Adult Acute Mental Health Unit, University Hospital Galway

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mental health commission

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

ADULT ACUTE MENTAL HEALTH UNIT, UNIVERSITY HOSPITAL GALWAY

Adult Acute Mental Health Unit, University Hospital Galway, Newcastle Road, Galway

Date of Publication:
07 April 2022

ID Number: AC0076

2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life
Mental health rehabilitation
Mental health care for people with intellectual disability

Conditions Attached:
None

Most Recent Registration Date:
30 June 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health Services, Community Healthcare West

Inspection Team:
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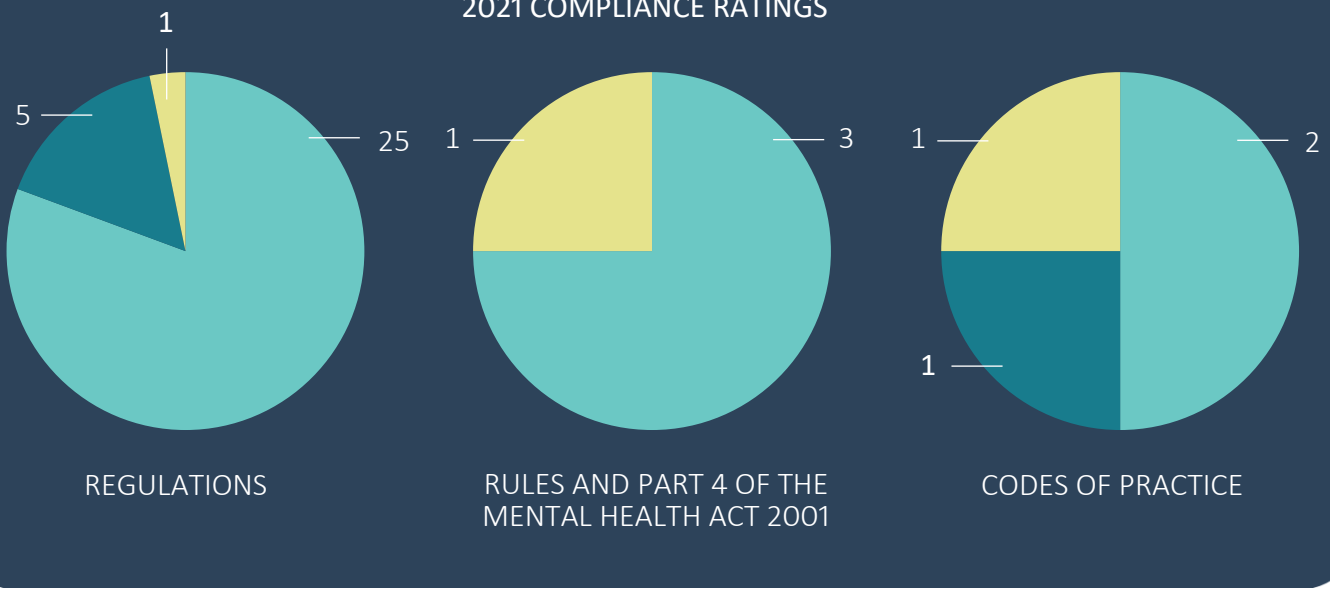
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
16 - 19 November 2021

Previous Inspection date:
25 – 28 August 2020

Inspection Type:
Announced Annual Inspection

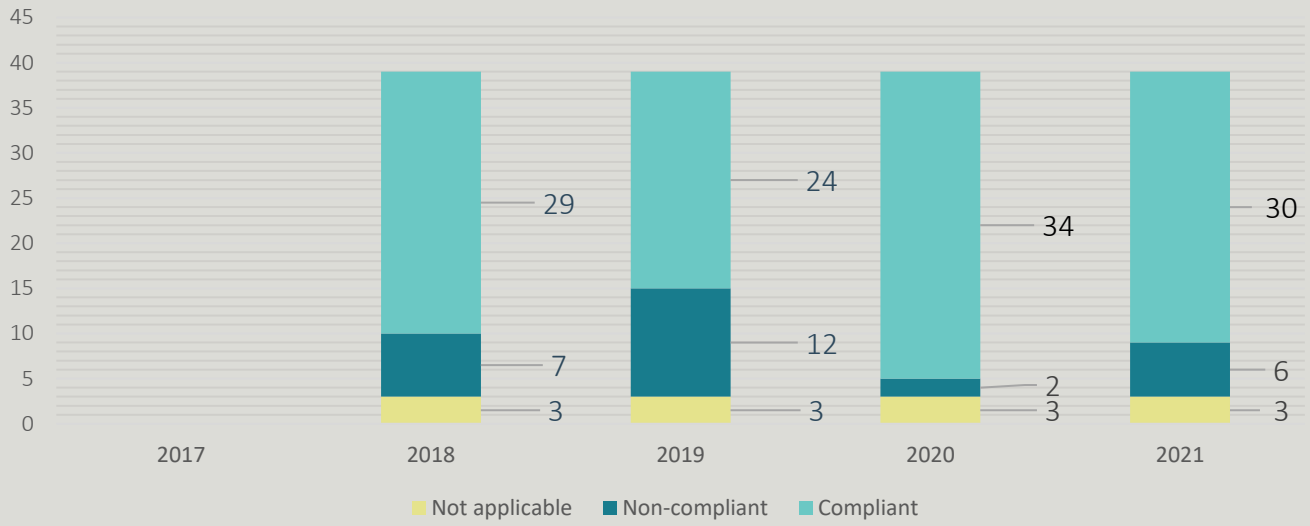
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

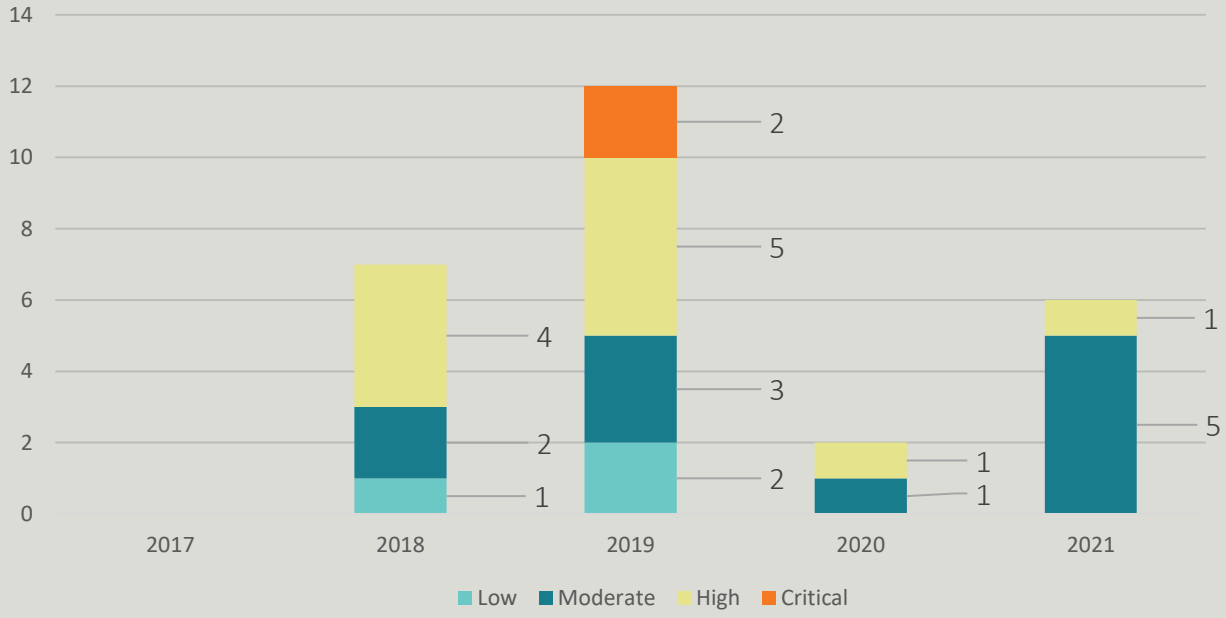
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 Adult Acute Mental Health Unit, University Hospital Galway was located on the grounds of the University Hospital Galway site. The approved centre was registered for 50 beds and consisted of four separate suites: Hazel, Ash, Holly, and Oak. Thirteen consultant led teams including Galway sector teams, psychiatry of later life teams, a mental health intellectual disability team, a rehabilitation and recovery team, and a mental health for homeless people team referred residents to the approved centre as appropriate. Two more consultant led teams had admitting rights, the liaison psychiatry team, and the perinatal mental health team.

Compliance Summary	2018	2019	2020	2021
% Compliance	81%	67%	94%	83%
Regulations Rated Excellent	9	12	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

Enforcement Action	Date Applied	Reasons	Outcome
Immediate Action Notice 10000151	01/09/2020	Immediate Action Notice was issued on foot of the last annual inspection regarding individual care plans.	Regular Individual Care Plan audits are taking place and audits are being forwarded to the Commission.

Safety in the approved centre

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

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

However, not all health and safety risks were monitored and documented by the approved centre.

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.
- The approved centre occupational therapy groups included cooking, baking, trauma-sensitive yoga, art therapy and walking and a life after discharge group which included: sleep hygiene, anxiety, goal setting, self-identity goals, Wellness Recovery Action Plan principles, activities of daily life building

skills, social skills, Healthy Me and relapse prevention. There was a safety planning group co-facilitated by a psychiatrist and an approved centre occupational therapist.

However, the approved centre has had a psychology post vacant since March 2021 and there was no date for a replacement. At the time of inspection the arrangement was that the community treating team's psychologist attended to the needs of the approved centre's residents.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre did not always provide services in a way that respected residents' privacy, dignity and autonomy.

- Most of the bedrooms were single en suite rooms.
- 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.

However, single bedroom en suites did not have doors due to an identified risk. This was not conducive to residents' privacy and dignity when showering and toileting. Single bedrooms did not have locks (with an override function) on the inside of the door and upon entering the room there was clear visibility into the en suites. The service was endeavouring to manage the competing risk issues and were in the process of implementing a solution.

Responsiveness to residents' needs

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

- Recreational activities included books, movies, board games, a pool table, outdoor table tennis, outdoor exercise machine, art, gardening, walks, art and crafts, bingo, relaxation. The approved centre provided access to recreational activities on weekdays and during the weekend.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

- The approved centre was under the governance of Community Healthcare West (formerly CHO 2), which consisted of the counties Mayo, Galway, and Roscommon. There was an area management team for the Galway and Roscommon Mental Health Services. The Area Management Team Meeting and the Quality and Safety Committee meeting were held monthly. A local Acute Unit Business Meeting was held monthly.
- The approved centre held a risk register, and this was monitored and maintained monthly at the Acute Unit Business Meeting. The approved centre risk register escalated risks to the Galway and Roscommon Mental Health Services risk register, where appropriate. Not all health and safety risks and clinical risks were documented and monitored in the approved centres risk register, as appropriate.
- All clinical incidents were reviewed at the respective multi-disciplinary team meetings. There was a Galway and Roscommon Serious Incident Management Team which reviewed serious incidents.
- An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The authority and responsibility of line managers for the various disciplines were clear. Staff training analysis and plans were completed to identify and address training needs.
- The Policy and Procedure Committee provided a multi-disciplinary approach to policy development, review, approval, and dissemination.
- The service implemented quality improvement audit tools to monitor and evaluate standards of care. Audit results were reviewed at the approved centre Acute Unit Business Meeting and at the Galway and Roscommon Audit and Quality Committee.
- The approved centre maintained a central log for minor complaints. There was a designated complaints officer who managed complaints in line with the HSE Your Service Your Say procedures. Clinical complaints were reviewed at the Complex Care Group and if appropriate, the learning from these complaints were discussed and disseminated.
- The Area Lead for Mental Health Engagement was a member of the Galway and Roscommon Area Management Team and the Quality and Safety Committee. There was a community Galway and Roscommon Mental Health Services forum which captured the views of previous residents of the approved centre. A designated advocate from the Irish Advocacy Network (IAN) contacted the approved centre on a weekly basis and spoke with residents and there were weekly Patient Feedback meetings held in the approved centre.

COVID-19 response

The approved centre closely monitored and managed the COVID-19 pandemic. There was a designated isolation area with separate clothing changing facilities for staff within the approved centre that could be utilised in the event of a COVID-19 outbreak. Contingency plans were in place. Infection Prevention Control processes were clearly outlined. COVID-19 was a standing agenda item at all the principal governance forums at a regional and local level. Where appropriate, policies and procedures had been updated to reflect the required process changes precipitated by the pandemic. A COVID-19 pathway for "Managing

Urgent and Emergency Mental Health Assessments" was developed and implemented in 2020 and remains in place to reduce the spread of infection, reduce time waiting for assessment and to increase service user satisfaction. As part of a COVID-19 pathway the approved center enhanced communication between general practitioners (GPs) and treating teams, to reduce Emergency Department presentations and subsequent admissions to the approved center by facilitating urgent appointments at the GPs request.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre is an implementation site for the “Reduction in the use of Restrictive Practices” and has established a Restrictive Practice Review Committee.

2. A Safewards Steering Committee has been established and the Safewards model is being implemented with the aim of reducing conflict, improving safety, and enhancing nurse-resident relationships.

3. Simulation based training workshops were implemented for Non-Consultant Hospital Doctor (NCHDs) and nursing staff to improve clinical skills in detecting and managing psychiatric scenarios.

4. A confidential visitors’ book was put into practice at the approved centre reception area in order to maintain visitors' confidentiality while continuing to document the required information.

5. Multi-disciplinary staff from the approved centre were trained in Decider Skills to enhance their therapeutic skill set. Decider Skills uses cognitive behaviour therapy to enhance how young people and adults monitor and manage their emotions and mental health.

6. St Andrews Nutrition Screening Instrument (SANSI) training was delivered to staff in order to implement screening on residents admitted to the approved centre.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Adult Acute Mental Health Unit, University Hospital Galway was located on the grounds of the University Hospital Galway site. The approved centre was registered for 50 beds and consisted of four separate suites: Hazel, Ash, Holly, and Oak. Thirteen consultant led teams including Galway sector teams, psychiatry of later life teams, a mental health intellectual disability team, a rehabilitation and recovery team, and a mental health for homeless people team referred residents to the approved centre as appropriate. Two more consultant led teams had admitting rights, the liaison psychiatry team, and the perinatal mental health team.

Access to the building was facilitated by security staff. Entry was enabled following appropriate infection prevention and control procedures which included hand washing and registration of all staff and visitors. Hazel, Oak and Ash suites were all located on the ground floor. Ash and Hazel were general adult suites which consisted of 18 and 19 beds respectively, however the service had the option of interchanging the bed numbers between them. Most of the bedrooms were single en suite rooms. Hazel suite contained one three-bedded and two two-bedded bedrooms. Ash suite contained one three-bedded and one two-bedded bedrooms. Both Hazel and Ash suites had access to a shared area, which contained a dayroom, a games room, a quiet room, a dining area, and an outdoor garden area. Oak suite was a high observation unit and consisted of five single en suite bedrooms. Oak suite also contained a dining room, a relaxation room, a seclusion room, and an outdoor garden area.

Holly suite, located on the first floor, consisted of eight single en suite bedrooms, and was dedicated to Psychiatry of Later Life. Residents had access to an outdoor enclosed space, which contained seating areas and multiple plant boxes. The first floor also housed administration/management offices, training rooms, an Electroconvulsive Therapy (ECT) suite and therapy facilities that included a relaxation room, an art room, and a therapy kitchen. Therapy facilities were accessed by residents of the approved centre by accompaniment of staff as appropriate.

On inspection, the premises were observed to be bright, clean, and well maintained. Ongoing internally works included adjustments to internal doors to reduce their noise levels and plans were in place to re-install suitable en suite single bedroom doors. Planned externally work included stabilising and heightening an external garden wall in Oak suite and to improve the decor of Holly suite garden.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**51**
Number of detained patients	17
Number of wards of court	1

Number of children	0
Number of residents in the approved centre for more than 6 months	3
Number of patients on Section 26 leave for more than 2 weeks	1

3.2 Governance

The approved centre was under the governance of Community Healthcare West (formerly CHO 2), which consisted of the counties Mayo, Galway, and Roscommon. There were two area management teams, one for Mayo Mental Health Service, the other for the Galway and Roscommon Mental Health Services. The Galway and Roscommon Mental Health Services overarching governance process encompassed the Area Management Team Meeting and the Quality and Safety Committee, both of which were held monthly. The approved centre was represented at these meetings by the relevant heads of discipline. Other Galway and Roscommon Mental Health Services committees and subgroups that intertwined with these meetings included:

- Drugs and Therapeutics Committee
- Audit and Quality Committee
- Complex Care Group
- Policy and Procedure Committee
- Health and Safety Committee

Within the approved centre, the governance was enhanced by a local Acute Unit Business Meeting which was held monthly. Standing items for this meeting included: clinical governance, COVID-19 management, audits / judgement support framework, tobacco free campus, maintenance, individual care plans and quality, safety, and risk. The Acute Unit Business Meeting was supported by various committees, sub-groups, and meetings some of which included: Consultant meetings, Nursing meetings between various nursing levels, Consultant and Senior Nurse meetings, Multi-task Attendants and Nursing meetings, Patient Feedback meetings, Galway General Hospital meetings, daily Safety Pause meetings, the Restrictive Practice Review Committee, Safewards Steering Committee, Delayed Discharge Meetings and Garda Liaison group. The Acute Unit Business Meeting fed into the Area Management Team Meeting, the Quality and Safety Committee and also into the various sub-committees and groups previously outlined. Committee and group members were appropriate consisted of representation from selected administrative and multi-disciplinary clinical personnel. These decision-making committees and subgroups consisted mainly of heads of discipline and managers which could potentially manifest into providing a bottom down management approach.

The approved centres registered proprietor held overall responsibility for the risk management process. All heads of discipline had received training in risk management procedures. The approved centre held a risk register, and this was monitored and maintained monthly at the Acute Unit Business Meeting. Dominant risks identified and closely monitored by the service included bed occupancy levels and staffing levels. These elements individually and combinedly put added pressure on staff and residents. At the time of inspection, the approved centre was over capacity and the bed occupancy records reflected this was a reoccurring issue

in previous months. The approved centre had established a Delayed Discharge Committee to support treating teams mobilise resources and systems to assist timely discharges which would aid occupancy levels.

Not all health and safety risks and clinical risks were documented and monitored in the approved centres risk register, as appropriate. Regulation 32: Risk Management Procedures further details this shortfall.
Incidents were reported, imputed, and analysed in line with the National Incident Management System. Incidents and incident trends were discussed quarterly at the Acute Unit Business Meeting. All clinical incidents were reviewed at the respective multi-disciplinary team meetings. There was a Galway and Roscommon Serious Incident Management Team which reviewed serious incidents. The approved centre risk register escalated risks to the Galway and Roscommon Mental Health Services risk register, where appropriate. This wider risk register was discussed monthly at the Galway and Roscommon Quality and Safety Committee meeting where risks were reviewed on rotation.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The authority and responsibility of line managers for the various disciplines were clear. There were formal and informal structures and processes in place for measuring and encouraging staff's performance planning and personal development. The formal arrangements and availability of clinical supervision varied across disciplines. Staff training analysis and plans were completed to identify and address training needs. The numbers and skill mix of staffing was not sufficient to meet residents' needs. The approved centre psychology post was vacant since March 2021. The arrangement was that the treating team's community psychologist attended to the needs of the approved centre's residents. However, this was conditional due to the combination of the treating teams lack of community psychology posts, community psychology vacancies and community residents competing clinical needs and risks.

The approved centre was dedicated to improving service quality. The approved centre had implemented various quality improvement initiatives as outlined above in section 2.0 Quality Initiatives. The Policy and Procedure Committee provided a multi-disciplinary approach to policy development, review, approval, and dissemination. The service implemented quality improvement audit tools to monitor and evaluate standards of care. Audit results were reviewed at the approved centre Acute Unit Business Meeting and at the Galway and Roscommon Audit and Quality Committee. Compliance with the *Judgement Support Framework* and other governing bodies was also discussed at these meetings. The approved centre maintained a central log for minor complaints. There was a designated complaints officer who managed complaints in line with the HSE Your Service Your Say procedures. Clinical complaints were reviewed at the Complex Care Group and if appropriate, the learning from these complaints were discussed and disseminated. It was unclear from the minutes provided by the approved centre if governance structures reviewed non-clinical complaints data. Minutes reviewed in relation to complaints included the approved centre Acute Unit Business Meeting and the Galway and Roscommon Area Management Team Meeting and the Quality and Safety Committee.

Resident engagement in governance and quality improvement processes were facilitated by the approved centre. The Area Lead for Mental Health Engagement was a member of the Galway and Roscommon Area Management Team and the Quality and Safety Committee. There was a community Galway and Roscommon Mental Health Services forum which captured the views of previous residents of the approved centre. These service user views and issues were represented by the Area Lead for Mental Health Engagement at the appropriate committees. A designated advocate from the Irish Advocacy Network (IAN) contacted the

approved centre on a weekly basis and spoke with residents. The IAN member communicated service users' views and issues to the approved centre management team on an ad hoc basis as there was no formal process embedded. The voice of the service user was sought by the approved centre through opportunities such as the "Comment, Compliments and Compliant" forms and the weekly Patient Feedback meetings held in the approved centre. The Patient Feedback meetings were minuted and resident's concerns were clearly documented, however not all issues were actioned and therefore it was sometimes unclear if resident's issues were escalated or discussed at a management forum. The approved centre sought service user involvement for initiatives such as the Safewards Model and the updating of the Galway Roscommon Mental Health Nursing Strategy.

The approved centre closely monitored and managed the COVID-19 pandemic. There was a designated isolation area with separate clothing changing facilities for staff within the approved centre that could be utilised in the event of a COVID-19 outbreak. Contingency plans were in place. Infection Prevention Control processes were clearly outlined. COVID-19 was a standing agenda item at all the principal governance forums at a regional and local level. Where appropriate, policies and procedures had been updated to reflect the required process changes precipitated by the pandemic. A COVID-19 pathway for "Managing Urgent and Emergency Mental Health Assessments" was developed and implemented in 2020 and remains in place to reduce the spread of infection, reduce time waiting for assessment and to increase service user satisfaction. As part of a COVID-19 pathway the approved center enhanced communication between general practitioners (GP) and treating teams, to reduce Emergency Department presentations and subsequent admissions to the approved center by facilitating urgent appointments at the GPs request.

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 (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) 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							
	2018		2019		2020		2021	
Regulation 18: Transfer of Residents	✓		✓		✓		X	Moderate
Regulation 21: Privacy	✓		X	Low	✓		X	Moderate
Regulation 26: Staffing	X	High	X	High	✓		X	Moderate
Regulation 28: Register of Residents	X	High	X	Low	✓		X	Moderate
Regulation 32: Risk Management Procedures	✓		✓		✓		X	High
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	X	High	X	High	✓		X	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.

5.0 Service-user Experience

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.
- 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.

Seven residents were interviewed. 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.

- Residents reported staff were helpful and approachable.
- Residents noted that the unit was modern, clean, and well-presented.
- Residents were complimentary about the quality and taste of the food.
- Residents were grateful for the therapeutic and recreational groups available to residents.
- Residents were familiar with their multi-disciplinary team and felt involved in their individual care planning.

Aspects for possible improvement from the resident interviews included:

- Residents felt staff were busy and at times this hindered their engagement with staff.
- Residents felt uncomfortable having to rely on nurses to charge their phones in the nurse's office.
- Residents felt the unit was too bright, florescent, and noisy which made the environment uncomfortable when in it for long spells.
- Residents commented there was not enough seats in the TV room in the recreational area of Hazel and Ash suites.
- Residents highlighted the importance of the provision of information on admission. They stated they did not get an information booklet on admission, and were subsequently misinformed by other residents, which contributed to unnecessary fear surrounding their admission.
- Residents felt the lack of doors in the bedroom en suites made them feel uncomfortable and that their privacy was at risk.
- Resident felt there should be exemptions made for individuals to smoke.

No residents completed the service user experience questionnaires.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the IAN representative.

- Residents valued the modern building, the en suite bedrooms, the facilities, and the indoor and outdoor space.
- Residents found the approved centre to be kept clean.
- Residents enjoyed the garden areas and the outdoor exercise equipment.
- Residents enjoyed the therapeutic and recreational activities. Specific groups mentioned included the walking groups, mindfulness, relaxation, occupational therapy groups, newspaper groups and creative writing groups.
- Residents praised the taste of the food.
- Residents found the staff welcoming, friendly and helpful.

Aspects for possible improvement from the IAN report included:

- Residents described the approved centre as too noisy and too bright, which contributed to some residents feeling over stimulated and overwhelmed.
- Residents felt outdoor garden areas should be easily accessible with doors left open.
- Residents voiced their dissatisfaction at not being able to smoke in oak suite, where leaving the unit was often not optional.
- Residents found the internet connection inconsistent which restricted their communication.
- Residents suggested a radio would be a good addition to the TV room.
- Resident felt more talking therapies and specialised therapies in areas such as eating disorders, addiction and autism would be helpful.
- Residents found the COVID-19 restrictions on visits and on the limiting of spaces in the occupational therapy groups frustrating.

6.0 Feedback Meeting

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

- Clinical Director
- Area Director of Nursing
- Acting Assistant Director of Nursing
- Director of Psychology
- Occupational Therapy Manager
- Principle Social Worker
- Registered Proprietor - General Manager
- Business Manager
- Electroconvulsive Therapy Nurse
- Mental Health Act Administrator
- CNM III
- CNM II x2
- Staff Nurse
- Area Lead for Mental Health Engagement
- Maintenance Manager
- Nurse Practice Development Co-Ordinator

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the residents' group profile and the individual residents' needs. The identifiers detailed in each resident's clinical file were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food choices within the approved centre. Food was properly prepared and comprised servings from different food groups as per the food pyramid. Residents received at least two choices for meals. Residents always had access to sufficient supplies of safe and fresh drinking water. There were multiple drinking fountains across all wards. The needs of residents who were identified as having special nutritional and dietary requirements at the time of inspection were assessed, addressed, and documented in the residents' individual care plans. Access to the dietetics service within the general hospital was facilitated and if required they provided input on the composition of residents' meals.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

There was appropriate and adequate catering equipment, crockery, and cutlery to suit the needs of residents. There were proper facilities for the refrigeration, storage, preparation, and serving of food. Hygiene was maintained to support food safety requirements.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in November 2021. Residents could bring in personal property and possessions on admission, and these were safeguarded when the approved centre assumed responsibility for them. The approved centre had secure facilities for the safe keeping of residents' valuables. The approved centre provided one safe per ward with large sums being sent to the accounts' office.

The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP). Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a range of recreational activities appropriate to the resident group profile throughout the week and weekend. This included: books, movies, board games, a pool table, outdoor table tennis, outdoor exercise machine, art, gardening, walks, art and crafts, bingo, relaxation.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in August 2020.

Visiting times were appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Justifications for the implementation of visiting restrictions for a resident were documented in the clinical file.

The reception area was used as a separate visiting area with private rooms also being available in the reception area so residents could meet visitors in private, unless there was an identified risk to the resident or others, or a health and safety risk. The visiting area and rooms were suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in February 2020.

Residents had Wi-Fi internet access in certain areas of the approved centre. Residents also had access to mail, fax, and telephone, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or a senior staff member was designated by the clinical director to examine incoming and outgoing resident communication where 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 November 2021. It included all policy regulation requirements including:

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

The clinical file of a resident was examined 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 consent received were documented for every search. The resident search policy and procedures was communicated to all residents. The relevant staff understood and were able to articulate the search policy.

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

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and protocols for care of residents who were dying, which were last reviewed in January 2020.

No deaths had occurred in the approved centre since the previous inspection and no end-of-life care was provided. Therefore, this regulation was inspected on the policy requirement only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Individual care plans (ICPs) were a composite set of documents. There was allocated space and sections for goals, treatment, care, and resources required. There was allocated space and sections for reviews. All ICPs were stored within the clinical file, were identifiable, 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. 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.

Five ICPs were inspected. ICPs identified appropriate goals for the resident. ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. ICPs identified the resources required to provide the care and treatment identified. ICPs were reviewed by the MDT in consultation with the resident on a weekly basis. 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 and met the needs of the residents, as documented in the residents' individual care plans (ICPs). There was an extensive occupational therapy group programme that incorporated four groups daily. These groups were held in the approved centres therapy rooms. There were slight overlaps with some activity times. Therapeutic group activities for Oak and Holly suite were held separately on the individual units. There was a weekly meeting where the residents could choose a group activity.

The therapeutic services and programmes provided by the approved centre were directed at restoring and maintaining residents' optimal levels of physical and psychosocial functioning. The approved centre occupational therapists ran groups, groups included cooking, baking, trauma-sensitive yoga, art therapy and walking. There was a life after discharge group which had different themed subgroups depending on the service users. Subgroups included: sleep, anxiety, goal setting, self-identity goals, Wellness Recovery Action Plan principles, activities of daily life building skills, social skills, healthy me and relapse prevention. One-to-one care and equipment were provided by the OT department. The approved centres full-time social worker, and a community occupational therapists ran a group once a week most weeks. There was a safety planning group co-facilitated by a psychiatrist and an approved centre occupational therapist, it was a closed group for individuals who have experienced issues with suicidality. There was no psychologist in the unit as the previous psychologist left, psychology was accessible through referral to a community psychologist.

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

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in place in relation to the transfer of residents. The policy was last reviewed in August 2020.

Full and complete written information regarding the resident was not transferred when he or she moved from an approved centre to another facility. A letter of referral including a list of current medications, was not transferred with the patient. Copies of resident notes were transferred; however, the content of these notes was unclear. Resident transfer forms were completed.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all relevant information about the resident was provided to the receiving centre as there was no letter of referral, 18 (1).

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures for responding to medical emergencies. The medical emergencies policy was last reviewed in October 2021. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator. Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The 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, and Body Mass-Index, weight, and waist circumference. The resident received an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram heart function test. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes according to age and gender, 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 February 2021.

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

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, the provision of such information might be damaging to the resident's physical or mental health, well-being, or emotional condition. Justifications for restricting information regarding a resident's diagnosis was documented in the clinical file.

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

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

All bathrooms, showers and toilets on the main corridors had locks (with an override function) on the inside of the doors. Single bedroom en suites did not have doors due to an identified risk. This was not conducive to residents' privacy and dignity when using the single bedroom en suites for showering and toileting purposes. Single bedrooms did not have locks (with an override function) on the inside of the door and upon entering the room there was clear visibility into bedroom en suites which further impacted resident's privacy and dignity when using the single bedroom en suites. The service was endeavouring to manage the competing risk issues and were in the process of implementing a solution. 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. Where residents shared a room, bed screening ensured that their privacy was not compromised.

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

The approved centre was non-compliant with this regulation because residents privacy and dignity were not appropriately respected at all times, due to residents single bedroom en suites having no doors and residents were not able to lock their bedroom doors with an override function when using the single bedroom en suites for showering and toileting purposes, 21.

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 (centrally controlled underfloor heating), and ventilated. Appropriate signage and sensory aids were provided to help residents orientation needs. Hazards and ligature points were minimised to the lowest practicable level. 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. Some residents reported the approved centre as being too bright. The condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff, and visitors. The approved centres internal doors were particularly noisy when opening and closing. The approved centre was in the process of addressing this issue by changing the magnetic door fixtures. The national infection control guidelines at the time were followed.

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 a designated sluice room and at least one assisted toilet per floor. Assisted devices and equipment were provided to address resident needs.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in October 2021. The policy included:

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

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

All entries in MPAR 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, which was documented in the clinical file.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the residents was stored securely in a locked storage press unless it required refrigeration. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy, and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy were last reviewed in November 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the use of CCTV. The policy was last reviewed in October 2019. The policy stated that the purpose and function of using CCTV was to observe residents in the AC.

CCTV was used solely by a health professional to observe a resident whose welfare they were responsible for in order to ensure the health, safety, and welfare of that resident. There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. The approved centre's use of CCTV and any other monitoring system was disclosed to residents, residents' representatives, and the Mental Health Commission. The CCTV cameras used to observe residents were not capable of recording or storing a resident's image and transmitted solely to a monitor that was viewed by their responsible health care professional. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre's use of CCTV.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

(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 in place, which was last reviewed in February 2021. The policy covered information and procedures in relation to the recruitment, selection, and Garda vetting requirements.

The numbers and skill mix of staffing was not sufficient to meet residents' needs. The approved centre had a multi-disciplinary team which included the disciplines of psychiatry, nursing, psychology, occupational therapy, social work, dietetics, and pharmacy. The approved centre has had a psychology post vacant since March 2021 and there was no date for a replacement. At the time of inspection the arrangement was that the community treating team's psychologist attended to the needs of the approved centre's residents.

This was a 50 bedded approved centre including a psychiatry of later life unit. There were 13 treating teams, two of these community teams did not have psychologist posts and three of the other community treating teams had vacancies at the time of the inspection. These factors lead to circumstantial psychology care being provided to residents in the approved centre. Access was dependent on community residents competing clinical needs and risks.

It was documented that an appropriately qualified staff member was on duty at all times. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance was available to staff on their desktops in the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.

Staff Training Table		
Profession	Mental Health Act 2001	
Nursing (68)	68	100%
Medical (33)	33	100%
Occupational Therapist (3)	3	100%
Social Worker (12)	12	100%
Psychologist (0)	0	0%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the numbers of staff and skill mix of staff was appropriate to the assessed needs of residents, the size and layout of the approved centre, as residents' access to psychology was circumstantial, as it depended on competing community residents' clinical needs and risks, 26(2).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the maintenance of records which contained procedures for the retention, access to and destruction of records. The policy was last reviewed in September 2019.

Records were created for each resident containing the required content by authorised persons. All residents' records were physically stored together and were secure, up to date, in good and logical order, and with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements. Resident records were reflective of the residents' status and the care and treatment being provided. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating MODERATE

(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; however, the register was not up to date. It contained the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006 with the exception of the residents' updated legal statuses which were not updated after admission. The legal statuses of all current residents were updated on the register prior to the completion of the inspection.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that an up-to-date register was maintained in relation to every resident in an approved centre, 28(1).

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to mental health tribunals. The policy was last reviewed in August 2020.

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process, including remote access to the tribunals. Staff attended Mental Health Tribunals and provided assistance as necessary when the patient required assistance to attend or participate in the process.

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 in relation to the management of complaints which was last reviewed in February 2021. The policy included the process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre. There was a nominated person responsible for dealing with all complaints who was available, and their contact details publicly displayed in 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. 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. 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 Your Say Your Service protocol was followed, and the clinical complaints review committee dealt with clinical complaints.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There was a comprehensive written policy and procedures in relation to risk management and incident management processes. The policy was approved in November 2021. The policy included all the policy related regulation requirements, including:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The record keeping requirement for risk management.
- The process for maintaining and reviewing the risk register.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies.

The risk management policy was not implemented throughout the approved centre. However, not all health and safety risks were monitored and documented by the approved centre, as appropriate. The approved centre's risk register did not document the identified risk that the bathroom en suite doors potential posed to residents, as appropriate. There was no documented evidence of the monitoring of this risk. Clinical risks were identified, assessed, treated and reported. However not all clinical risks were monitored and documented. The risk to residents' dignity and privacy in relation to the removal of the single bedroom en suite doors was not documented on the approved centre's risk registrar, as appropriate. There was no documented evidence of the monitoring of this risk.

Individual risk assessments were completed prior to and during the required criteria. Incidents were recorded and risk-rated in a standardised format, and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission (MHC) 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 non-compliant with this regulation because the registered proprietor did not ensure that the approved centre's risk management policy was implemented in relation to the following:

a) **Not all health and safety risks were monitored and documented in the approved centre risk register, as appropriate, 32(1).**
b) **Not all clinical risks were monitored and documented in the risk register, as appropriate, 32(1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate and indemnity scheme statement 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 displayed prominently in the centre's reception area.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 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

The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed and was dated November 2021. It contained protocols that were developed in line with best international practice, including:

- 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 ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training 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. There was a facility for monitoring EEG on two channels. 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 record of an involuntary patient who had received ECT was reviewed. As the patient had been assessed as not having capacity to provide consent, ECT was administered according to section 59(1)(b) of the Mental Health Act 2001. A Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed by two consultant psychiatrists. The Form 16 was placed in the patient's clinical file and a copy was sent to the Mental Health Commission within five days. The patient received the appropriate information from two consultant psychiatrists explaining the nature, purpose, procedure, benefits, alternative treatments, consequences of not receiving ECT, and side-effects of the treatment.

The patient received the appropriate examinations and assessments including cognitive assessments before each programme of ECT. The programme of ECT was terminated after seven sessions as the patient's condition did not improve.

The approved centre was compliant with this rule.

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion, which was last reviewed in February 2021. The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

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

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

Evidence of Implementation: Seclusion facilities were furnished and maintained to ensure respect for resident dignity and privacy, as far as practicable taking Rule 5.1 (direct observation) into account. Residents in seclusion had access to adequate toilet and washing facilities. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

One episode of seclusion was reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage resident's unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner and/or a registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion. The seclusion order did not last longer than eight hours and the resident was informed of reasons for, likely duration of, and circumstances

leading to discontinuation of seclusion, unless it was detrimental to the resident. The resident was informed of the ending of an episode of seclusion. Residents' rights to dignity, bodily integrity, and privacy were respected. Cultural awareness and gender sensitivity was demonstrated.

A registered nurse undertook direct observation for the first hour following the initiation of a seclusion episode, with continuous observation thereafter. A written record of the resident's well-being was made by a nurse every 15 minutes, including the level of distress and behaviour displayed by the resident. Following a risk assessment, a nursing review took place every two hours. During this review, at least two staff entered the seclusion room. A medical review of the patient was undertaken no later than four hours after the commencement of the episode of seclusion and reviewed every four hours.

The seclusion episode was recorded in a clinical file and seclusion register by the person who initiated seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of the episode. A copy of the seclusion register was placed in the clinical file. The episode was reviewed by members of the multi-disciplinary team and documented in clinical file within two working days.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

making. The Form 17 also contained the approval by a consultant psychiatrist and the authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

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

Evidence of Implementation: The clinical file of one resident who had been physically restrained was inspected. Physical restraint was only used in exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others and after staff had first considered all other interventions. Use of physical restraint was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated, staff members of the same sex were present where practicable. Staff were aware of the resident's requirements in relation to the use of physical restraint in the resident's individual care plan.

The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered health professional, and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident. The consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A clinical practice form 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. As soon as practicable and with the resident's consent, the resident's representative was informed of the use of PR, this was recorded in the clinical file.

The registered medical practitioner completed a medical examination of the resident within two hours of the episode of restraint taking place. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in their care as soon as was practicable. Each episode of

physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical file no later than two working days after episode.

The approved centre was 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 operational policy and procedures relating to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was last reviewed in November 2021. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent dose of Dantrolene is stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite with a private waiting area, adequately equipped treatment room, and an adequately equipped recovery room. High-risk residents were treated in a rapid-intervention area. There was facility for monitoring EEG on two channels. Material and equipment for ECT, including emergency drugs, were in line with international best practice. Up-to-date protocols for 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 file of a voluntary patient who had received ECT was reviewed. All relevant requirements relating to capacity and consent were followed by the centre and the appropriate information on ECT given to the resident by the consulting psychiatrist. The patient had capacity to understand and received appropriate verbal and written information explaining the nature, purpose, procedure, benefits, consequences of not receiving ECT, alternative treatments, and side-effects of the treatment proposed. The resident had capacity to make a free choice whether to receive ECT or not. The resident was given 24 hours to reflect on the information given and was informed of their right to access an advocate of their choosing. The resident could raise questions at any time, and these were answered. The resident communicated their decision to consent to each programme of ECT in writing to the consultant psychiatrist or a registered medical practitioner. An assessment of capacity to consent was undertaken and documented. Evidence of systematic monitoring of cognitive functioning throughout the programme of ECT was documented, ensuring that the resident could give informed consent for ECT, including anaesthesia.

The approved centre was compliant with this Code of Practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in September 2019, it included all the policy-related criteria for this code of practice.

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident admission was inspected in relation to the admission process. Their admission was because of a mental illness. With the resident's consent, their family member was involved in the admission process. The resident received an admission assessment, which included: the presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, and a risk assessment. The resident received a full physical examination.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents. Full and complete written information regarding the resident was not transferred when he or she moved from an approved centre to another facility. A letter of referral was not transferred with the patient, copies of resident notes were transferred. Resident transfer forms were completed.

Discharge: The clinical file of a resident who was discharged from the approved centre was reviewed during the inspection process. The discharge plan included the following: estimated date of discharge; documented communication with the relevant general practitioner, primary care team, and community

mental health team; a follow up plan; and a reference to early warning signs of relapse and risks. The discharge meeting was attended by residents, the key worker, and relevant members of the multi-disciplinary team.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the general practitioner, primary care team, and community mental health team within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made within one week.

The approved centre was non-compliant with this code of practice because the Registered Proprietor did not ensure the compliance with Regulation 18: Transfer of Residents, 30.1.

Appendix 1: Corrective and Preventative Action Plan

Regulation 18: Transfer of Residents					
Reason ID: 10002577		**The registered proprietor did not ensure that all relevant information about the resident was provided to the receiving centre as there was no letter of referral, 18 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The transfer from and referral letter that is being utilized is to be replaced with a newly developed, standalone transfer referral letter that contains all necessary information in one document. A copy of this is to retain in the clinical file.	Re-audit	Achievable	31/05/2022	Dr David McGuinness (CNM3), Nurse Practice Development Co-ordinator, Clinical Audit Team, AAMHU. Staff Nurse Fiona Martyn, Micheal Freeney, Michael Bunyan
Preventative Action	Email communication to staff. Discussion at Business Meeting AAMHU.	Re-audit	Achievable	31/05/2022	Dr David McGuinness (CNM3)

Regulation 21: Privacy					
Reason ID: 10002578		**Residents privacy and dignity were not appropriately respected at all times, due to residents single bedroom en suites having no doors and residents were not able to lock their bedroom doors with an override function when using the single bedroom en suites for showering and toileting purposes, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A saloon type door for all ensuite bathrooms (the one inspectors saw in the mock up room) is anticipated to be delivered from the UK in April 2022. This is to be installed for all ensuite bathrooms	Health and Safety Walkabout, Risk Register Review	Achievable	31/05/2022	Registered Proprietor, Clinical Director, Business Manager Maintenance
Preventative Action	Continue with existing control measures as per risk register until doors installed	Risk Register Review	Achievable	31/05/2022	CNM2's

Regulation 26: Staffing					
Reason ID: 10002581		**The registered proprietor did not ensure that the numbers of staff and skill mix of staff was appropriate to the assessed needs of residents, the size and layout of the approved centre, as residents' access to psychology was circumstantial, as it depended on competing community residents' clinical needs and risks, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Clinical Psychologist input is provided by the Multidisciplinary Teams in reaching from the community sectors	Required Psychology input is documented in care plan and discussed at MDT meetings which are attended by team Psychologists.	Achievable	31/05/2022	Director of Psychology and MDT team lead
Preventative Action	Dedicated Clinical Psychologist has been appointed for the AAMHU	Expected start date April/May 2022	Achievable	31/05/2022	Director of Psychology

Regulation 28: Register of Residents					
Reason ID: 10002576		**The registered proprietor did not ensure that an up-to-date register was maintained in relation to every resident in an approved centre, 28(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The hard copy register of residents and electronic register of residents is to be standardized to an electronic register of residents which is password protected and maintain on the P-drive folder. This excel document will include change of status and will be updated regularly by CNM2	Re-audit	Achievable	31/05/2022	CNM3, Sarah Potter, CNM2 Siobhan Moorhead, Staff Nurse , Nicola Downey. CNM3 Dr David McGuinness,
Preventative Action	A reminder email to nursing staff to highlighting the importance of documenting any change of status at the time of change	Audit	Achievable	31/05/2022	All nursing staff.

Regulation 32: Risk Management Procedures					
Reason ID: 10002579		**The registered proprietor did not ensure that the approved centre's risk management policy was implemented as not all health and safety risks were monitored and documented in the approved centre risk register, as appropriate, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The health and safety risks that the inspectors highlighted were updated and reviewed on the Risk Register AAMHU January 2022.	Please see- risk Register -AAMHU January 2022 Re-audit	Achievable	31/05/2022	Clinical Director, Quality Patient Safety Advisor Business Manager Clinical Audit Team AAMHU
Preventative Action	Continue to monitor health and safety risks The site specific safety statement (SSSS) is currently being reviewed for 2022 in the AAMHU	Risk Register review and monitoring at business meeting. Update review dates on risk register Site Specific Safety Statement 2022 AAMHU	Achievable	31/05/2022	Dr David McGuinness (CNM3) Assistant Director of Nursing Clinical Director. All staff in the AAMHU
Reason ID: 10002580		**The registered proprietor did not ensure that the approved centre's risk management policy was implemented as not all clinical risks were monitored and documented in the risk register, as appropriate, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The clinical risks that the inspectors highlighted were updated and reviewed on the Risk Register AAMHU January These risks will be monitored	Re-audit	Achievable	31/05/2022	Registered Proprietor, Clinical Director, Business Manager Clinical Audit Team AAMHU

	and reviewed at the business meeting				
Preventative Action	Continue to document and review clinical risks at the business meeting	Risk Register review at business meeting Update review dates on risk register	Achievable	31/05/2022	Dr David McGuinness (CNM3)

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.

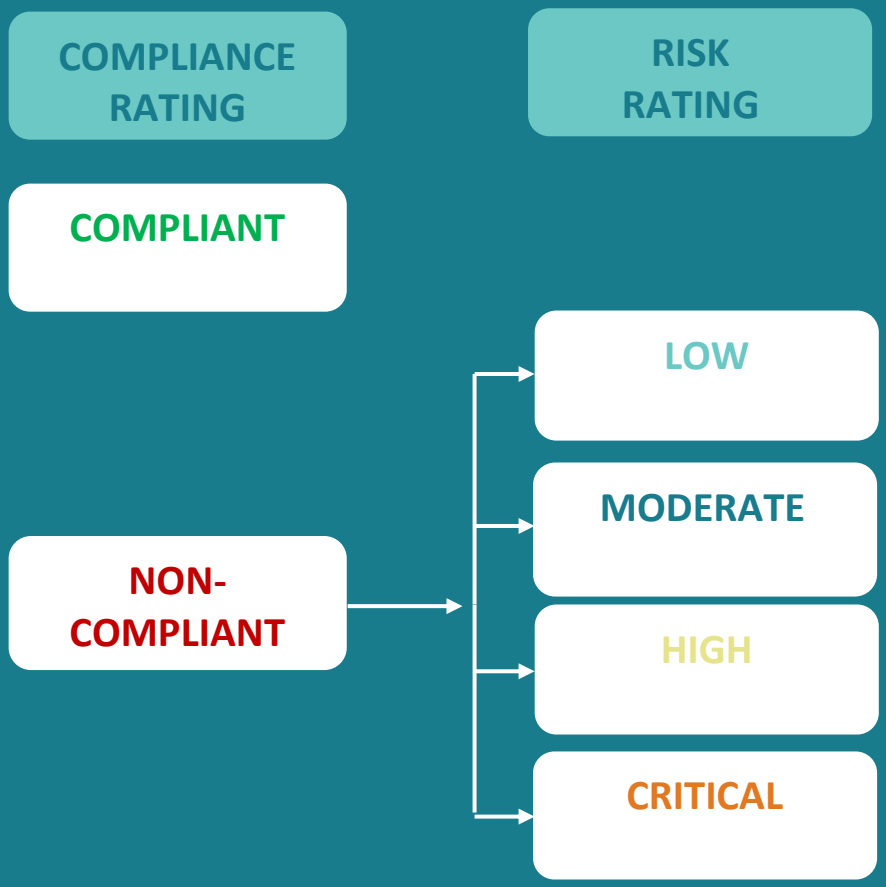
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation, and interview to assess compliance with the requirements.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