Acute Psychiatric Unit, Cavan General Hospital

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

ACUTE PSYCHIATRIC UNIT, CAVAN GENERAL HOSPITAL

Acute Psychiatric Unit, Cavan General Hospital, Cavan, Co Cavan

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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:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

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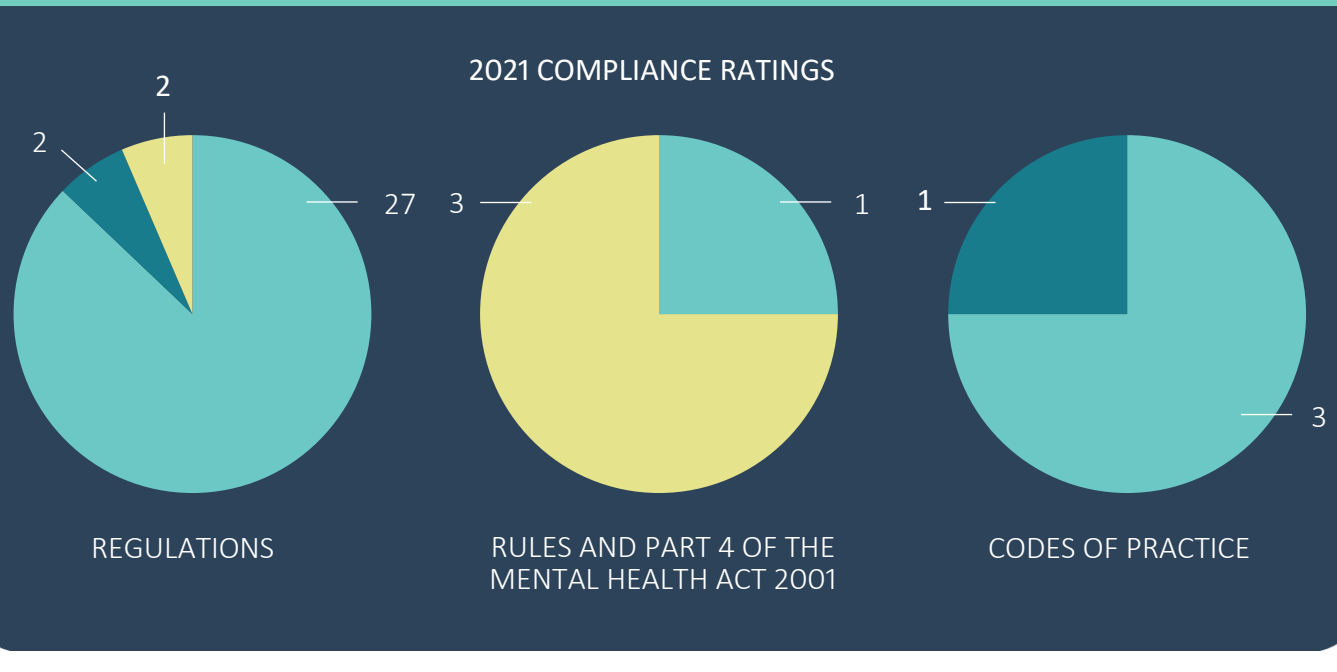
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
9 - 12 November 2021

Previous Inspection date:
2 - 6 November 2020

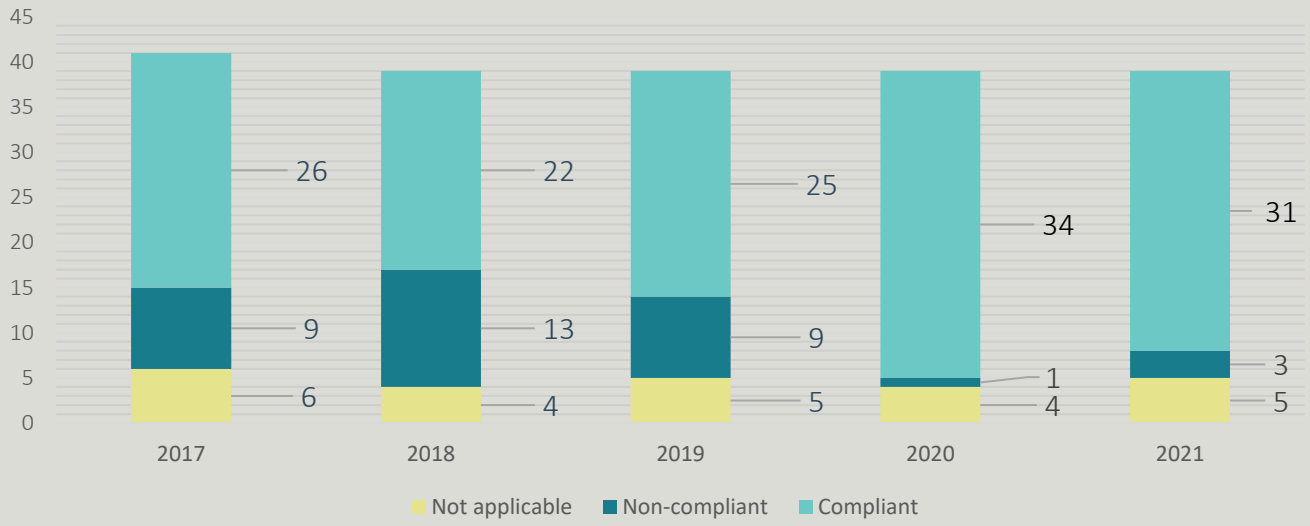
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2017 – 2021

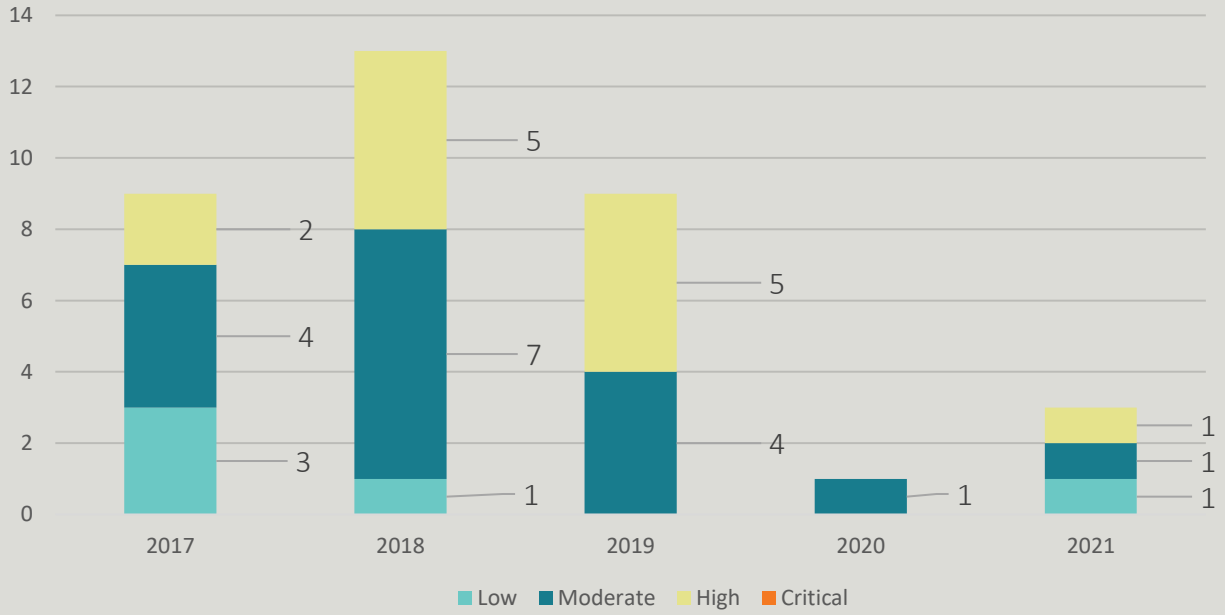
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 Psychiatric Unit (APU) was located on the lower ground floor of Cavan General Hospital. It served Monaghan and most of Cavan. The adult community mental health sector teams transferred care of their service users to the one inpatient treating team who worked directly in the approved centre. The Psychiatry of Later Life (POLL) team for Cavan Monaghan also admitted to the approved centre and this team managed the care and treatment of these residents.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	74%	63%	74%	97%	91%
Regulations Rated Excellent	0	0	4	N/A	N/A

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

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 26(4) and 26(5): Staffing the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*	Health care staff were trained in the Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes. Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.
The approved centre was not in breach of Condition 1 and the approved centre was compliant with Regulation 26: Staffing at the time of inspection.	

Escalation and enforcement actions since last inspection

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

Escalation and enforcement actions since this inspection

There was no escalation and enforcement actions since this inspection.

Safety in the approved centre

We found that the approved centre mostly operated safe practices which reduced risk of harm.

- 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.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However, not all ligature points were minimized to the lowest practicable level, based on risk assessment. As identified in the approved centre's own ligature audit, there were a number of ligatures which had been risk rated with planned remediation for year end.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to needs of residents but that not all individual care plans met an acceptable standard.

- 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.
- There was a wide range of therapeutic services and programmes which were appropriate to residents' needs. Examples of groups facilitated included: creative art, music therapy, wellness recovery action plan, social entitlements group, cognitive behavioural therapy principles, anxiety management, and relaxation. A sessional music therapist and an artist both facilitated weekly sessions. Art projects were visible in the unit. A recovery educational facilitator provided educational recovery focused support.

However:

- Three of the five care plans reviewed showed very similar generic type goals. For example, 'stable mental health and stable physical health' were the identified goals for three of the five care plans reviewed and there was no documentation of progression of these goals over the weeks reviewed. The specific goals expected to stabilize mental health or physical health were not documented.

Respect for residents' privacy, dignity and autonomy

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

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

Responsiveness to residents' needs

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

- Recreational activities included a gym, table tennis, a football table, exercise groups, walking, quizzes, bingo, movies, DVDs, a television, a PlayStation, reading, music, jigsaws, painting, drawing, crosswords, newspapers, card playing, skittles, gardening, and baking. 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 part of the HSE's Community Healthcare Organisation (CHO) Area 1 of five counties: Cavan, Donegal, Leitrim, Monaghan, and Sligo. The Cavan/Monaghan Mental Health Service governance processes encompassed two core monthly meetings: the Cavan Monaghan Mental Health Service Area Management Team meeting and the Quality and Patient Safety Committee meeting.
- Business meetings were held monthly to discuss improvements to the approved centre.
- All clinical incidents were reviewed and discussed at respective multi-disciplinary team meeting. The risk register was a standing item on the monthly business meeting.
- An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The numbers and skill mix of staff were sufficient to meet resident needs.
- Performance was monitored through Key Performance Indicators (KPI's), by feedback from audits and Corrective and Preventative Action Plans (CAPAs), Nursing Metrics and monthly supervision for allied health professionals.
- Residents had access to advocacy services if required. The Area Lead for Mental Health Engagement attended the Area Management Team bi-monthly meetings.
- At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms evident for resident and carer involvement in the process of quality improvement.
- No complaints had been escalated to the complaints officer since the last inspection.

COVID-19 response

The approved centre followed Public Health Guidelines for COVID-19.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had been awarded a grant through *Bank of Ireland Begin Together Arts Fund* in partnership with Business to Arts, a charitable organisation that enabled and supported creative partnerships between businesses, individuals and the arts. The monies awarded were to be used to complete an art project with residents in the approved centre.

2. Members of the Multi-disciplinary Team (MDT) had met weekly engaged in a Balint model of reflection. This consisted of a case presentation followed by general discussion with an emphasis on emotional content of the professional – patient relationships.

3. A new information booklet for residents had been completed.

4. A Recovery Education Facilitator had commenced working in the approved centre.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Acute Psychiatric Unit (APU) was located on the lower ground floor of Cavan General Hospital. It served the adult population of counties Monaghan and most of Cavan. Parts of west Cavan were affiliated with the APU in Sligo General Hospital. The adult community mental health sector teams transferred care of their service users to the one inpatient treating team who worked directly in the approved centre. The Psychiatry of Later Life (POLL) team for Cavan Monaghan also admitted to the approved centre and this team managed the care and treatment of these residents.

Under the clinical leadership of an inpatient consultant psychiatrist, the team comprised of nursing staff, medical staff, an occupational therapist, a social worker and administration staff. There was no in-patient psychologist and psychology was accessed on a referral basis to the relevant community sector team. There was a music therapist and an artist who worked in the approved centre on a sessional basis. A Recovery Education Facilitator worked in the approved centre two days a week.

The approved centre comprised of four, four-bedded dormitories. The beds had been reduced in one of these dormitories from six to allow for more space during the pandemic and up to the time of inspection. Therefore, although registered for 25 beds, 23 beds were available for residents. There were four single en suite bedrooms in one corridor that had been used as an isolation/admission corridor. Residents had been admitted to one of these four rooms and remained in isolation for five days or more as required. In a different area there were a further three single bedrooms with toilet and handwash basin facilities. There was a large spacious dining room, two television rooms, a music room, a family room, a quiet room, a well-equipped occupational therapy room and an activities kitchen. There was a recreational room with exercise machines, table tennis and a football table for resident use.

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

Resident Profile	
Number of registered beds	***25***
Total number of residents	**13**
Number of detained patients	4
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part was part of the HSE's Community Healthcare Organisation (CHO) Area 1 which comprised of a large geographical area, spanning five counties: Cavan, Donegal, Leitrim, Monaghan, and Sligo. The Cavan/Monaghan Mental Health Service governance processes encompassed two core monthly meetings: the Cavan Monaghan Mental Health Service Area Management Team meeting and the Quality and Patient Safety Committee meeting. Both meetings were scheduled monthly and were facilitated via teleconference calls due to the pandemic. The meeting minutes were maintained and evidenced discussions on key issues such as quality, safety and risk; comments, compliments, and complaints; performance monitoring; compliance; resources and service provision.

Business meetings were held monthly to discuss improvements to the approved centre and minutes of the previous meetings were provided to the inspection team. These meetings were attended by the acting executive clinical director, consultants, nursing management, a service user representative, and health and social care professionals working in the approved centre discussing improvements to the approved centre.

The approved centre inputted all incidents into the National Incident Management System (NIMs). All clinical incidents were reviewed and discussed at the next respective multi-disciplinary team meeting. The Risk register was also a standing item on the monthly business meeting. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The risk management procedures sought to actively reduce identified risks to the lowest practicable level of risk.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. The numbers and skill mix of staff were sufficient to meet resident needs. Performance was monitored through Key Performance Indicators (KPI's), by feedback from audits and Corrective and Preventative Action Plans (CAPAs), Nursing Metrics and monthly supervision for allied health professionals. Heads of discipline from medical, social work, occupational therapy, and nursing each provided a clear overview of the governance within their respective departments. The approved centre had strong linkages with Cavan General Hospital, in terms of clinical support for infection control, medication safety and access to medical consultancy.

Residents had access to advocacy services if required; advocacy contact details were displayed within the approved centre. The approved centre had received an electronic device from the advocacy services to enable communication with the residents during the COVID-19 pandemic. The Area Lead for Mental Health Engagement attended the Area Management Team bi-monthly meetings.

At a local level, regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer involvement in the process of quality improvement. No complaints had been escalated to the complaints officer since the last inspection.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 15: Individual Care Plan	✓		✓		✓		✓		✗	Low
Regulation 22: Premises	✗	High	✗	High	✗	High	✓		✗	High
Code of Practice relating to the Admission of Children under the Mental Health Act 2001	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	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.
Regulation 25: Use of Closed-Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Ten completed service user experience questionnaires were returned to the inspectors. Two residents spoke to the inspection team. Both residents interviewed spoke positively about their experiences in the approved centre and the care and treatment they had received. In particular the activities programme were described as very beneficial. The residents stated that they saw their medical team at least twice weekly. Overall comments about staff were very positive.

Of the ten completed questionnaires, eight residents indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood. The remaining two indicated that they could not remember. All ten of the respondents indicated that they knew their multi-disciplinary team members and their keyworkers. Nine respondents indicated that they knew what their care plan was, the remaining one resident ticked 'no' to this question. Of the nine respondents who knew what their care plan was, five indicated that they were 'always' involved in setting goals for their individual care plans, four indicated that they were involved 'sometimes'.

All ten respondents indicated that they were happy with how staff talked to them, that they had space for privacy and that their privacy and dignity was respected. All ten indicated that there were enough activities during the day and that they could communicate freely with their families, friends and the advocate.

Eight respondents indicated that they were 'always' able to give feedback to staff, and to make a complaint when they were not satisfied with any part of their stay. The remaining two indicated 'sometimes' for this

question. Seven respondents indicated that they were 'always' able to discuss worries or concerns with a member of staff, with three respondents indicating 'sometimes' to this question.

On a scale of 1-10, with 1 being poor and 10 being excellent, one resident rated 5 out of 10 for their overall experience of care and treatment, three residents rated 7, 8 and 9 respectively and five residents rated 10 out of 10. One questionnaire was left blank for this section.

5.2 Advocacy

The approved centre had an advocacy service. In line with national restrictions and infection control measures, the Irish Advocacy Network (IAN) representative had engaged with the residents once weekly using an electronic tablet during COVID-19. The representative's details were displayed, and residents could contact the IAN outside of the planned meetings.

The Inspectors received a report from the IAN representative. Feedback from the residents to the IAN representative suggested that the residents were pleased with the care in the approved centre and that staff were friendly and supportive. The availability of both a social worker and an occupational therapist was noted. A number of residents had commented positively on a walking group. Residents had commented on the support available around planning for discharge and sessions with a recovery education facilitator. Other feedback was that new locks on the lockers in the bedrooms was appreciated by the residents.

Concerns raised to the IAN representative by the residents were that occasionally items went missing and the issue was raised with management. All other feedback or issues of concern were specific to individual residents.

6.0 Feedback Meeting

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

- Acting Executive Clinical Director
- General Manager
- Consultant Psychiatrist
- Area Director of Nursing
- Principal Psychologist
- Occupational Therapy Manager
- Principal Social Worker
- Occupational Therapist
- Social Worker
- Infection Control Nurse
- Risk Manager
- Area Lead for Mental Health Engagement
- Complaints officer
- Nurse Practice Development Coordinator
- Acting Director of Nursing
- Clinical Nurse Manager 3 (Compliance and Training)
- Policy Development, Quality, Audit & Research Coordinator

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 appropriate resident identifiers. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food encompassing the different food groups as per the food pyramid. Residents received at least two choices per meal. Residents had sufficient supplies of safe fresh drinking water, which was always accessible.

The needs of residents identified as having special nutritional and dietary requirements were assessed, addressed and documented in residents' individual care plans. A dietician from the main hospital was available to be consulted on referral.

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. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans (ICP).

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 in relation to residents' personal property and possessions. The policy was last reviewed in April 2019.

Resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe keeping of the resident's monies, valuables, personal property, and possessions. A safe was provided in each bedroom and there was a safe in the nursing office for the secure safe keeping of residents' monies should they wish to avail of it.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile throughout both the week and weekend. These included: a gym, table tennis, a football table, exercise groups, walking, quizzes, bingo, movies, DVDs, a television, a PlayStation, reading, music, jigsaws, painting, drawing, crosswords, newspapers, card playing, skittles, gardening, and baking.

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. Mass was available online. A priest and multi faith ministers visited on request.

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 policy and procedures in relation to visits. The policy was last reviewed in May 2020.

Visiting was appropriately and reasonably restricted in line with the general hospital's guidelines and was on an emergency basis only. No individuals were noted to have restrictions recorded or required in their clinical file. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident or others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The area was 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 policy and procedures in relation to resident communication. The policy was last reviewed in September 2021.

Residents had access to mail, fax, e-mail, Internet, telephone, Residents had their own mobile phones unless risk assessed otherwise. Residents had access to the ward phone and to computers with internet facilities under supervision. Also, an electronic tablet from the Irish Advocacy Network was used freely by residents for communication. The unit consultant or a senior staff member was designated by the acting executive clinical director to examine incoming and outgoing resident communication were there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to searches. The policy was last reviewed in December 2018.

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.

No searches have taken place since the last inspection. The resident search policy and procedure had been communicated to all residents. The relevant staff could articulate the searching processes as set out in the policy.

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 policy and procedures in relation to care of the dying. The policy was last reviewed in April 2020. No resident had died in the approved centre since the last inspection.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating LOW

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

The individual care plan (ICP) was an identifiable and composite single page document that was typed each week. The ICP included allocated space/sections for goals, treatment, care, and the resources required. The ICP was identifiable, uninterrupted, and separate from the progress notes.

Not all ICPs identified appropriate goals for the residents. Evidence from three of the five care plans reviewed showed very similar generic type goals and did not show any progression of these goals over the weeks reviewed. The lack of progress was considered to be due to the generic wording of the goals with the associated needs. For example, 'stable mental health and stable physical health' were the identified goals for three of the five care plans reviewed. The specific goals expected to stabilize mental health or physical health were not documented.

The care and treatment required to meet the goals identified was documented along with the named resource or discipline. The ICP's had been reviewed by the multi-disciplinary team (MDT) in consultation with the resident weekly and had been updated following these reviews. In most instances, the resident completed a Pre MDT Care Plan Assessment form prior to the meeting.

The approved centre was non-compliant with this regulation because the individual care plans did not identify appropriate goals for all the residents. In three of five reviewed, the goals developed were generic and did not address the specific individual needs for those residents.

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 assessed needs of the residents, as documented in their individual care plans (ICPs). There was a comprehensive therapeutic timetable. The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. The approved centre had both a full time and dedicated senior occupational therapist and social worker. Access to psychology was on a referral basis. A sessional music therapist and an artist both facilitated weekly sessions. Art projects were visible in the unit. A recovery educational facilitator provided educational recovery focussed support. Eight of the 13 residents were observed in a group with the majority of the remaining in isolation following admission.

Residents had access to an occupational therapy kitchen, music room, quiet room and a gym. Examples of groups facilitated included: creative art, music therapy, wellness recovery action plan, social entitlements group, cognitive behavioural therapy principles, anxiety management, and relaxation. There was a weekly meeting to plan for the week ahead, the residents could elect three further group topics. Where a resident required a therapeutic service or programme not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Residents had access to a psychologist via the community mental health teams. Residents had access to a dietitian and a physiotherapist by referral to the general hospital.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in March 2020. Full and complete written information regarding the resident was transferred when they moved from the approved centre to another facility. This included a letter of referral listing current medications, and the resident's transfer form. This Information was sent in advance, or at least accompanied the resident upon transfer.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written general health policy and procedures. The policy was last reviewed in May 2021.

The approved centre had an emergency resuscitation trolley and staff had access at all times to an automated external defibrillator.

One clinical file was examined in relation to provision of general health services during the inspection process. Residents received appropriate general health care interventions in line with their individual care plans. Residents' general health needs were monitored and assessed as indicated by their specific needs, but not less than every six months.

The six monthly health assessment documented a physical examination, smoking status, and blood pressure. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, an electrocardiogram, and prolactin levels.

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, medication review, 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 provision of information policy and procedures in place. The policy was last reviewed in November 2020.

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

Residents were provided with written and verbal information on their diagnosis. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The staff's communication with residents, general demeanour, and dress was observed as being respectful during the inspection. Staff called residents by their preferred name. Staff sought permission before entering the residents' rooms as appropriate. Staff were discreet when discussing the residents' condition or treatment needs.

All bathrooms, showers, and toilets had locks on the inside of the door, unless there was an identified risk to a resident. Where residents shared a room, bed screening ensured their privacy. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas and their windows had opaque glass. Noticeboards did not display resident indicators. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was a well laid out unit with sufficient spaces provided for residents to move about, including outdoor spaces and garden. Communal rooms were appropriately sized and included, two sitting rooms, one large dining room with a seating area, a quiet room, and a music room. Private and communal areas are suitably sized and furnished to remove excessive noise. There was a sufficient number of toilets and showers for residents in the approved centre.

There was a ligature reduction programme that had in parts been implemented throughout the year. Not all ligature points were minimized to the lowest practicable level, based on risk assessment. As identified in the approved centre's own ligature audit there were a number of ligatures which had been risk rated with planned remediation for year end.

The national infection control guidelines were followed. A corridor with four single full en suite bedrooms was used for all admissions. Rooms were ventilated. Good protocols and practices in the management, and prevention of infection were followed, in line with the general hospital guidelines.

The approved centre was non-compliant with this regulation because ligature points were not all minimized to the lowest practicable level and therefore the condition of the physical structure was not developed and maintained with due regard to the specific needs of residents and the safety and well-being of residents, staff, and visitors, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, prescribing, storing and administration of medicines. The policy was last reviewed in February 2019 and 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 of these were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, frequency of medication, and the date of discontinuation for each medication. The Medical Council registration number and signature of the medical practitioner prescribing the medication were included in all cases.

All entries in the MPARs were legible. When a resident's medication was withheld, the justification was noted in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage press unless it required refrigeration.

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 health and safety policy and procedures in place. The policy was last reviewed in September 2021.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written staff policy and procedures in place. The policy was last reviewed in November 2020.

The number and skill mix of staffing were sufficient to meet the residents' needs. An appropriately qualified staff member was always on duty, and this was documented. The approved centre had one multi-disciplinary team. This included psychiatry, nursing, occupational therapy and social work. Psychology input was via referral.

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

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

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (23)	23	100%
Medical (2)	2	100%
Occupational Therapist (1)	1	100%
Social Worker (1)	1	100%
Psychologist (0)	N/A	N/A

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written 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 October 2021.

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All policies and procedures requiring review every three years had been reviewed and updated as required.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the mental health tribunal process. Staff attended mental health tribunals and provided assistance as necessary when the patient required assistance to attend or participate in the process. Resources and facilities were provided by the approved centre to support patients in accessing mental health tribunals remotely.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to their complaints process. The policy was last reviewed in March 2021 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person based in the approved centre who was responsible for dealing with all complaints. The complaints procedure including how to contact the complaints manager was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the resident having made a complaint.

All complaints were handled promptly, appropriately, and sensitively. Minor complaints and formal complaints were documented in the complaints log. Details of complaints as well as subsequent investigations and outcomes, were fully recorded and kept distinct from residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written risk management policy and procedures in place. The policy was last reviewed in September 2021. The policy addressed all policy requirements of the regulation.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for a risk was identified and known by staff. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with the relevant legislation and documented in the risk register as appropriate. Corporate risks were documented in the risk register. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

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

Incidents were recorded and risk-rated in a standardised format, 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 compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre was adequately insured against accidents and injury to residents. The approved centre's in date insurance certificate and indemnity scheme statement was available to the inspection team. The approved centre's insurance covered public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, with one condition relating to the certificate of registration attached to it which was displayed prominently. Where changes arose in relation to the information detailed in the certificate of registration, this was communicated to the MHC.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of 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 consultant psychiatrist had undertaken a capacity assessment, which measured the patient's ability to consent to receiving treatment.

In relation to this patient who was unable to consent to treatment, a Form 17 (administration of medicine for more than 3 months involuntary patient (adult) – unable to consent) had been appropriately completed for the patient. The form 17 documented the following:

- The names of the medication prescribed.
- Confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.

- Details of discussions with the patient, including:
    - The nature and purpose of the medications.
    - The effects of the medications, including any risks and benefits.
    - Any views expressed by the patient.
    - Supports provided to the patient in relation to the discussion and their decision-making.
    - Approval by a consultant psychiatrist.
    - Authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

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.

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

- The provision of information to the resident.
- Those who can initiate and who may implement physical restraint.
- Child protection processes when a child was physically restrained.

There was a written record that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained. An annual report on the use of physical restraint in the approved centre had been completed.

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

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint, where practicable, same sex staff members were present at all times. The resident's next of kin were not informed about the physical restraint, there was an explanation documented in the clinical file for not informing the resident's next of kin.

The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered medical practitioner, a registered nurse or other members of the multi-disciplinary team. In this instance the resident was standing during the restraint and the episode lasted for under 30 minutes. The consultant psychiatrist or the duty consultant psychiatrist was notified as soon as was practicable and this was recorded in the clinical file. The registered medical practitioner completed a medical examination of the resident (physical examination) within three hours after the start of the restraint. 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, it was signed by the consultant psychiatrist within 24 hours of the episode and placed in the resident's clinical file.

Staff were aware of relevant considerations in the individual care plan pertaining to resident's requirements in relation to the use of physical restraint. Special consideration was given when restraining

a resident who was known by the staff involved in physical restraint to have experienced physical or sexual abuse.

The resident was afforded an 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 clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

Admission of Children

NON-COMPLIANT

Risk Rating **MODERATE**

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

There was a written policy in relation to the admission of children. The policy was reviewed annually, and it was last reviewed in May 2020. The policy covered:

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

The inspection team reviewed a clinical file in relation to one child admitted to the approved centre since the last inspection. The approved centre was an adult facility, and age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. Provisions were in place to ensure the safety of the children, that their views would be heard and to respond to the children's needs.

Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre in relation to child protection issues, staff had received training in relation to the care of children with staff having contact with the child having undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff.

Appropriate accommodation was designated and included segregation according to age and gender, sleeping arrangements, and bathroom areas. Staff were gender sensitive. The child had their rights explained and information about the approved centre and facilities provided in a form and language that they could understand. The clinical file recorded the child's understanding of the explanation given.

Appropriate visiting arrangements for families, including children, were available. The Mental Health Commission was notified of all children admitted within 72 hours with the appropriate notification form.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5(b).

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.

The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed and was dated January 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.

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.

There was a named consultant psychiatrist with overall responsibility for ECT management and a named consultant anaesthetist with overall responsibility for anaesthesia. There were always at least two registered nurses in the ECT suite, one of whom was a designated ECT nurse. The ECT suite was situated in a theatre in the general hospital and therefore was not inspected.

The file of a voluntary patient who had received ECT was reviewed. All relevant requirements relating to capacity and consent were followed by the approved 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 they were 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

COMPLIANT

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

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

Admission: The admission policy, which was last reviewed in July 2021, included all the policy-related criteria for this code of practice.

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

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

There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policy/policies.

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

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 complied with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who was discharged was inspected in relation to the discharge process. The discharge assessment inspected addressed the psychiatric and psychological needs of the resident, their current mental state examination, their comprehensive risk assessment and management plan, and their informal needs. The discharge was co-ordinated by a keyworker. A preliminary discharge summary was sent to the general practitioner/primary care/CMHT within three days. A comprehensive discharge summary issued within 14 days.

The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10002573	**The individual care plans did not identify appropriate goals for all the residents. In three of five reviewed, the goals developed were generic and did not address the specific individual needs for those residents.**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training programme in the development of individual care plans which has been devised already by Cavan Monaghan Mental Health Service will be organised for all clinical staff in Acute Psychiatry Unit.	Audit individual care plans quarterly Annual audit of training records	no barriers to implementation	30/06/2022	CNM3 in Policy Development Quality and Risk
Preventative Action	Heads of discipline to ensure all staff including new staff in Acute Psychiatry Unit are trained in development of individual care plans	Annual audit of training records of all staff in the Acute Psychiatry Unit	no barriers to implementation	30/06/2022	Heads of discipline

Regulation 22: Premises					
Reason ID : 10002574		**Ligature points were not all minimized to the lowest practicable level and therefore the condition of the physical structure was not developed and maintained with due regard to the specific needs of residents and the safety and well-being of residents, staff, and visitors, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is a schedule of works ongoing to remove and mitigate ligature points.	Ligature audit upon completion of the scheduled work.	We are dependent on the availability of outside contractors to complete the scheduled works It could prove difficult to change certain structures within the Unit to reduce the ligature risk eg the ceilings	30/09/2022	ADON Acute Psychiatry Unit Business Manager Cavan Monaghan Mental Health Service
Preventative Action	The Acute Psychiatry Unit Ligature Reduction Group, will oversee the implementation of the scheduled works to minimise ligature points to the lowest practicable level.	ligature audit after scheduled work completed and regularly thereafter.	no barriers to implementation	24/02/2022	ADON Acute Psychiatry Unit Business Manager

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10002572		**Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All admissions of children to the Acute Psychiatric Unit will be assessed upon admission by the Occupational Therapist in the Acute Psychiatric Unit and an interest checklist will be completed in order to ensure facilities, activities and interventions are appropriate to age and ability and are beneficial. Therapeutic interventions can be provided on a 1:1 basis and the MDT will also liaise with other services to provide facilities and activities if required.	An audit of provision of age appropriate facilities and programme of activities after each admission of a child to the Acute Psychiatric Unit	No barriers to implementation	24/02/2022	Occupational Therapist Acute Psychiatric Unit
Preventative Action	Ensure all relevant staff implement the policy 'Therapeutic Services and Programmes'. All relevant staff shall read and understand the policy. Staff who have not read the policy 'Therapeutic Services and Programmes' will be directed to read the policy immediately.	An analysis of the Cavan Monaghan Mental Health Service policy portal will be carried out by line managers and heads of discipline on a regular basis.	No barriers to implementation	31/03/2022	Heads of discipline

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.

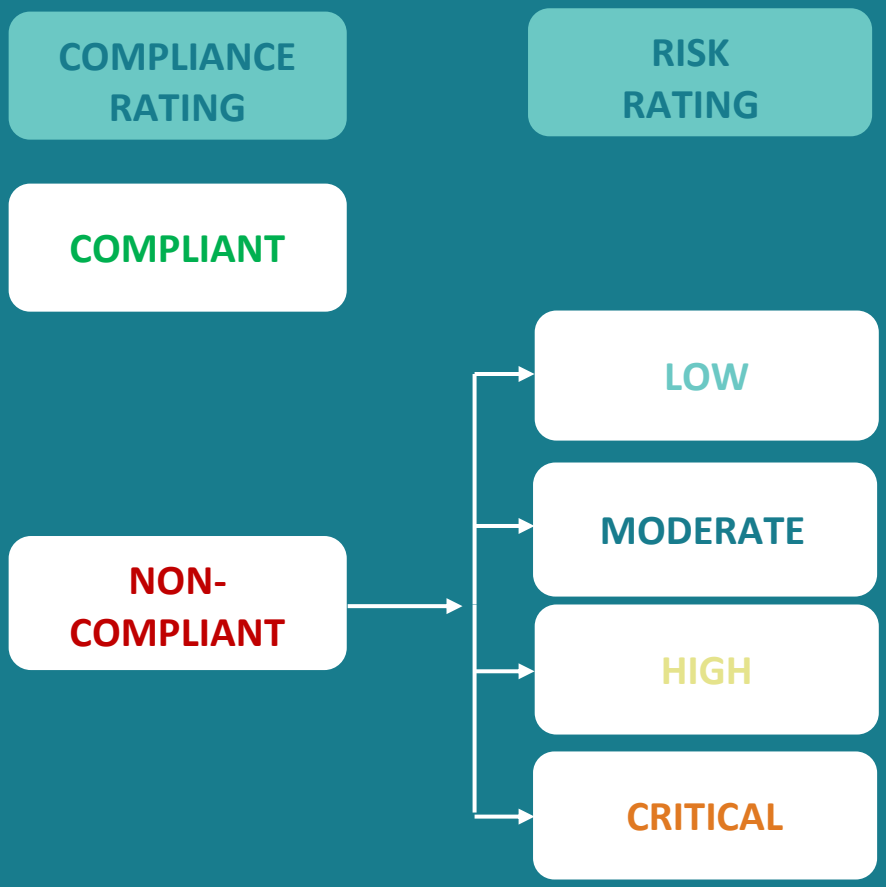
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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