Haywood Lodge

mhc
coimisiún meabhair - shláinte
mental health commission

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

HAYWOOD LODGE

Heywood Road
Clonmel
County Tipperary
E91 NV91

Date of Publication:
11 August 2022

ID Number: AC0154

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care/ Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
23 April 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, Head of Service
CHO 5 Mental Health Service.

Inspection Team:
Mary Connellan, Lead Inspector
Megan Barry Sheehy
Martin McMenamin

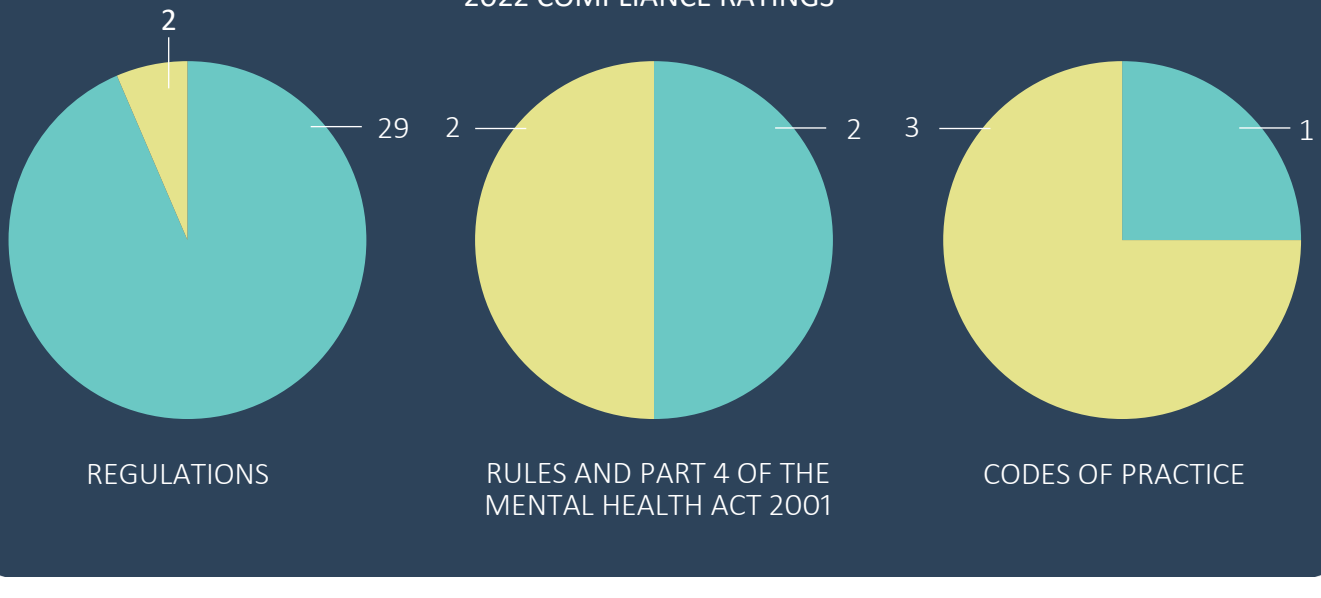
Inspection Date:
17 – 20 May 2022

Previous Inspection date:
10 – 13 August 2021

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

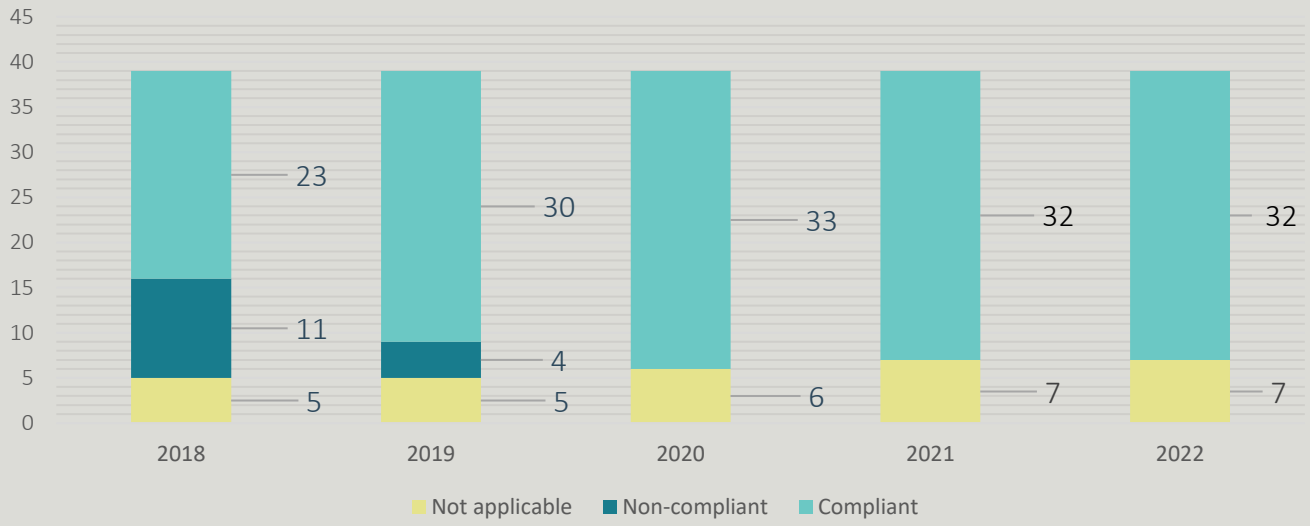
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

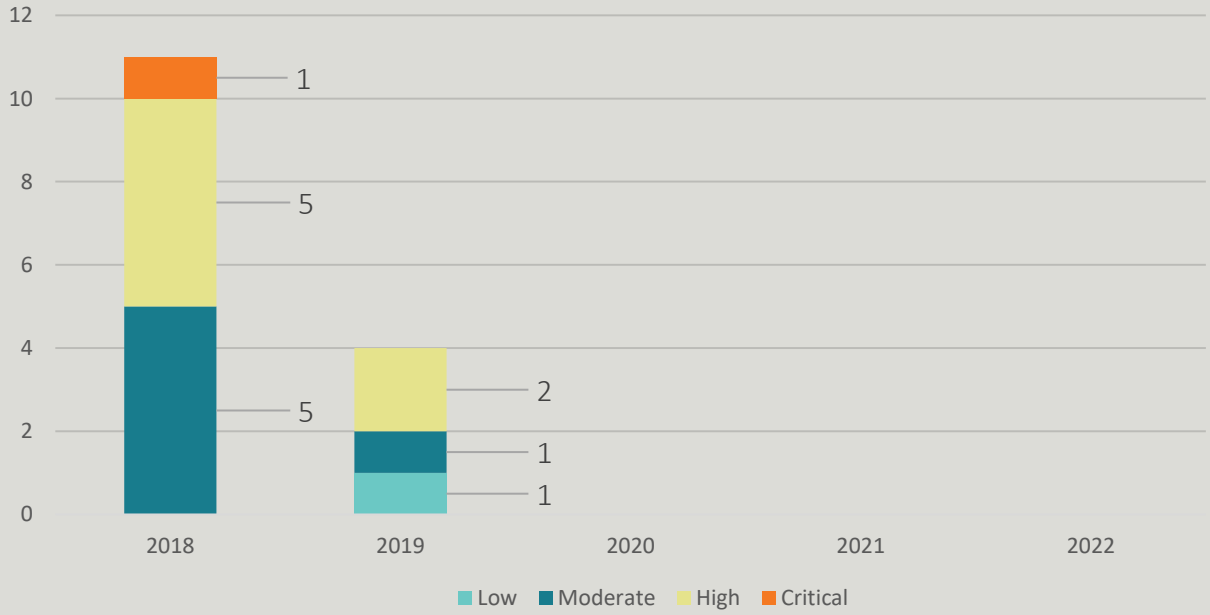
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022



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 2018 – 2022



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. 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

Haywood Lodge was on the outskirts of Clonmel town and could cater for a total of 40 residents. The approved centre was divided into two units: East House and West House. East House was for residents generally over sixty-five years of age and all were under the care of the Psychiatry of Later Life (POLL) team. West House was a dedicated Rehabilitation and Recovery unit. Primarily it accommodated residents with enduring mental illness and had strong links with the community services in Clonmel town.

Haywood Lodge achieved 100% compliance for the third consecutive year. It also demonstrated a strong emphasis on person-centred care and treatment. Staff have worked hard to maintain a high quality service and are commended for this.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	68%	88%	100%	100%	100%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety in the approved centre

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

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- 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.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, stored and administered in a secure and safe manner.

Appropriate care and treatment of residents

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

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident. Care plans reflected the differing needs of residents in each unit.
- The approved centre had two occupational therapists and two activation nurses. They engaged with external partners and agencies such as a recreational hub in St Luke's Hospital known as the *Studio* and the Education Training Board providing a suite of programmes in accordance with assessed needs
- 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.
- End of life care was provided that was appropriate to physical, emotional, social, psychological, and spiritual needs of residents.
- There was a peer support worker who worked with residents in West House and the wider Rehabilitation and Recovery team. They were a member of this multi-disciplinary team attending the

weekly meetings and working with residents on a one-to-one basis. Supported by social work services and the peer support worker, all residents from West House had completed one of four planned sessions in Safeguarding Training.

Respect for residents' privacy, dignity and autonomy

We found that facilities and processes respected residents' privacy and dignity and that interactions respected residents' wishes.

- The two houses had twenty en suite bedrooms in each. Each bedroom had an external door that led directly to a garden area.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- 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 and their families.

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. These included a weekly visit from a therapy dog, music sessions, gardening, cooking, beauty care, audio library, walking groups, relaxation groups, current affair groups, knitting and sewing. There was a bus available to the approved centre and social outings had been organized.
- Residents had their own individual "*Care at A Glance"* board in their room, which included recreational pursuits. Each room had a television and residents also had access to an electronic tablet. Activity packs were available for residents at the weekends.
- 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. Residents had been involved in the co-production of resident information leaflets with the peer support worker and social worker.
- 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, Leadership and Accountability

We found that good governance structures and processes were in place.

- Haywood Lodge was under the governance and management of the South East Community Healthcare (SECH) Organisation. This encompassed Waterford/Wexford and Carlow/Kilkenny/South Tipperary
- The Carlow/Kilkenny/South Tipperary Executive Management Team (EMT) meeting and Carlow/Kilkenny/South Tipperary Quality and Safety Executive Committee (QSEC) meeting were both held monthly.
- The approved centre had a monthly Quality Patient Safety Committee (QPSC) meeting.
- There were clearly defined processes within the approved centre with regard to risk management. Incidents were recorded, risk rated and reviewed. There was a risk review meeting every three months. The approved centre maintained a risk register and risks were escalated to the EMT as appropriate.
- The service had systems and plans in place to proactively ensure that mandatory staff training was completed.
- An advocacy service was available to the approved centre, and the representative visited the residents or held a meeting by zoom weekly or fortnightly. The Support and Advocacy Service (SAGE) also visited on request.
- The complaints procedures were displayed throughout the approved centre and there was a culture of recording and addressing minor complaints. Audits of the minor complaint's logs had been completed with identified actions to improve the residents experience in the approved centre as applicable.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A Therapeutic Garden Project had commenced in the approved centre.

2. A Social Farming initiative had been progressed.

3. New Individual Care Planning (ICP) booklets had been introduced into both East and West House. As each resident's ICP was updated the new booklet was used. These were based around the core needs of the different resident profile groups.

4. Identification plaques for the resident rooms in East House had been introduced. These were personalized to individual requests or a reminiscent theme.

5. A "*Care at a Glance*" board was in every resident's room. The planned daily and weekly activities along with appointments and any individual care provision for a resident was noted on each board. These were both pictorial and/or phrased in words.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on Haywood Road on the outskirts of Clonmel town. Although primarily built as community residential facility, it served as a mental health facility since 2012. The approved centre was divided into two wards known as East House and West House. The two houses were structurally similar with twenty en suite bedrooms in each. Sleeping accommodation was designed in a figure of eight style with two internal courtyards. Each bedroom had an external door that led directly to a garden area. There was also a large garden separating the two houses that was accessible to all the residents. In each house there were communal dining areas, sitting rooms and a quiet or reading room. There was a separate activities area that had group rooms, an occupational therapy kitchen, laundry facilities, and a Tribunal room.

East House was for residents generally over sixty-five years of age and all were under the care of the Psychiatry of Later Life (POLL) team. Some were long stay residents with the remaining referred to the POLL team from general practitioners or through the liaison psychiatry team who served the South Tipperary population. Residents initially had been assessed in the general hospital setting, in a nursing home, or in their own homes. Where appropriate residents were admitted to East House for further assessment and treatment before discharge home or to a nursing home.

West House was a dedicated Rehabilitation and Recovery unit. Primarily it accommodated residents with enduring mental illness and had strong links with the community services in Clonmel town. It also served the South Tipperary population; however, there was some availability for residents under the care of Rehab and Recovery teams in the wider South East community healthcare region. The model of care used was the Recovery Star. The Recovery Star was a tool for supporting and measuring change when working with adults who had experienced mental health problems.

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

Resident Profile	
Number of registered beds	***40***
Total number of residents	**34**
Number of detained patients	2
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	25
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Haywood Lodge was under the governance and management of the South East Community Healthcare (SECH) Organisation. This encompassed Waterford/Wexford and Carlow/Kilkenny/South Tipperary. There was an executive management team for Carlow/Kilkenny/South Tipperary which provided the management and governance structure for the approved centre and the wider mental health services in this region.

The Carlow/Kilkenny/South Tipperary Executive Management Team (EMT) meeting and Carlow/Kilkenny/South Tipperary Quality and Safety Executive Committee (QSEC) meeting were both held monthly. There was a policy group for the wider SECH with representatives from the approved centre. All policies were up to date at the time of the inspection.

The approved centre convened a monthly Quality Patient Safety Committee (QPSC) meeting. Chaired by the services manager, representatives included local and senior nursing management, administrative managers, the consultant psychiatrists, the health and social care professional members of the multi-disciplinary teams, technical personnel, household supervisor, risk manager and the area lead for mental health engagement. Agenda items were specific to the approved centre and included Mental Health Commission annual inspection reports, service user engagement and recovery, risk management, health and safety, staff training, therapeutic services, individual care plans, and COVID-19 preparedness planning. This meeting also looked at a regular number of audits each month.

The person with responsibility for risk management processes was known by staff and was supported by the risk manager. There were clearly defined processes within the approved centre with regard to risk management. Incidents were recorded, risk rated and reviewed. There was a risk review meeting every three months. The approved centre maintained a risk register and risks were escalated to the EMT as appropriate. Heads of discipline and management staff were trained in risk management.

There was an organizational chart defining key personnel and lines of responsibility and accountability. Both multi-disciplinary teams who worked in the approved centre were resourced with medical, nursing, and health & social care professionals. Nursing staff numbers were adequate and in line with their registration requirements. The service had systems and plans in place to proactively ensure that mandatory staff training was completed. This was almost at a hundred percent. Clinical supervision was arranged locally by the respective heads of discipline. Unusually occupational therapy staff were managed by an occupational therapy manager in the primary care service and not the mental health service. Senior management assured the inspectors that they would look into this anomaly.

An advocacy service was available to the approved centre, and the representative visited the residents or held a meeting by zoom weekly or fortnightly. The Support and Advocacy Service (SAGE) also visited on request. Their contact details were displayed in the approved centre and provided to residents and families in an information pack. The complaints procedures were displayed throughout the approved centre and there was a culture of recording and addressing minor complaints. Audits of the minor complaint's logs had been completed with identified actions to improve the residents experience in the approved centre as applicable.

The area lead for mental health engagement was part of the senior management team, but because of the COVID-19 pandemic the area lead did not have direct involvement with the residents in the approved centre. The area lead for mental health engagement attended the QPSC meeting for the approved centre and was trying to engage service user family representation for this committee. The COVID-19 pandemic had impacted the local forum for mental health engagement. This had been re-established and meetings had now resumed, including South Tipperary, Carlow and Kilkenny. A six-week training schedule was ongoing for its members at the time of inspection. This had been supported by staff in the approved centre and the wider mental health service.

There was a peer support worker who worked with residents in West House and the wider Rehabilitation and Recovery team. They were a member of this multi-disciplinary team attending the weekly meetings and working with residents on a one-to-one basis. They had been involved in the co-production of resident information leaflets. Supported by social work services and the peer support worker, all residents from West House had completed one of four planned sessions in Safeguarding Training.

A new Individual Care Planning (ICP) template had been introduced in each house. These had been developed bespoke to the specific needs of the different resident profile. In East House where residents where generally older adults, ICP templates included allocated sections for managing mental health needs; physical health needs; use of time, therapeutic and recreational needs; social and psychological health needs; support care needs, and any other additional needs. In West House where all residents were under the care of a Rehabilitation and Recovery team, the ICP template was based on the Recovery Star for mental health and wellbeing. The 10 core themes include: managing mental health needs; physical health needs; use of time, therapeutic and recreational needs; living skills; friends and community; relationships; addictive behaviour; home & discharge planning; identity and self-esteem and trust and hope.

The approved centre followed all guidance as set out by the HSE- Health Protection Surveillance Centre (*HPSC)* for Residential Care Facilities. Residents were all accommodated in single en suite rooms. Visits had been restricted unless for compassionate grounds during the pandemic. At the time of inspection, visiting had resumed and visits were accommodated in the resident's own room or in the garden. Staff adhered to infection prevention control guidance. An infection control nurse worked in the mental health service and was available to the approved centre. A preparedness plan had been developed and updated as required throughout the intervening year. All residents and staff had been offered vaccination for coronavirus.

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

There were no areas of non-compliance on this inspection.

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team on any matter relating to their care whilst in the approved centre.
- The Peer Advocacy in Mental Health 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.

Eighteen completed service user experience questionnaires were returned to the inspectors. Four of these had been completed by a family member on the resident's behalf. Two residents and one relative spoke with the inspectors.

Feedback from the two residents and family member was positive. Staff were described as excellent. The food was praised. The size of the bedrooms received positive commentary, as did the cleanliness of the approved centre.

Fourteen completed forms indicated that the residents knew who their multi-disciplinary team members were, three stating "no" to this question. Twelve indicated that they knew who their key worker was, with four stating "no" to this question. The remaining forms were blank for these questions. Seven of the eighteen indicated that they were "always" involved in setting goals for their individual care plan, six indicated "sometimes" and two "never" for this question. Twelve questionnaires indicated that the resident/family member understood what the individual care plan was, two said no and the remaining were not completed.

Thirteen residents/family members indicated that there were enough activities during the day, two said "no" and the remainder were left blank for this question. Thirteen respondents said "yes" to having space for privacy, twelve felt their privacy and dignity were respected, while one indicated "no" for this question. The remainder did not answer this question.

Sixteen respondents indicated that they were happy how staff talked to them, two were left blank. Thirteen respondents ticked that they “always” felt safe in the approved centre and one indicated “sometimes” to this question. The remaining were left blank.

On a scale of 1-10, with 1 being poor and 10 being excellent, three residents rated 4, 5, and 6 out 10 (respectively) for overall experience of care and treatment, four rated 8, three rated 9 and 5 rated 10 out 10. Three forms did not have this section completed.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the Peer Advocacy in Mental Health representative. Feedback from the residents to the advocate overall was positive. Comments specifically related to the variety and quality of food, the activities provided and the therapeutic programmes. In this regard, the art classes and the cooking and music groups were rated favourably. Residents had said they liked having their own room and liked the garden spaces. The residents had praised all staff. When discussing areas for improvement with the advocate, a resident said that they would like to go out more. It was also stated that the approved centre could be quite noisy.

6.0 Feedback Meeting

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

- Clinical Director
- Head of Service/ Registered Proprietor
- Consultant Psychiatrist
- Social Work Manager
- Occupational Therapy Manager Primary Health
- Principal Psychology Manager
- Senior Occupational Therapist
- Business Manager
- Activity Nurses x 2
- Household Supervisor
- Clinical Nurse Manager Grade 11 x 1
- Clinical Nurse Manager Grade 1 x 2
- Clinical Nurse Manager Grade 3
- Assistant Director of Nursing x 2
- Acting Area Director of Nursing

Apologies were received on behalf of the Executive Clinical Director.

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

There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. The service used photographs, and addressograph labels. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Menus changed daily and rotated over a four week menu cycle. Residents had at least two choices for meals. Food was available for residents outside of the arranged mealtimes. There was a source of safe, fresh drinking water available to residents at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. There was access to both dietetics and speech and language therapy.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, preparation and serving of food. Food was transported to the approved centre from the main kitchen located in Tipperary University Hospital. 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, if required, that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. The approved centre was in receipt of a bursary from the local Marks and Spencer shop who provided clothing for residents if required. Residents had access to laundry facilities.

At the time of inspection, no residents were wearing nightclothes during the day as indicated by their individual care plan.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2021.

Residents' 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, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. The approved centre facilitated structured recreational activities on weekdays and during the weekend. There was a schedule of activities for residents from both houses and two activity nurses facilitated a range of interactive groups based on resident needs and likes. These included a weekly visit from a therapy dog, music sessions, gardening, cooking, beauty care, audio library, walking groups, relaxation groups, current affair groups, knitting and sewing. There was a bus available to the approved centre and social outings had been organized.

Residents had their own individual "C*are at A Glance"* board in their room, which as desired included recreational pursuits. Each room had a television and residents also had access to an electronic tablet. Activity packs were available for residents at the weekends.

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. There was an oratory in the approved centre and mass had resumed monthly in the approved centre since pandemic restrictions had eased.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

At the time of the inspection, visits to the approved centre were in line with infection control measures and public health guidance. Visiting times were appropriate and reasonable. A separate visitors' room was provided where residents could meet visitors in private. Visits were also facilitated in the resident's single bedroom and garden areas. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visitors' room was suitable for children visiting a resident.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in February 2021.

Residents had access to mail, email, internet, and telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Wi-Fi was available in both East and West House.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others. This was not applicable to any resident at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in June 2021 and included all requirements related to:

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

Risk was assessed prior to a search of a resident or their property appropriate to the type of search being undertaken. Resident consent was sought prior to all searches; the request for and the received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents. Relevant staff could articulate the searching processes as set out in the policy.

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

record of the search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and protocols for care of residents who were dying, which were last reviewed in July 2021. There was an addendum to the policy in relation to COVID-19 that was also dated July 2021.

The end of life care provided was appropriate to residents' physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected, as were the privacy and dignity of the residents. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end of life care.

The clinical files of five residents who had died were inspected. All deaths had been managed in accordance with the resident's religious and cultural practices, with dignity and propriety and in a way that accommodated the resident's family, and next of kin. Residents were also supported by a visiting palliative care team. Advanced care directives relating to end of life care as well as DNAR (Do Not Attempt Resuscitation) orders were evidenced in the clinical files, where applicable.

All deaths of residents were notified to the Mental Health Commission within the required 48-hour time frame.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. A new ICP template had been developed and had been implemented since the last inspection. Additional elements relating to rehabilitation and recovery were included in the template used for West House. The ICPs were stored within the clinic file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT at least six monthly, in consultation with the resident or/and their family representative. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre had two occupational therapists and two activation nurses. They engaged with external partners and agencies such as a recreational hub in St Luke's Hospital known as the *Studio* and the *Education Training Board* (ETB) providing a suite of programmes in accordance with assessed needs. Examples included a social farming programme, social outings, shopping and cooking, mindful walking, art therapy and music therapy. Pet therapy was also provided on a weekly basis in the approved centre.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Examples of these were dietetics and speech and language therapy.

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 on the transfer of residents. The policy was last reviewed in September 2019.

The clinical file of a resident who had been transferred was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer, to a named individual, including a letter of referral that contained a list of current medications and a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy. The policy was last reviewed in July 2021.

The approved centre had an emergency bag and staff had access at all times to an Automated External Defibrillator (AED). Clinical files were examined in relation to provision of general health services during the inspection. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The approved centre was served by a General Practitioner (GP) practice, and a GP was available Monday to Friday in the approved centre.

The clinical files of five residents who had been in the approved centre over six months were reviewed. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, body mass-index and weight. For residents on anti-psychotic medication there had been an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG).

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

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in May 2021.

The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and residents' rights. There were separate information packs and booklets for East and West House, both with specific information relating to the speciality of the respective house.

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

Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to a resident. 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 compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space and to appropriately sized communal rooms. Each resident had their own bedroom with en suite. There was the facility to lock wardrobes and lockers in all bedrooms and residents carried keys to lock their own room where appropriate. There was suitable and sufficient heating within the approved centre, and it was well ventilated. Each bedroom had a door that opened out into a garden. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics and the lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre. Ligature points were minimized to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43 degrees Celsius. Current national infection control guidelines were followed.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address resident needs. The approved centre provided

suitable furnishings to support resident independence and comfort. The approved centre provided assisted devices and equipment to address resident needs. Sixteen bedrooms in East House had fixed ceiling hoists and there was one transportable hoist.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in July 2020. The policy included:

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

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

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition: this was documented in the clinical file. Directions to crush medication were only accepted from the resident's medical practitioner with a documented reason as to why. There was no pharmacist working directly in the approved centre, however staff reported that they liaised with pharmacy staff working in Tipperary University Hospital from where medication was supplied.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator. Schedule 2 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last approved in July 2020. There was a site specific Safety Statement that had been reviewed and updated in October 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 operational policy and procedures in relation to staffing. The policy which was last reviewed in March 2022 included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staff were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times. This was documented. There were two multi-disciplinary teams that provided in reach assessment, care and treatment for the approved centre. Both these teams were resourced with medical, nursing, social work, occupational therapy and psychology staff. There were two activation nurses and two occupational therapists who worked solely in the approved centre. Almost all healthcare staff were trained in Fire safety, Basic Life Support, Management of violence and aggression and the Mental Health Act. For staff whose training was not up to date, there was evidence that this was directly because of COVID-19 and training had been arranged to remedy this.

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.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (32)	28	86%	32	100%	29	92%	32	100%	32	100%

Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Medical (3)	3	100%	3	100%	2	66%	3	100%	3	100%
Occupational Therapist (2)	2	100%	2	100%	1	50%	2	100%	2	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (2)	2	100%	2	100%	1	50%	2	100%	2	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating the creation of, access to, retention off and destruction of records. The policy was last reviewed in June 2021.

Resident records were secure, up-to-date, and in good order, and were physically stored together in a secure office. All resident records were reflective of the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use.

Documentation of inspections relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All policies and procedures requiring a three-yearly review 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, including remote access to the tribunals. Staff attended Mental Health Tribunals and provided assistance as necessary when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in June 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 responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission or soon thereafter. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented and actioned appropriately. An audit had been done of the minor complaints logs. All complaints (that were not minor) were dealt with by the nominated person; however, no complaints had been made since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management as well as a Safety Statement. The policy was last reviewed in April 2022. The risk management policy and associated safety statement addressed all policy requirements, including:

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

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

Individual risk assessments were completed prior to and during physical restraint and mechanical restraint. There had been no episodes of physical restraint since the last inspection. Individual risk assessments were also completed in conjunction with medication requirements or administration; at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm; resident transfer and resident discharge. 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. A person with responsibility for risk management and the Quality Patient Safety Committee (QPSC) 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, with the information provided 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. Mock emergency evacuations had been conducted since the last inspection.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Evidence of Implementation:

The approved centre had a written operational policy and procedures relating to the use of mechanical restraint.

Mechanical restraint was only used for the enduring risk of harm to the self or others or used to address an identified clinical need. Mechanical restraint was used only when less restrictive alternatives were unsuitable. Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of the consultant psychiatrist or by the duty consultant psychiatrist acting on his or her behalf.

The clinical files of eight residents who had been mechanically restrained were reviewed on inspection. The clinical files contained a contemporaneous record which specified the following: there was an enduring risk of harm to the self or others; less restrictive alternatives were implemented without success; the type of mechanical restraint; the situation in which mechanical restraint was being applied; the duration of the restraint; the duration of the order; and the review date.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined.

It was documented that the responsible consultant psychiatrist had assessed the patients' capacities to consent to receive treatment.

A Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed for patients who were assessed as not having capacity to consent to treatment. They documented: the names of the medications prescribed; a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications, and details of the discussion with the patient, the patients views, as well as any supports provided to the patient in

relation to the discussion and their decision-making. These forms also included approval by a consultant psychiatrist and an 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.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in September 2019, included all of the policy-related criteria for this code of practice. There was an addendum to the policy in relation to COVID-19 dated March 2021.

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who was admitted to the approved centre was reviewed on inspection. A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the following: presenting problem; past psychiatric history; family history; medical history; current and historic medication; where relevant, social and housing circumstances; current mental health state; risk assessment; full physical examination; and, and other relevant information.

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

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed on inspection. The discharge plan included the following: estimated date of discharge; documented communication with the relevant general practitioner, primary care team and community mental health team (CMHT); a follow-up plan; and a reference to early warning signs of relapse and risks. The discharge

meeting was attended by residents, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate, where appropriate and with the consent of the resident.

The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. Discharge was coordinated by a key worker. The preliminary discharge summary was sent to the general practitioner, primary care team, and CMHT within three days. The comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. The family member, carer, or advocate was involved in the discharge process, where appropriate.

The approved centre was compliant with this Code of Practice.

Appendix 1 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.

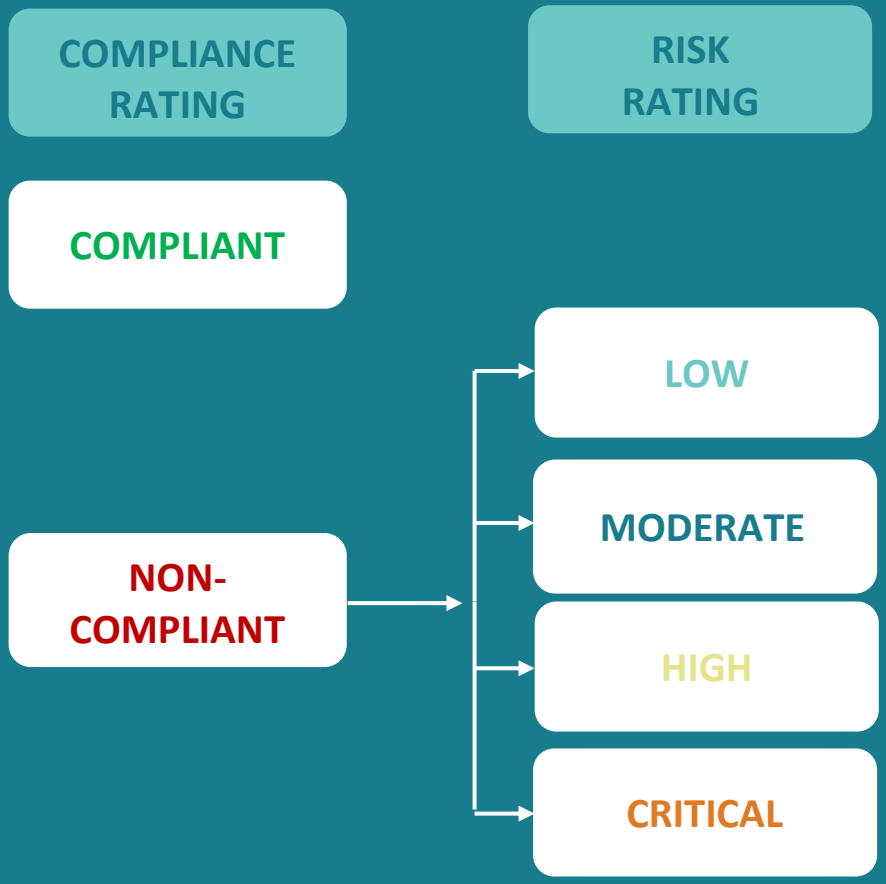
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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