Social Worker based on the unit. This has ensured continuity of care as well as continued multi-disciplinary team (MDT) participation for each patient from a social work perspective.

- Electronic I-Pad's /Mp3's were acquired for use with residents in therapy. This included residents listening to their psychologist doing relaxation strategies; introducing basic mindfulness; talking through basic emotional regulation exercises and other psychological interventions.

- Psychology started running an online Cognitive Behavioural Therapy (CBT) programme with residents called Silvercloud in the community. This was offered to residents in Sliabh Mis.

- The Psychology Department commenced reflective supervision with staff to support learning and development.

- A specific e-mail address was set up on both units so that family and friends could e-mail the resident during their inpatient stay.

- A COVID-19 leaflet was developed to inform all residents on admission of what would happen. It outlined residents would be required to take a swab and to self-isolate until the result of the swab was returned.

- Sliabh Mis launched an information and communication pack for families during COVID-19. The pack contained the Sliabh Mis information booklet, HSE Family, Carer and Supporter Guide, communication information on how to contact consultants and nurse mangers to discuss their relative's recovery. With the consent of the residents, the relative/significant other was contacted and the information communication pack was posted to the family member/significant other. The aim of the information and communication pack was to provide relatives with information and reassurance about their relative's care during restricted COVID-19 visiting periods.

- 'Celebration of the seasons' was a project aimed at supporting residents to be aware of the changes each season bring. To create an awareness of new life and new growth around those in the approved centre and special occasions like Christmas and Easter. Throughout the calendar year staff planned celebrations which orientated residents to the time of year for example: St. Patricks Day, April Fool's day, May Day, Rose of Tralee week and Fair Day in Kenmare.

- Introduction of safety pauses. Safety awareness helped all teams to be more proactive about the challenges faced in providing safe, high quality care for patients. Safety pauses were held throughout

the day amongst the multi-disciplinary team members for a maximum of 5 minutes. This meeting supported focus on things everyone needed to know to maintain safety. Based on one question 'what patient safety issues do we need to be aware of today', resulting in immediate actions. The four P's Patients: Professionals: Processes: Patterns prompted the discussion.

- Physical care needs were introduced as part of the core care planning for patients.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the ground floor of University Hospital Kerry. The approved centre consisted of three Wards and it was registered to accommodate 34 residents in total. Reask ward was an acute ward and Valentia a sub-acute Ward, both with 15 beds each. Brandon Ward was a four bedded high observation unit.

The accommodation facilities on both Reask Ward and Valentia Ward consisted of three, four bedded dormitories, with three single en suite bedrooms each. Brandon Ward had four single en suite bedrooms. Reask and Valentia Wards had access to a shared corridor, which contained a dining room and a variety of multi-functional rooms such as a quiet room, two sitting rooms and a visitors' room. Residents also had access to an exercise room, which contained a treadmill, an exercise bike and a cross-trainer. Brandon Ward had a separate open plan dining and sitting room. The therapy corridor consisted of a group room, an arts and crafts room and an occupational therapy kitchen. The approved centre had two well-maintained enclosed courtyards; one for both Reask and Valentia Ward and one for the residents in Brandon Ward. At the time of the inspection, the approved centre had one designated multi-disciplinary team, and the Psychiatry of Later Life team.

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

Resident Profile	
Number of registered beds	***34***
Total number of residents	**19**
Number of detained patients	6
Number of Wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
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, formerly known as Community Healthcare Organisation (CHO) 4. The approved centre was governed under the Kerry Mental Health Services. The Kerry Mental Health Management team convened on a monthly basis for both the business and strategic meetings. The meeting minutes evidenced discussions on key topics such as risk management; quality and patient safety; complaints; finance; human resources and compliance.

The Kerry Mental Health Service Quality and Patient Safety meeting was scheduled quarterly. The approved centre management meeting which met every five weeks was a multi-disciplinary team forum to discuss local operational issues such as risk management; patient safety issues; compliance; health and safety and compliments and complaints. The approved centre had various other different meetings and working groups such as the Mental Health Compliance meeting; Policy, Procedure and Protocol group and Drugs and Therapeutic group. Furthermore, a Bed Management meeting was held twice per week.

The approved centre had a standardised process for the management of risks and incidents. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. This was based on a lack of fire drills as documented in a fire audit completed in September 2021 which highlighted an identification of a fire risk relating to a faulty closer on a fire door to a sub fire compartment. The risk of COVID-19 was actively managed through the approved centre's risk management processes.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The numbers and skill mix of staff were not sufficient to meet resident needs. Non-urgent assessed needs for occupational therapy could not be met as the approved centre did not have access to a designated occupational therapist. The Kerry Mental Health Management team's strategic meeting discussed topics such as mental health engagement. The Area Lead for Mental Health Engagement also attended the Kerry Mental Health Service management meetings.

Within the approved centre, resident was facilitated through regular community meetings. Family engagement alongside resident engagement was also provided through suggestion boxes and with the complaints process. Formal complaints were reviewed at the Kerry Mental Health Service Management team meeting. The approved centre demonstrated a commitment to improving quality. Performance was measured through the continual review of key performance indicators; comments, compliments and complaints; incident reports and audit findings. The inspection highlighted non-compliances in the approved centre increased from the previous year. The 2020 inspection noted four non-compliances which increased to eight non-compliances during this inspection period. High risk issues, such as sourcing a Senior grade Occupational Therapist and the CCTV monitors which were identified during the previous inspection in 2020 had not been addressed.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 16: Therapeutic Services and Programmes	✗	High	✓		✓		✓		✗	High
Regulation 21: Privacy	✓		✗	Moderate	✗	Critical	✓		✗	Low
Regulation 22: Premises	✗	High	✗	Critical	✗	High	✓		✗	High
Regulation 25: CCTV		N/A		N/A	✗	Low	✗	Low	✗	Moderate
Regulation 26: Staffing	✗	Critical	✗	High	✗	High	✗	Moderate	✗	High
Regulation 32: Risk Management Procedures	✗	High	✗	High	✗	High	✓		✗	Moderate
Code of Practice on the Use of Physical Restraint	✗	Low	✗	High	✗	High	✓		✗	Low
Code of Practice on the Admission of Children	✗	High	✗	Moderate	✗	High	✗	High	✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the

	Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Four questionnaires were returned to the inspection team. These were completed by service users. Three of respondents understood what their Individual care plan (ICP) was, and two individuals reported they were always involved in goal setting for their ICP. One person reported this was sometimes and the remaining individual expressed they did not understand what their ICP was.
Three respondents reported they knew their multi-disciplinary team (MDT) Members and all four highlighted they knew who their keyworker was.
Three of respondents reported there were enough activities for them during the day whilst one indicated there were not.
All respondents expressed they always felt safe in the approved centre and were happy with how the staff spoke with them. One in four highlighted in their questionnaire they did not feel their privacy and dignity were respected however all individual questionnaires reported they had space for privacy. Two of the respondents reported they always felt able to give feedback to staff and were able to make a complaint when they were not satisfied with any part of their stay in the approved centre.

On and scale of 1-10 with one being poor and 10 being excellent rating the overall experience of care and treatment, the individual ratings rated by each respondent were 2,8,8 & 10 respectively. No additional comments were given on the questionnaires.

A peer support worker delivered one lived experience session a week.

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:

- Executive Clinical Director
- Registered Proprietor Nominee
- Occupational Therapist Manager
- Principal Psychologist Manager
- Social Worker
- Assistant Director of Nursing
- Clinical Nurse Manager III

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. A minimum of two resident identifiers appropriate to the resident group profile were used. Identifiers included an identification sticker containing resident medical record number, resident name, resident date of birth and each resident's address.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food 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 had sufficient access to safe and fresh filtered drinking water in each of the three units in the approved centre. The needs of residents who had special nutritional and dietary requirements were assessed and this was documented in residents' individual care plans. Residents had access to a dietitian and speech and language therapist to address residents' needs as required.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

There were proper facilities for the refrigeration, storage, preparation, cooking and serving of food. Food was cooked within the main Kerry University Hospital and delivered to the approved centre.

Hygiene was maintained to support food safety requirements.

Residents were provided with crockery and cutlery that was suitable for their needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents did not wear nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with suitable male and female emergency personal clothing that was appropriate to their needs and considered their preferences, dignity, bodily integrity, and religious 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 operational policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in September 2020. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their individual care plan (ICP).

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions; this was compiled at resident admission. The property checklist was kept separate from the resident's ICP.

The approved centre had secure facilities, including a safe for the safekeeping of residents' valuables. A property room was provided for storing non-valuable items. Large sums of monies were sent to the central office.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile during the week and at weekends. Activities included a walking group, bingo, movies, television, exercise groups and quizzes. Residents also had access to self-directed activities such as reading, movies, television and utilising the garden space.

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. Residents had access to multi-faith chaplains if requested. Televised mass was facilitated in the day room.

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 operational policy and procedures in relation to visits. The policy was last reviewed in July 2020. Visitors were permitted to come to the approved centre in line with hospital guidance. Each resident was allowed two visits a week respectively.

There was a separate visitors' 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 visits.

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, their own mobile phones after risk assessment, two portable telephones within the approved centre, Wi-Fi enabled internet, and four electronic tablets. There were no restrictions on resident's communication at the time of the inspection. The senior staff member only examined incoming and outgoing resident communication, on the basis of 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 and procedures in relation to the implementation of resident searches. The policy was last reviewed in September 2020. The policy addressed all of the requirements of the regulation, including the following:

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

The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

The clinical file of one resident who was searched was inspected. The resident's consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The search was implemented with due regard to the resident's dignity, gender and privacy. The resident was informed by the person implementing the search what was happening during the search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. Due regard was implemented with dignity, privacy and gender when undertaking the search.

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 August 2020. As no resident had died in the approved centre since the last inspection, compliance for this regulation was assessed on the basis of the Care of the Dying Policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP), five of which were reviewed on inspection. All ICPs were recorded in a composite set of documentation. The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, as soon as was possible but within seven days of admission. The ICP was discussed, agreed where practicable and drawn up with the participation of the resident and their representative, family and next-of-kin, as appropriate.

The ICPs identified appropriate goals, appropriate care and treatment, and interventions. All ICPS specified the resources required to provide the care and treatment identified, including the frequency and responsibilities for implementing the care and treatment. The MDTs reviewed care plans once a week. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances and goals; this was documented.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the needs of the residents, as documented in the residents' individual care plans (ICPs). However, the therapeutic services and programmes provided by the approved centre were not holistically directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

The social worker offered individual sessions for assessed needs and the psychologist facilitated two group sessions weekly alongside individual sessions as required. The clinical nurse specialist (CNS) coordinated the timetable when they were on duty however the CNS groups were not facilitated when the CNS was not on duty. Groups facilitated by the CNS included relaxation sessions, walking groups, exercises and educational groups. Residents did not have access to occupational therapy outside of urgent referrals as there was no occupational therapist in the approved centre since the end of June. Residents in the Brandon Unit did not have access to urgent OT assessments or an occupational therapist.

Where a resident required a therapeutic service or programme that was not provided internally such as physiotherapy, dietetics and speech and language therapy, 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 because the registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, as residents did not have access to an occupational therapist, 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 in September 2020. The clinical file of one resident who had been transferred from the approved centre was examined. Full and complete written information regarding the resident was transferred when they moved from approved centre to another facility. This Information was sent in advance, or at least accompanied the resident upon transfer, to a named individual. This included a letter of referral including a current list of medications and a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures for responding to medical emergencies. The medical emergencies policy was last reviewed in July 2020. The approved centre had an emergency trolley and staff had access at all times 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. Residents received a medication review. There were no residents in the approved centre at the time of inspection who had not been in the approved centre for six- months.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including Breast Check, cervical screening, retina check if diabetic, and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a policy and procedures in relation to the provision of information to residents. The policy was last reviewed in 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 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 the medication information sheets included information on indications for use of all medications to be administered to the resident, as well as 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

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

The general demeanour of staff and the manner in which staff addressed and communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. Staff were dressed appropriately to their role and function which was an indicator of respect for residents.

Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass however the visiting rooms on Reask and Valentia wards did not have blinds, curtains, or opaque glass on the door observation panels.

All bathrooms, showers, and toilets had locks on the inside of the door. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times as the visiting rooms for both Valentia and Reask Wards did not have blinds fitted to the door observation panels.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was clean, hygienic, and free from offensive odours. The wards had appropriately sized communal rooms. All rooms were well ventilated and heating was appropriate and sufficient in bedroom areas. All rooms were centrally heated. Private and communal areas were suitably sized and furnished to remove excess noise. Appropriate signage and sensory aids were provided to support residents orientation and the lighting in communal rooms suited the needs or residents and staff.

There was sufficient space, indoors and outdoors provided for residents to move freely. Hazards including large open spaces, steps and stairs, slippery floors, hard and sharp edges or rough surfaces were minimised in the approved centre however not all ligatures were reduced to the lowest practical level based on risk assessment.

The approved centre was not in a good state of repair internally. There were several minor repair issues noted throughout the approved centre. These issues had been reported to the maintenance department but had been outstanding at the time of inspection. These included paint damage, holes in walls from previous building work in the Brandon unit clinical room, conference room and nurses' station which were all outstanding for 10 months. There were damaged ceiling tiles in the Brandon Unit clinical room from a previously repaired leak. Several wall corners were damaged and dented due to collision impacts to the walls. A request was sent into the maintenance department seven months prior to the time of inspection for protective aluminium covers to be fitted which had not been progressed or completed. The closing mechanism of the clinical nurse management office fire door was broken causing the fire door to remain ajar. While this door was in the approved centre, it was not in the clinical section of the approved centre.

It was located just inside the entrance of the approved centre, on a short corridor containing offices that led onto the Wards. The office door formed a sub compartment to the corridor which was a compartment to contain fire and a fire exit pathway. This issue had not been resolved since it was reported seven months previously.

There was a programme of general maintenance, cleaning, decontamination, repair of assistive equipment. Records were maintained. There was not a programme of decorative maintenance.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet available. The approved centre had a designated sluice and cleaning room, as appropriate. All bedrooms sized were adequate to address resident's needs. The approved centre also provided suitable furnishings to support resident independence and comfort and assisted devices or equipment to address resident needs.

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

a) **The premises were not maintained in good structural and decorative condition. Repair issues such as chipped paint, damaged walls, a damaged emergency door release pad, and a broken fire door closing mechanism had not been resolved at the time of inspection, 22(1)(a).**
b) **A programme of decorative maintenance was not developed and maintained throughout the approved centre, 22 (1)(c).**
c) **The condition of the physical structure and the overall environment was not developed with due regard to the safety of residents as all ligature points were not minimised to the lowest practicable level based on risk assessment, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in 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. Direction to crush medication was only accepted from the resident's medical practitioner and the medical practitioner provided a documented reason why the medication is to be crushed. The pharmacist was consulted about the type of preparation to be used and the medical practitioner documented in the MPAR which medications were to be crushed. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

Medication dispensed 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 policy was last reviewed in September 2020.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating MODERATE

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the use of closed circuit television viewing (CCTV). The policy was last reviewed in September 2020. The policy detailed 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. CCTV cameras used to observe residents were incapable of recording or storing a resident's image on a tape, disc, or hard drive.

The CCTV monitors in Reask and Valentia wards were not viewed solely by the health professionals responsible for the residents. The monitors were viewable from open access nurses' stations desks on a corridor outside the dormitory rooms on both Reask and Valentia wards within the approved centre. This was not resolved from the 2020 inspection. CCTV was not used to monitor a resident if they acted 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 non-compliant with this regulation because CCTV monitors in Reask and Valentia wards were not viewed solely by the health professionals responsible for the residents, 25(1)(a).

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 written operational policy and procedure in relation to staffing. The policy was last reviewed in September 2020. The policy included the recruitment and selection process of the approved centre, including Garda vetting requirements.

The numbers and skill mix of staffing were not sufficient to meet resident needs as the approved centre did not have a dedicated occupational therapist (OT) at the time of inspection. An OT post was vacant in the approved centres since the end of June 2020. When the approved centre did have a staff grade occupational therapist, the residents on the Brandon unit did not have access to this OT. The multi-disciplinary team (MDT) consisted of medical, psychology, social work and nursing staff.

An appropriately qualified staff member was on duty and in charge at all times; this was documented. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated 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.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (32)	32	100%
Medical (5)	3	100%
Social Worker (1)	1	100%

Psychologist (1)	1	100%

The approved centre was non-compliant with this regulation because the numbers and skill mix of staffing were not sufficient to meet resident needs. The approved centre did not have a designated occupational therapist, 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 a written operational policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was 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 register of residents which was held electronically and in paper form. 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

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre used the HSE's *Your Service Your Say* policy and their own written operational policy and procedures in relation to the management of complaints which was last reviewed in September 2020. The policy included the process for the management of complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

The complaints procedure, including how to contact the available nominated individual, was publicly displayed in the approved centre. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints were handled promptly, appropriately and sensitively. The 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. All complaints were dealt with by the nominated person and recorded in the complaints log. 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.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There was a comprehensive written policy and procedures in relation to risk management and incident management processes. The policy was last reviewed in September 2020 in relation to risk management and incident management processes. The policy included all of the policy related regulation requirements, including:

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

The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical and corporate risks were identified, assessed, reported, treated, monitored, and recorded in the risk register however, not all of the components of the risk management policy were implemented throughout the approved centre. One element of the risk management practices did not actively reduce

an identified risk to the lowest level of risk. Health and safety risks, specifically in relation to the residents being able to evacuate safely in the event of a fire were not identified on the risk register or treated. A fire door to a sub compartment along the administration corridor entering from the main hospital was faulty as the closing mechanism did not work and therefore the door did not close properly. This compromised the sub fire compartment it was identified as, in the prevention of fire. This was not identified as a fire risk at the time of inspection when the closing mechanism had not been resolved seven months since it was identified. A fire safety audit also highlighted no fire drills has occurred had been completed since the previous inspection.

Individual risk assessments were completed prior to episodes of physical restraint, seclusion, and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were effectively mitigated.

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.

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 non-compliant with this regulation for the following reasons:

a) A health and safety risk was not identified, assessed, reported, treated, monitored, or recorded in the risk register; A faulty fire door was not identified as a fire risk and was not present on the risk register, 32(1).
b) No fire drills had been completed since the previous inspection, 32(1).

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy and procedures in relation to the use of seclusion, and the policy was reviewed annually. The policy addressed who may implement seclusion, the provision of information to the resident, and ways of reducing rates of seclusion use.

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

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings which did not endanger resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file.

One seclusion episode contained within the resident's clinical file was inspected. In this episode, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

The resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident was informed of the ending of seclusion. A written record of the resident was made by the nurse every 15 minutes, which included the level of distress and

behaviour of the resident. The resident received a medical review by the registered medical practitioner every four hours. The seclusion episode did not last longer than 30 minutes.

This episode of seclusion was recorded in the resident's clinical file and this use of seclusion was recorded in the seclusion register. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the resident's clinical file and available to inspectors. This episode of seclusion was reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion.

The approved centre was compliant with this rule

9.0 Inspection Findings – Mental Health Act 2001

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 LOW

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

INSPECTION FINDINGS

Processes:
The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated September 2021. It addressed the following:

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

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

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

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

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident was deemed to have capacity and did not consent to their next of kin being informed. This was documented in the clinical file. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. There was no documentary evidence that the episode of physical restraint was reviewed by members of the multi-disciplinary team (MDT) or documented in the clinical file no later than two working days after the episode. The clinical practice form was placed in the clinical file. The resident was given the opportunity to discuss the episode with members of MDT as soon as was practicable.

The approved centre was non-compliant with this code of practice because the episode of physical restraint was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode, 9.3.

Admission of Children

NON-COMPLIANT

Risk Rating HIGH

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes:
The approved centre had a written policy in relation to the admission of a child, which was last reviewed in July 2020. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: The clinical file of one child resident who was admitted to the approved centre was examined on inspection. Age-appropriate facilities were not provided by the approved centre. Provisions were in place for the following: ensuring the safety of the child; responding to the child's special needs as a young person in an adult setting; and, ensuring the right of the child to have their voice heard. Staff who had contact with the child had undergone Garda/Police vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated, including age and gender segregated sleeping and bathroom areas. Staff observation acknowledged gender sensitivity; observation arrangements, including assignment of the designated staff member, was provided as considered clinically appropriate.

There was no documented evidence to suggest the child resident had their rights explained and information about the ward and facilities provided in a form and language they can understand or the child's understanding of the explanation given. Advice from the Child and Adolescent Mental Health Service was available in the approved centre. The approved centre did not have access to a children's advocacy service. Appropriate visiting arrangements for families were available. The Mental Health Commission was notified of the child admission within 72 hours, using the associated notification form. Additionally, consent for treatment was obtained from the child's one or both parents.

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

a) **The child resident was not provided with age-appropriate facilities as the approved centre was an adult facility, 2.5(b).**
b) **The child resident did not have access to age-appropriate advocacy services, 2.5(b).**
c) **There was no evidence to suggest that the child resident had their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical file did not record this child's understanding of the explanation given, 2.5(h).**

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes:
The approved centre had a single policy in relation to admission, transfer, and discharge which was reviewed in September 2021.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: current mental health state, risk assessment, presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, work situation, education, 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 coordinated by the resident's 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, informational needs, a current mental state examination, 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 the relevant health care provider within three days of discharge. A comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, and names and contact details of key people for follow-up. The discharge summary also included risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 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 21: Privacy					
Reason ID : 10002434		**The registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times as the visiting rooms for both Valentia and Reask Wards did not have blinds fitted to the door observation panels.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Frosted contact to be applied to windows to afford privacy while upholding Health and Safety requirements.	Awaiting contractor to apply contact	Achievable	31/03/2022	ADON
Preventative Action	All staff are aware of Regulation 21 and are asked to knock on doors before entering.	Staff have been informed of requirement. Also reflected in policy.	Achievable	18/01/2022	ADON

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 25: Use of Closed Circuit Television					
Reason ID : 10002433		**CCTV monitors in Reask and Valentia wards were not viewed solely by the health professionals responsible for the residents, 25(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Management team have engaged with an external contractor who will provide monitors which can be viewed only by health professionals.	Currently going through procurement process	Achievable	31/03/2022	ADON/Area Administrator
Preventative Action	Staff to ensure that no non-healthcare profession can view monitor.	Monitors to be turned off when nursing staff are not at station	Achievable	18/01/2022	ADON

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.

Regulation 32: Risk Management Procedures					
Reason ID : 10002435		**A health and safety risk was not identified, assessed, reported, treated, monitored, or recorded in the risk register; A faulty fire door was not identified as a fire risk and was not present on the risk register, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Continuous regular fire inspections to be conducted. Continuous visits by Fire Officer to be facilitated. Faulty Fire has been identified as a Fire Risk and placed on the Risk Register.	Commenced as of 18/01/22	Achievable	18/01/2022	ADON
Preventative Action	Education and Training to be provided for staff in Fire Training and on Risk Management.	Schedule of training dates has been prepared.	Achievable	31/03/2022	ADON
Reason ID : 10002436		**No fire drills had been completed since the previous inspection, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire Drill to be held following completion of staff training	Schedule of training dates has been prepared.	ADON in discussion with Fire Officer in relation to dates for training and Fire Drill	31/03/2022	ADON
Preventative Action	All staff are aware of Fire Plan including location of fire exits etc. Induction book for patients includes details of what to do in the event of a fire. This will be updated to include a map	In progress	Achievable	31/03/2022	ADON

	showing location of fire exits.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10002422		**The episode of physical restraint was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode, 9.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Developed an MDT review sticker to remind MDT to review physical restraint.	In place	Achievable	18/01/2022	Heads of Discipline
Preventative Action	All staff to be aware of COP and related documentation.	Audit	Achievable	18/01/2022	Heads of Discipline

Code of Practice relating to Admission of Children Under the Mental Health Act 2001

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.

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.

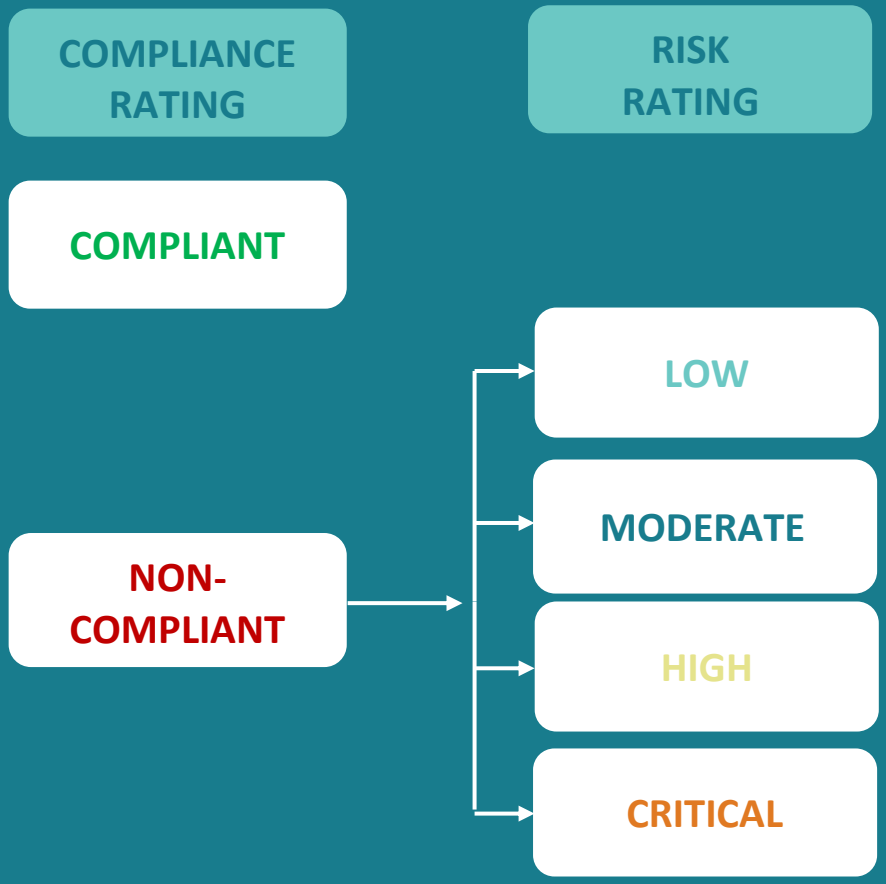
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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