St Patrick's University Hospital

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mental health commission

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

ST PATRICK'S UNIVERSITY HOSPITAL

James's Street, Dublin 8

Date of Publication:
Friday 04 February 2022

ID Number: AC0125

2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
N/A

Inspection Team:
Fergal Duffy, Lead Inspector
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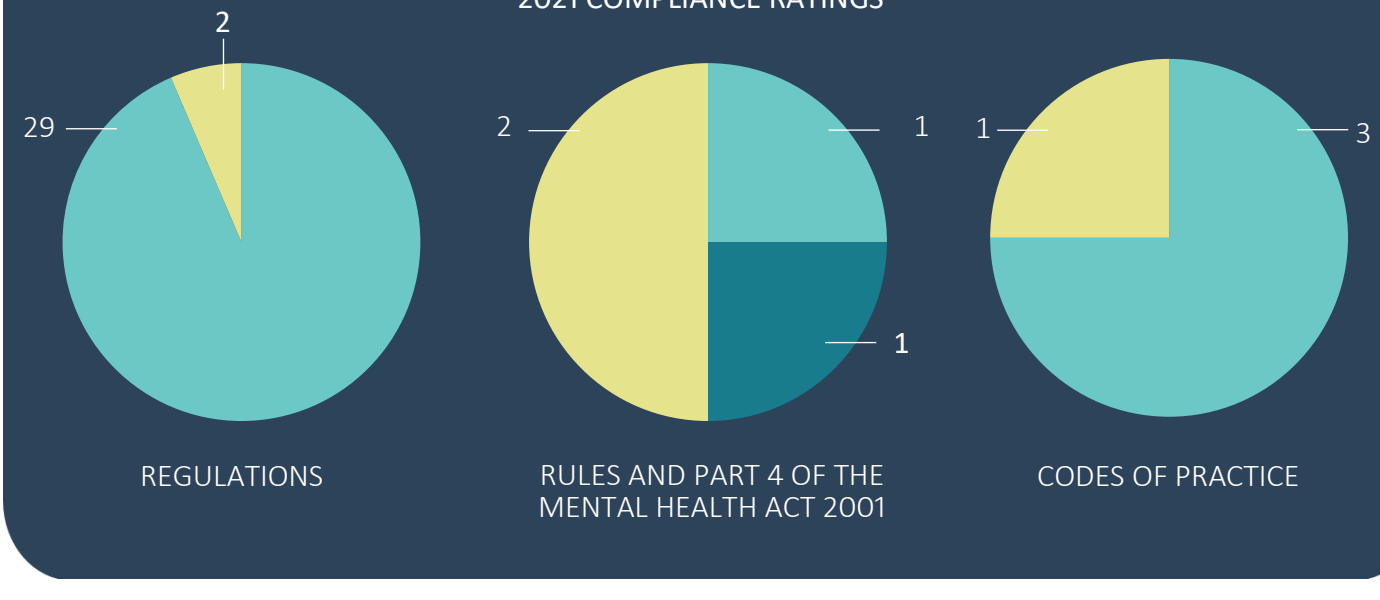
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
24 – 27 August 2021

Previous Inspection date:
1 – 4 September 2020

Inspection Type:
Announced Annual Inspection

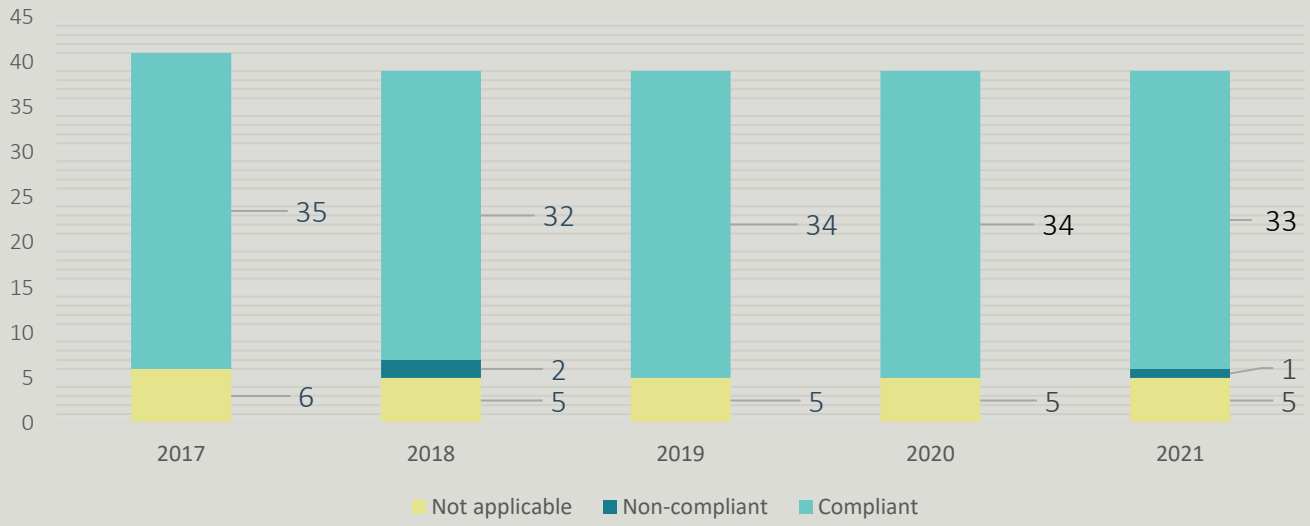
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

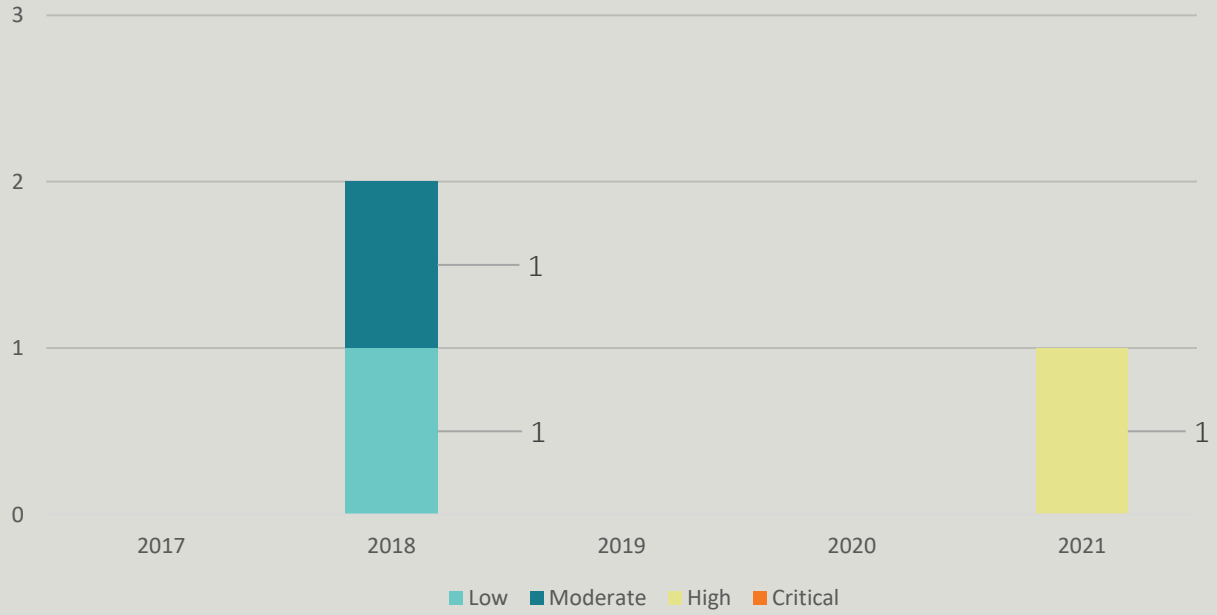
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2017 – 2021



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

The approved centre was an independent hospital and part of the St. Patrick's Mental Health Service (SPMHS). The original hospital structure was an 18th century listed building. A variety of extensions had been developed over the years. The approved centre was registered to accommodate 241 residents. It comprised eight wards, including a Special Care Unit, and an eating disorder unit. Fifteen consultant psychiatrist led multi-disciplinary teams provided care and treatment to residents.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	100%	94%	100%	100%	97%
Regulations Rated Excellent	22	19	25	N/A	N/A

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

Conditions to registration

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

Escalation and enforcement actions since last inspection

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

Escalation and enforcement actions since this inspection

There were no escalation and enforcement actions since this inspection.

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm and that effective systems were in place to safeguard patients.

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

Appropriate care and treatment of residents

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

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.
- Therapeutic programmes included open dietetics, recovery skills and relapse prevention. Pillars of wellness included stress management, decider skills, mindfulness, behavioural activation, and an overview of mental health disorders. There was also yoga nidra, a yoga sleep group, art therapy and Information Cafe for service users close to discharge.
- St. Patrick's Mental Health Services developed a Home Care treatment service. This new service provides access to full multi-disciplinary team (MDT) care and treatment on a 24-hour basis, seven days a week to people in their own home, using on-line applications and resources.

Respect for residents' privacy, dignity, and autonomy

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

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

Responsiveness to residents' needs

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

- Recreational activities included self-directed activities, such as board games, jigsaws, books, TV, and internet. There were quizzes, baking groups, a daily hospital walk, mini golf, access to the pottery and art room, virtual bingo, online crochet group and yoga nidra in the evenings.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

There was a robust system of governance in the approved centre.

- St. Patrick's University Hospital was part of St. Patrick's Mental Health Services (SPMHS). The hospital was established in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a Board of Governors consisting of both ex-officio and appointed members. The Senior Management Team (SMT) were responsible to the Board of Governors for the operation of the approved centre. A detailed clinical and corporate governance structure was in place.

- The SMT met fortnightly. Issues such as service development, health and safety, facilities, and risk management, including review of the overall risk register were discussed at these meetings.
- In addition to the SMT process the governance structure included a clinical governance committee which was held weekly and a risk and safety committee which was held monthly. Subordinate committees focused on specific aspects of service governance.
- Each clinical discipline had its own governance structure, with clear line management processes in place.
- There was an active clinical audit process documented. Policies were reviewed and updated as required. Key performance indicators assisted the approved centre to measure how well they were doing in relation to achieving set goals. Clear systems were in place to support and monitor quality improvement.
- The Datix electronic database was used to record and monitor all risks within the approved centre. The database was linked to the Electronic Health Record (EHR) for each resident and applicable risk information was populated in the relevant section of the resident's clinical file. There were comprehensive risk assessments for the approved centre, which were escalated to the risk register as appropriate. Escalated risks were agenda items at senior management meetings.
- A variety of methods were used to engage service users, past and present, in co-production of service provision including a consultative forum. Service user input into future developments in SPMHS was also facilitated using these methods and further supported by the project advisory service user forum. There was service user representation on interview panels for new appointments within the hospital.

COVID-19 response

In response to the COVID-19 pandemic, the service developed and implemented a comprehensive COVID-19 management plan to help prevent the spread of the virus. Operational initiatives focused on maintaining a safe and effective service while observing public health requirements. These initiatives included the conversion of St. Edmundsbury Hospital to a COVID-19 isolation facility, provision of home care packages including provision of the full therapeutic milieu using on-line resources and the re-organisation of face-to-face therapeutic provision in the context of social distancing needs.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. St. Patrick's Mental Health Services developed a Home Care treatment service. This new service provides access to full multi-disciplinary team (MDT) care and treatment on a 24-hour basis, seven days a week to people in their own home, using on-line applications and resources.

2. A Pillars of Wellness programme was commenced in December 2020. It is a recovery education programme available to all service users who are in-patients, or on a Home Care admission. It covers topics such as: What is mental health, behavioural activation, introduction to respective disorders, stress, coping skills, sleep, and information on the services available at St. Patrick's University Hospital.

3. The Well Bean Café: A new confectionary/coffee kiosk was built in the centre's garden to encourage service users to enjoy the gardens and fresh air. The kiosk was designed with the pandemic in mind with two service areas and separate access and egress points. It had a distinct colour scheme to attract service users to the area. Additional outdoor seating was installed in the garden area outside the kiosk.

4. The Environmental Services Department re-developed and upgraded the 9-hole mini golf area in St Patricks University Hospital. This area was initially developed in 1988 and was modernised in 2021. There was also a new seating area beside the mini golf course where service users could interact without playing golf.

5. The Psychology Department at St Patricks Mental Services developed and introduced three new programmatic initiatives: (i) The Trauma Programme-was a closed group designed to treat individuals experiencing symptoms of Post-Traumatic Stress Disorder (PTSD); (ii) The Temple Formulation Group-was a closed group designed to treat individuals experiencing mental health difficulties who also have a co-morbid addiction or substance misuse/abuse diagnosis; (iii) The Young Adult Formulation Group Programme-was a closed group designed to help young adults learn the skills to develop a psychological understanding or formulation of their mental health difficulties.

6. St Patrick's Mental Health Services had established processes to engage and consult with past and present service users-specifically surveys, focus groups, a consultative forum, and a project advisory forum. These service user engagement processes informed service design and delivery.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was an independent hospital and part of the St. Patrick's Mental Health Service (SPMHS). It was located on Steeven's Lane in Dublin. The original hospital structure was an 18th century listed building. A variety of extensions had been developed over the years. The approved centre was registered to accommodate 241 residents. The approved centre comprised eight wards: Dean Swift, including Special Care Unit (acute admissions), Stella (general adult-female only), Grattan (general admissions), Delaney (general admissions), Kilroot (general admissions), Vanessa (care of the elderly), Clara (eating disorders), and Temple (addictions service). The approved centre did not admit children. The approved centre was well maintained and decorated throughout. From the reception area in the hospital to all the wards, the décor and furnishings provided a respectful and relaxed environment to service users. Residents had access to a large garden and therapy garden within the approved centre grounds. Fifteen consultant psychiatrist led multi-disciplinary teams provided care and treatment to residents.

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

Resident Profile	
Number of registered beds	241
Total number of residents	224
Number of detained patients	13
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	2
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

St. Patrick's University Hospital was part of St. Patrick's Mental Health Services (SPMHS). The hospital was established in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a Board of Governors consisting of both ex-officio and appointed members. The Senior Management Team (SMT) were responsible to the Board of Governors for the operation of the approved centre. A detailed clinical and corporate governance structure was in place.

The SMT met fortnightly. Issues such as service development, health and safety, facilities, and risk management, including review of the overall risk register were discussed at these meetings. In addition to the SMT process the governance structure included a clinical governance committee which was held weekly and a risk and safety committee which was held monthly. Subordinate committees (the clinical finance group met fortnightly; the senior staff meeting convened monthly; the clinical council group sat fortnightly; an

infection control committee meeting was held monthly; a research ethics committee was held quarterly; a falls committee was held every two months; a drugs and therapeutics committee was held every two months; an editorial committee met every two months; a hospital development committee met monthly and an advocacy sub-group met monthly) focused on specific aspects of service governance. An organisational chart was available which identified the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place. There was an active clinical audit process documented. Policies were reviewed and updated as required.

The inspection team met with heads of clinical disciplines as part of the inspection process. This provided a clear overview of the governance issues and current risks within their respective departments. Each head of discipline was based in the approved centre. Defined lines of responsibility were evident in each department. Each head of discipline met with intradisciplinary staff on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the senior management team. All disciplines had formal and informal clinical supervision arrangements in place where appropriate. All clinical departments had formal staff performance appraisal processes in place. All disciplines reported that their staffing numbers were currently in accordance with agreed numbers.

All clinical staff had received training on clinical risk management, appropriate to their role and function. The Datix electronic database was used to record and monitor all risks within the approved centre. The database was linked to the Electronic Health Record (EHR) for each resident and applicable risk information was populated in the relevant section of the resident's clinical file. There were comprehensive risk assessments for the approved centre, which were escalated to the risk register as appropriate. All heads of discipline identified strategic aims for their teams and discussed potential operational risks within their departments, which were escalated to the risk register if required. There were clear processes for escalation of risks. Key personnel and their role in management of identified risks were recorded. Escalated risks were agenda items at senior management meetings. Key performance indicators assisted the approved centre to measure how well they were doing in relation to achieving set goals. Clear systems were in place to support and monitor quality improvement.

Governance processes made provision for the involvement of service users and their representatives where appropriate. A variety of methods were used to engage service users, past and present, in co-production of service provision– specifically surveys, focus groups and a consultative forum. Service user input into future developments in SPMHS was also facilitated using these methods and further supported by the project advisory service user forum. There was service user representation on interview panels for new appointments within the hospital. Community meetings, suggestion boxes, a complaints process and an independent advocacy service also provided feedback to staff and management about the resident experience of service provision. There were clear processes in place to follow up on any issues identified by service users. There was strong emphasis on the experience of service users in academic research undertaken in SPMHS. Similarly, quality improvement initiatives concentrated on the consumer; an example being the admission pathway project, where end-to-end process mapping was used to ensure a seamless transition from first contact through admission to the appropriate unit.

In response to the COVID-19 pandemic, the service developed and implemented a comprehensive COVID-19 management plan to help prevent the spread of the virus. Operational initiatives focused on maintaining a safe and effective service while observing public health requirements. These initiatives included the conversion of St. Edmundsbury Hospital to a COVID-19 isolation facility, provision of home care packages including provision of the full therapeutic milieu using on-line resources and the re-organisation of face-to-face therapeutic provision in the context of social distancing needs.

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	
Part 4 of the Mental Health Act 2001: Consent to Treatment	✓		✓		✓		✓		✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Restraint	As the approved centre did not use mechanical restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.

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.

The feedback from service users was very complimentary of SPMHS. All respondents reported being provided with information about their diagnosis, care, and treatment. All the respondents' said staff were available to provide therapeutic assistance for any worries or concerns they had. All respondents said the staff upheld the dignity and privacy of residents. All respondents said they were free to communicate with family, friends, and advocacy services. 90% of respondents said they were familiar with their care plan and involved in goal setting as part of the care planning process. The average standard of care rating was nine out of ten.

There were some issues for possible improvement highlighted; a quarter of respondents said there were not enough activities for residents. One respondent expressed dissatisfaction with the food.

5.2 Advocacy

The approved centre had an advocacy service.

The Inspectors did not receive a report from the IAN representative, who was on leave at the time of the inspection.

6.0 Feedback Meeting

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

- Chief Executive Officer
- Director of Services
- Programme Director for Clinical Governance
- Clinical Director
- Assistant Clinical Director
- Director of Nursing
- Occupational Therapy Manager
- Director of Psychology
- Head of Social Work
- Mental Health Act Administrator
- ECT Nurse Specialist

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The service provided clarification in relation to the system it operates for resident dining to enable social distancing and in relation to procedures relating to Part 4 of the Mental Health Act 2001 (as amended) - Consent to Treatment.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Emergency clothing was re-stocked when it needed to be. No residents wore nightclothes during the day.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to residents' personal property and possessions. The policies were last reviewed in August 2018 and September 2018. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities including safes and property rooms were provided for the safe keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. Self-directed activities included television, books, board games, outdoor gardening, and a gym.

There was also Lego kits, colouring, sudoku and crosswords available. Recreational activities included quizzes, baking groups, a daily hospital walk, mini golf, access to the pottery and art room, virtual bingo, online crochet group and yoga nidra in the evenings.

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. Multifaith chaplains visited by request and religious texts were available.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in March 2021. Visiting times were appropriate and reasonable, and the visiting process took account of COVID-19 precautions and infection control requirements. Visits were by appointment only and for half an hour duration, and only one person could visit a resident at a time. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Visiting rooms were suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy on service user access to communication facilities was last reviewed in March 2020. Residents had access to postal mail, the internet, and telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The clinical file of one resident was examined on inspection in relation to the search process. Risk was assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches and the request for consent and the received consent were documented for every search. The resident search policy and procedure was communicated to all residents and relevant staff were documented to have read and understood the policy on searches.

Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every search of a resident and every property search was available, which included the

reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in August 2021. One sudden death had occurred within the approved centre since the previous inspection. The sudden death of the resident was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

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 -team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Due to COVID-19 therapeutic activities had moved from face-to-face delivery to technology-based interventions. Microsoft Teams was the chosen platform for delivering therapeutic services. Microsoft Teams daily activities commenced with morning lectures, anti-tension and yoga classes and occupational therapy (OT) lectures. Social Work lectures, dietetics, information café, and art therapy groups were delivered throughout the summer.

Therapeutic programmes included open dietetics, recovery skills and relapse prevention. Pillars of wellness included stress management, decider skills, mindfulness, behavioural activation, and an overview of mental health disorders. There was also yoga nidra, a yoga sleep group, art therapy and Information Cafe for service users close to discharge.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in April 2020. The clinical file of one resident who had been transferred in an emergency was examined. Communications between the approved centre and the receiving facility were documented and followed up with a written referral.

Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer to a named individual, which included a resident transfer form and letter of referral that contained a list of current medications.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a medical emergencies policy. The policy was last reviewed in January 2020. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Residents received appropriate general health care interventions in line with individual care plans. A six-monthly general health assessment was inspected, in relation to one resident who was in the approved centre for a period greater than six months. This six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status including diet and physical activity, a medication review and Body Mass-Index (BMI), weight and waist circumference.

The file of one resident on antipsychotic medication was inspected. The resident received an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG) heart function test.

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

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in March 2019. The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents' rights.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Resident's privacy and dignity was appropriately respected at all times. The manner in which staff spoke with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Where a resident shared a room the bed screening ensured that their privacy was not compromised.

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was clean, hygienic and free from offensive odours. Suitable furnishings were provided to support resident independence and comfort. There was at least one assisted toilet per floor. Assisted devices and equipment were provided to address resident needs.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had several written policies and procedures on the ordering, prescribing, storing and administration of medicines, all of which were in date. Together, the policies included:

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

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

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy and a garda vetting policy and procedures in place in relation to the recruitment, selection, and Garda vetting requirements. The staffing policy was last reviewed in September 2018. The Garda vetting policy was last reviewed in May 2019. The approved centre had fifteen multi-disciplinary teams. These teams included psychiatry, nursing, occupational therapy, psychology, and social work staff. Nine multi-disciplinary teams included a pharmacist and all other teams had access to a pharmacist. The number and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times, and this was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022. The following is a table showing the numbers and percentages of staff trained in the Mental Health Act 2001.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (241)	241	100%
Medical (32)	32	100%
Occupational Therapist (9)	9	100%
Social Worker (12)	12	100%
Psychologist (21)	21	100%
Cognitive Behavioural Therapist (6)	6	100%

Addiction Therapist (8)	8	100%
Pharmacist (9)	9	100%
Pharmacy Technician (9)	9	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had several written operational policies and procedures in relation to the maintenance of records. The policies were all in date. Residents' electronic records were secure, up-to-date, and in good order. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in May 2019 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in May 2019. The risk management policy addressed all requirements of the regulation.

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of electro-convulsive therapy (ECT) for involuntary patients. The policy was last reviewed in September 2019. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice. All staff involved in ECT had appropriate training and education in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one involuntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed unable to consent to receiving ECT. ECT was administered according to section 59(1)(b) of Mental Health Act 2001, as amended. A Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed by two

consultant psychiatrists for each ECT programme. A form 16 was placed in the patient's clinical file and a copy of it was sent to the MHC within five days.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, and a current mental state examination. Cognitive assessments were completed and recorded before and after each ECT session. The process was in line with best international practice by the consultant psychiatrists.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT was recorded.

The approved centre was compliant with this Rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

The Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* documented a description of the medication prescribed to the patient i.e., antidepressant, mood stabilising, hypnotic and antianxiety medication, as well as physical health treatment. The Form 17 did not document the specific names of medications prescribed to the patient.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because in relation to one patient: A Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* did not document the specific names of medications prescribed to the resident.

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in January 2021. The policy covered:

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

Training and Education: Written record that all staff involved in physical restraint had read and understood the policy.

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

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

The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre compliant with this Code of Practice.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in place in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was last reviewed in May 2019. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice. All staff involved in ECT had appropriate training and education in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT-suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk voluntary patients were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had responsibility for ECT management.

A named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed his or her capacity to consent to receiving treatment, and this was documented in their clinical file. The voluntary patient was deemed capable of consenting to receiving ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable the voluntary patient to make a decision on consent to ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that they could understand. The voluntary patient was informed of his or her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia. A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The

prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, a current mental state examination. Cognitive assessments were completed and recorded by consultant psychiatrists before and after each ECT session.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT was recorded.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in February 2019, the transfer policy was last reviewed in April 2020, and the discharge policy was last reviewed in April 2021. All policies combined included all of the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

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

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

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

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to relevant healthcare professionals within three days. A comprehensive discharge summary letter was issued within 14 days of discharge. The discharge summary letter included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health and social issues, follow-

up arrangements, and names and contact details of key people for follow-up. The discharge summary 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

Part 4 of the Mental Health Act 2001: Consent to Treatment					
Reason ID : 10002394					
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All form 17's completed since inspection 2021 now record the specific names of the psychiatric medications prescribed.	The Mental Health Act Administrator now monitors the completion of Form 17's to ensure they are completed as required, i.e. that they record the names of the psychiatric medications prescribed	None	24/11/2021	Responsible Consultant Psychiatrist Mental Health Act Administrator
Preventative Action	A copy of the relevant service users medication and prescription record (MPAR) is attached to the form 17 in advance of completion and the Responsible Consultant Psychiatrist is requested to record the names of the psychiatric medications prescribed on the form 17.	The Mental Health Act Administrator now monitors the completion of Form 17's to ensure they are completed as required, i.e. that they record the names of the psychiatric medications prescribed	None	24/11/2021	Responsible Consultant Psychiatrist Mental Health Act Administrator

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.

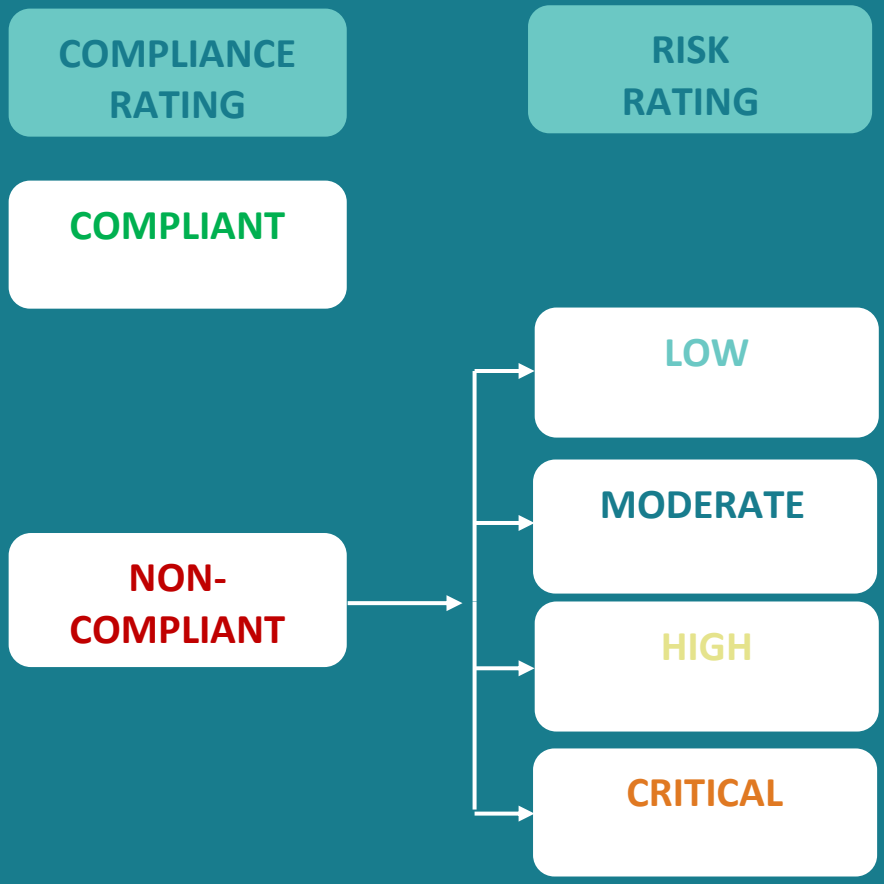
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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