Creagh Suite

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

CREAGH SUITE

St Brigid's Healthcare Campus,
Creagh, Ballinasloe, Co Galway

Date of Publication: 11 August 2022

ID Number: AC0171

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Psychiatry of Late Life

Conditions Attached:
None

Most Recent Registration Date:
3 October 2019

Registered Proprietor:
HSE

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

Inspection Team:
Mary Connellan, Lead Inspector
Raj Ramasawmy

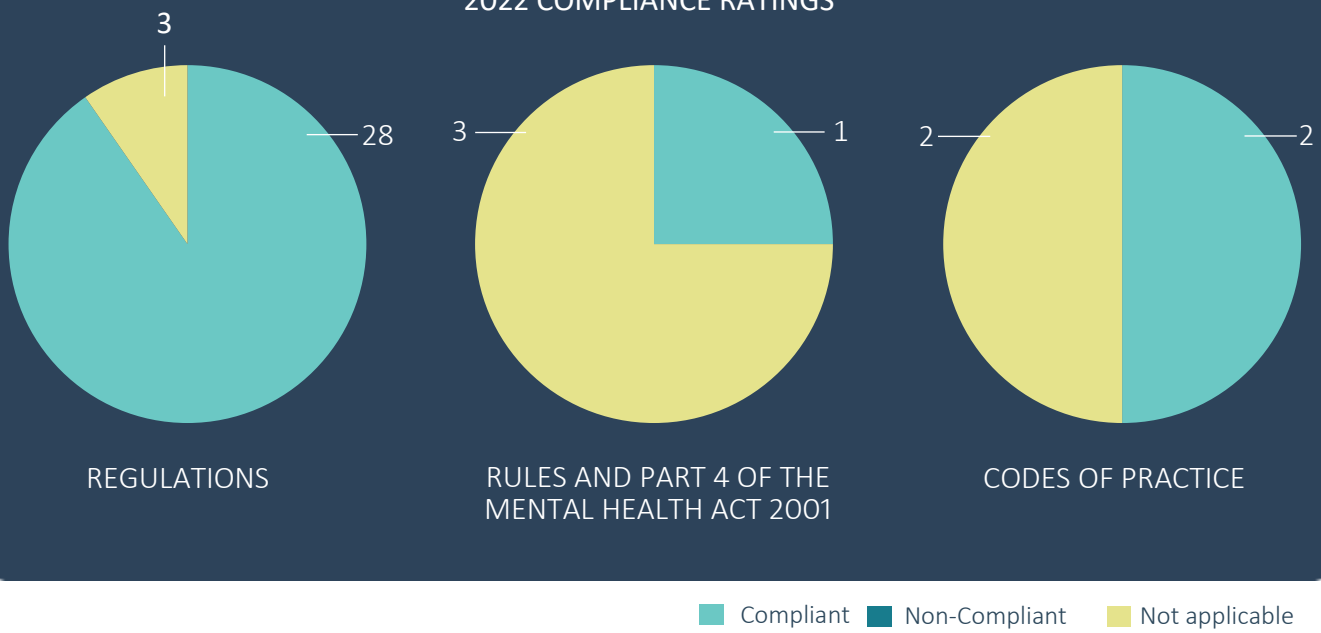
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
12 - 14 April 2022

Previous Inspection date:
2 - 5 March 2021

Inspection Type:
Announced Annual Inspection

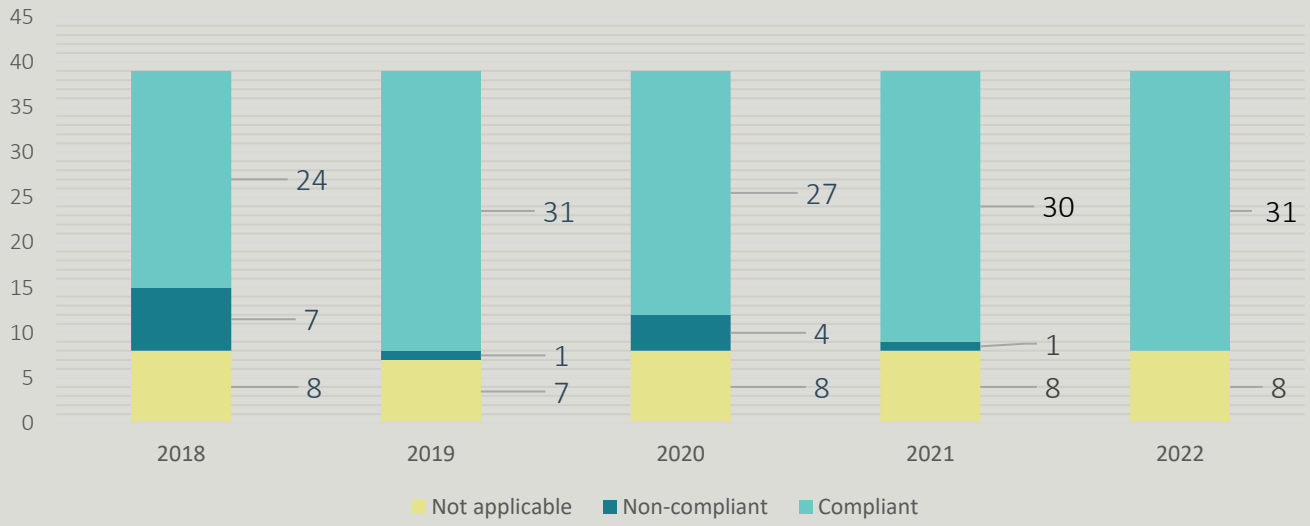
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

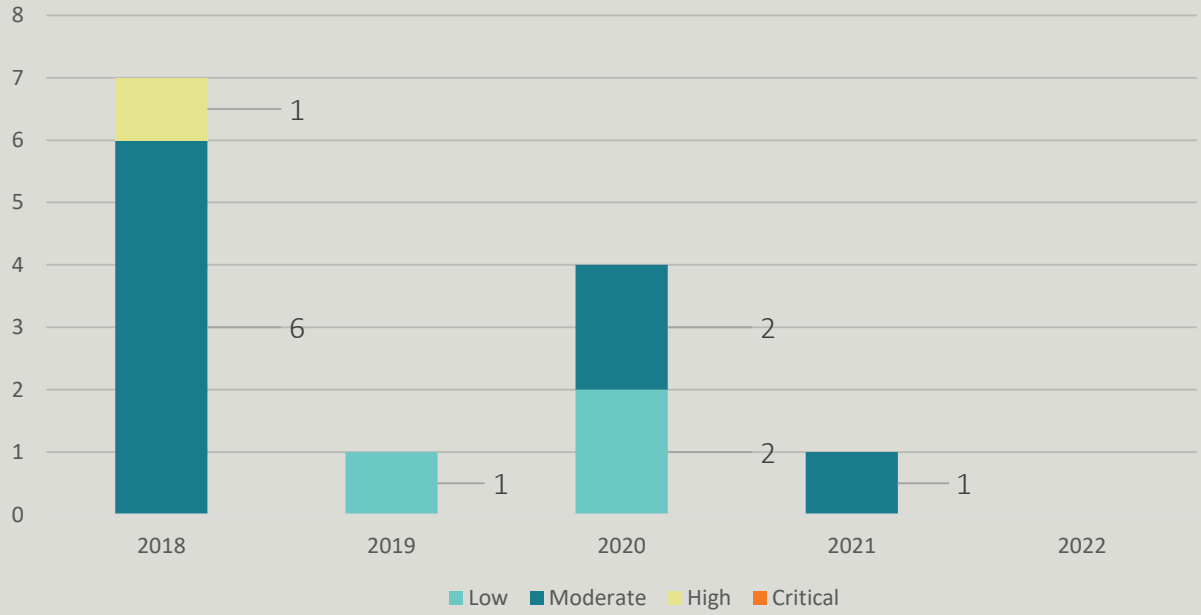
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

The Creagh Suite was located on the grounds of St Brigid's Campus, Ballinasloe. Most residents had been referred to the approved centre for the management and care of more complex mental health needs and dementia. The layout and the decoration of Creagh Suite was of high standard and met the needs of the elderly population.

There was one Psychiatry of Later Life (POLL) Multi-Disciplinary Team (MDT) that provided the care and treatment for all the residents in the approved centre. Referrals to the approved centre had come either directly from this team, from one of the other two POLL teams in the Galway Roscommon regions, or from any of the general adult teams throughout Galway and Roscommon.

Creagh Suite achieved 100% compliance with Regulations, Rules and Codes of Practice.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	77%	97%	87%	97%	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.
- Therapeutic activities provided included mindful colouring, relaxation therapy, pet therapy, hand massage, and music therapy. There was a fully equipped sensory room that residents could attend on a sessional basis. Each resident had an individual therapeutic activity box with materials relating to personal pursuits, memories and reminiscence.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.
- There was a social worker and a psychologist on the POLL team, access to a mental health dietitian and access to a physiotherapist and speech and language therapist.
- End of life care was provided that was appropriate to physical, emotional, social, psychological, and spiritual needs of residents.

Respect for residents' privacy, dignity and autonomy

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

- Bedrooms had been reconfigured to include two single en suite rooms, two three bedded rooms with en suite and three two bedded rooms with en suite. At the time of inspection, all residents were accommodated in single occupancy rooms to limit pandemic infection risks.
- 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 elderly residents and their families.

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. Activities included current affairs, manicures, music and song, art, TV, DVD's, radio, games and puzzles.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance

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

- The approved centre was under the leadership and management of Community Healthcare West and was governed under the Galway Roscommon Mental Health Services (GRMHS). The Galway Roscommon Mental Health Services Area Management Team meeting and Quality and Safety Committee (QSC) meeting were both held monthly.
- The approved centre convened a monthly business meeting. Chaired by the clinical director, representatives included nursing staff working in the approved centre, local nursing management,

the consultant psychiatrist, the health and social care professional members of the multi-disciplinary team, maintenance staff, a pharmacy representative, and the mental health dietitian when available.

- A risk management meeting was also held weekly for all of GR5 and included representation from the approved centre.
- Regular audits had been completed and there was a focus on continuous improvement and enhancement of the resident experience. Feedback from family members was regularly sought.
- Galway Roscommon Mental Health Services had launched a five-year *Nursing Services Strategy* (*2022-2027).* The nursing team in Creagh suite were committed to implementing the five strategic priorities.
- Families were involved in their loved one's care and documentation evidenced regular contact with family members by staff. Each resident had their own iPad to converse with family during the pandemic which was assisted and facilitated by staff.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Safewards: This was an evidence-based model that provided effective nursing interventions to create safer therapeutic ward environments in mental health settings. The Creagh Suite had engaged with families of the residents regarding the implementation of safewards. The Creagh Suite had an implementation group and had commenced with two of the interventions: *Clear Mutual Expectations* and *Know Each Other*.

2. National Dementia Programme: Two trained facilitators provided expert interventions on the management of dementia with enduring mental health issues to all staff working in the Creagh Suite.

3. Community Intervention Teams (CIT): The approved centre was working with the CIT to ensure as many residents as possible were assessed and looked after in the approved centre, as opposed to attending other health care facilities.

4. A Smart TV and individual tablets with internet connection were available and used for communication with families and to watch sports, religious, or other events.

5. Pet therapy: A pet dog visited the approved centre once weekly.

6. Garden: A water feature purchased with funding from the National Dementia Office had been added to the garden.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Creagh Suite was located on the grounds of St Brigid's Campus, Ballinasloe. While it was an older style building, it was a well presented, clean and airy and had been developed to cater for the specific needs of an elderly population. Most residents had been referred to the approved centre for the management and care of more complex mental health needs and dementia. While a resident could be discharged to another facility, for example a nursing home, it was more common for residents to reside in the approved centre. The corridors had been painted in a streetscape style, and the colour schemes and soft furnishings were conducive to a relaxing environment. Bedrooms had been personalized and included family photographs, resident belongings and memorabilia.

There was a large open dining room that was also used for activities outside of mealtimes. There was a designated sensory room and a conservatory style seating area. This was being sub-divided to facilitate a space for hand massage and nail care. Bedrooms had been reconfigured to include two single en suite rooms, two three bedded rooms with en suite and three two bedded rooms with en suite. Each of these rooms had a fixed hoist. At the time of inspection all residents were accommodated in single occupancy rooms to limit pandemic infection risks. There was an enclosed garden that was well maintained, had seating areas and was used regularly by the residents and their visitors in fine weather.

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

Resident Profile	
Number of registered beds	***14***
Total number of residents	**6**
Number of detained patients	0
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	4
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the leadership and management of Community Healthcare West and was governed under the Galway Roscommon Mental Health Services (GRMHS). The wider Community Healthcare West encompassed Mayo. Galway Roscommon Mental Health Service was divided into six sectors, GR1 to GR6. The approved centre was located in GR5. The Galway Roscommon Mental Health Services Area Management Team meeting and Quality and Safety Committee (QSC) meeting were both held monthly. The approved centre was represented, and minutes evidenced discussion and action on strategic agenda items such as finance, human resources, health and safety, risk management and policies and procedures.

The approved centre convened a monthly business meeting. Chaired by the clinical director, representatives included nursing staff working in the approved centre, local nursing management, the consultant psychiatrist, the health and social care professional members of the multi-disciplinary team, maintenance staff, a pharmacy representative, and the mental health dietitian when available. Agenda items were specific to the approved centre and included Mental Health Commission annual inspection reports, Health and Safety, and Drugs and Therapeutic and Clinical Governance. The latter included therapeutic services and evidence-based activities, complaints, incident reviews, risk register, staff training, policies and procedures, programme of maintenance, data protection and infection prevention and control. More recently, *Safewards* had been added to the agenda. A risk management meeting was also held weekly for all of GR5 and included representation from the approved centre.

There was one Psychiatry of Later Life (POLL) Multi-Disciplinary Team (MDT) that provided the care and treatment for all the residents in the approved centre. Referrals to the approved centre had come either directly from this team, from one of the other two POLL teams in the Galway Roscommon regions, or from any of the general adult teams throughout Galway and Roscommon. While the approved centre was in transition with occupational therapy, a service was being provided in the interim period. There was a social worker and a psychologist on the POLL team, access to a mental health dietitian and access to a physiotherapist. General Health and physical Care needs were assessed and treated by the medical staff, namely the non-consultant hospital doctors and the consultant psychiatrist. Nonetheless, it was considered a deficit that those residents who were in a long-term facility did not have access to a local General Practitioner (GP) service. This was being actively followed up by the management team. At the time of the inspection, occupational therapy was being cross covered by two other teams. The service was waiting for a replacement, due to commence in the weeks following the inspection.

The approved centre was a specialist service for the assessment, care and treatment older adults with complex presentations generally related to a diagnosis of dementia. There was a strong emphasis on the resident's physical presentations and appropriate assessments to alleviate distress. Each resident had undergone a comprehensive medical assessment to include consideration of possible delirium or undetected pain and discomfort. Part of the risk assessment included tests such as the Waterlow Skin Assessment, Nutritional Screening, Falls Risk Assessment Tool (FRAT) and Pain Assessment in Advanced Dementia (PAINAD). All residents were assessed by a Speech and Language Therapist (SALT) and as required were followed up. Galway Roscommon Mental Health Services had launched a five-year *Nursing Services Strategy* (*2022-2027).* The nursing team in Creagh suite were committed to implementing the five strategic priorities.

The approved centre policies and procedures were part of the wider suite of policies for Galway Roscommon Mental Health Services. There was a local operational policy that set out the day-to-day procedures and protocols for the approved centre. Regular audits had been completed and there was a focus on continuous improvement and enhancement of the resident experience. Feedback from family members was regularly sought.

While an advocacy service was available to the approved centre, the representative did not routinely visit the residents. 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. Families were involved in their loved one's care and documentation evidenced regular contact with family members by staff and vice versa. Staff knew the residents' close family members and kept them informed of any changes and arrangements. Each resident had their own iPad to converse with family during the pandemic which was assisted and facilitated by staff.

At the time of inspection, residents were all accommodated in single occupancy en suite rooms. The approved centre followed all guidance as set out by the HSE- Health Protection Surveillance Centre (*HPSC)* for Residential Care Facilities. Visits had been restricted unless for compassionate grounds and staff adhered to infection prevention control guidance. 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 found 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.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice 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.
- Family representatives were contacted inviting them to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.

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' and the families experience of the approved centre as outlined below. One completed service user experience questionnaire was returned to the inspectors. One resident representative spoke with an inspector over the telephone. Overall feedback was positive.

The completed questionnaire indicated that the resident knew who their multi-disciplinary team members were. The resident indicated that they knew who their keyworker was. This resident documented that they may forget names of both the team and the keyworker. The resident ticked to indicate that they did not have concerns or worries and that they were happy with how staff talked to them. They indicated that they felt there were enough activities during the day.

The resident said 'yes' to having space for privacy and that they felt their privacy and dignity were respected. The resident said that they 'always' felt safe in the approved centre and they were able to give feedback to staff and make a complaint.

On a scale of 1-10, with 1 being poor and 10 being excellent, the resident rated the approved centre 10 out of 10.

Overall feedback from the resident representative was positive. In particular, the staff were praised as were the processes for the individual care plan meetings with the doctor and the wider team. The service was praised as to how the COVID-19 pandemic was managed, which included regular feedback and communication with family members.

It was suggested that staff have larger name badges and that perhaps staff pictures with names could be displayed. While general health care needs were met, the lack of direct access to a local General Practitioner (GP) was raised as a concern by the relative/resident representative.

5.2 Advocacy

The approved centre had an advocacy service. Information regarding the Peer Advocacy in Mental Health (formerly the Irish Advocacy Network) was displayed in the approved centre.

The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

6.0 Feedback Meeting

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

- Clinical Director
- Consultant Psychiatrist
- General Manager and Registered Proprietor
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3 x 2
- Clinical Nurse Manager 1
- Occupational Therapy Manager
- Senior Social Worker

Apologies were received on behalf of the Principal Psychology Manager.

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. These included photographs, patient identification number and date of birth. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. 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.

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 in hot boxes from the main kitchen located on the same campus. 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.

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 November 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. These included hand massage, current affairs, manicures, music and song, art, TV, DVD's, radio, games and puzzles.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

At the time of the inspection, visits to the approved centre were curtailed and in line with infection control measures and Health Protection Surveillance Centre (HPSC) guidance. Outside of these restrictions visiting times were appropriate and reasonable. A separate visitors' room or visiting area was provided where residents could meet visitors in private. 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, which were last reviewed in February 2020.

Residents had access to mail, email, internet, and telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. Each resident had their own electronic tablet and Wi-Fi was available.

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 November 2021. The policy 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.

No searches had been carried out in the approved centre since the previous inspection. Therefore, this regulation was inspected on the policy requirement only.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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 file of a resident who had died was inspected. The death was 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.

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

Six individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment. 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 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.

Therapeutic activities provided included mindful colouring, relaxation therapy and music therapy. There was a fully equipped sensory room that residents could attend on a sessional basis. Each resident had an individual therapeutic activity box with materials relating to personal pursuits, memories and reminiscence. Each resident had had a functional assessment by an occupational therapist.

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 this included physiotherapy 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 August 2020.

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 October 2021.

The approved centre had an emergency trolley 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 process. 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 clinical files of four 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 February 2021.

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

Residents were provided with the details of their multi-disciplinary team 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. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.

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

The approved centre was 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. There was suitable and sufficient heating within the approved centre, and it was well ventilated. 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. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address the 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.

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 October 2021. The policy included:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, all 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.

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 November 2021. There was a site specific Safety Statement that had been reviewed and updated in July 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 February 2021 included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

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. This was documented. All healthcare staff were trained in Fire safety, Basic Life Support, Management of Violence and Aggression and the Mental Health Act. Children First training had also been completed by all healthcare staff. The training table below shows the training completed by the multi-disciplinary team members designated to, or who attend the approved centre.

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 (15)	15	100%	15	100%	15	100%	15	100%	15	100%
Consultant Psychiatrist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Medical (1)	1	100%	1	100%	1	100%	1	100%	1	100%

Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	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 September 2019.

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 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 February 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 complaints 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. 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 November 2021. 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 person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical 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.

Individual risk assessments were completed prior to and during physical restraint and mechanical restraint. 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. The person with responsibility for risk management and the risk advisor 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.

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 at the main entrance to the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 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. The policy was last reviewed in February 2022.

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 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 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated February 2022. It addressed the following:

- The provision of information to the resident
- Who can initiate and who may implement physical restraint.

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

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

Evidence of Implementation: The clinical file of a resident who was physically restrained was reviewed on inspection. Physical restraint (PR) was used in rare, exceptional circumstances and was in the best interests of the resident, where the resident posed immediate threat of harm to the self or others. PR was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered. The use of PR was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using PR. PR was initiated by a registered medical practitioner (RMP), registered nurse (RN) or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated staff member was responsible for leading in the physical restraint of the resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) or duty CP was notified as soon as practicable; this was recorded in the clinical file.

The RMP completed a medical examination of the resident (physical examination), no later than three hours after the episode of PR. The episode of PR was recorded in the clinical file. The clinical practice form was completed by the person who initiated and ordered the use of PR no later than three hours after the episode. The clinical practice form was signed by the CP within 24 hours. The resident was informed of the reasons for, likely duration of, and circumstances leading the discontinuation of PR unless the information may have been prejudicial to the resident's mental health, well-being, or emotional condition. The resident's next of kin or representative was informed of the use of PR and a record of this communication was placed in the clinical file. Staff were aware of relevant considerations in the individual care plan pertaining to the resident's requirements and needs in relation to the use of PR. A same sex staff member was present at all times during the PR episode. The resident was afforded the opportunity to

discuss the episode with members of the MDT involved in their care as soon as was practicable. The completed clinical practice form was placed in the resident's clinical file. The episode of PR was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had 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.

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

Discharge: The discharge policy, which was last reviewed in April 2022, 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 other relevant information. The resident's family member, carer, or advocate was involved in the admission process, with the resident's consent.

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; 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; 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 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.

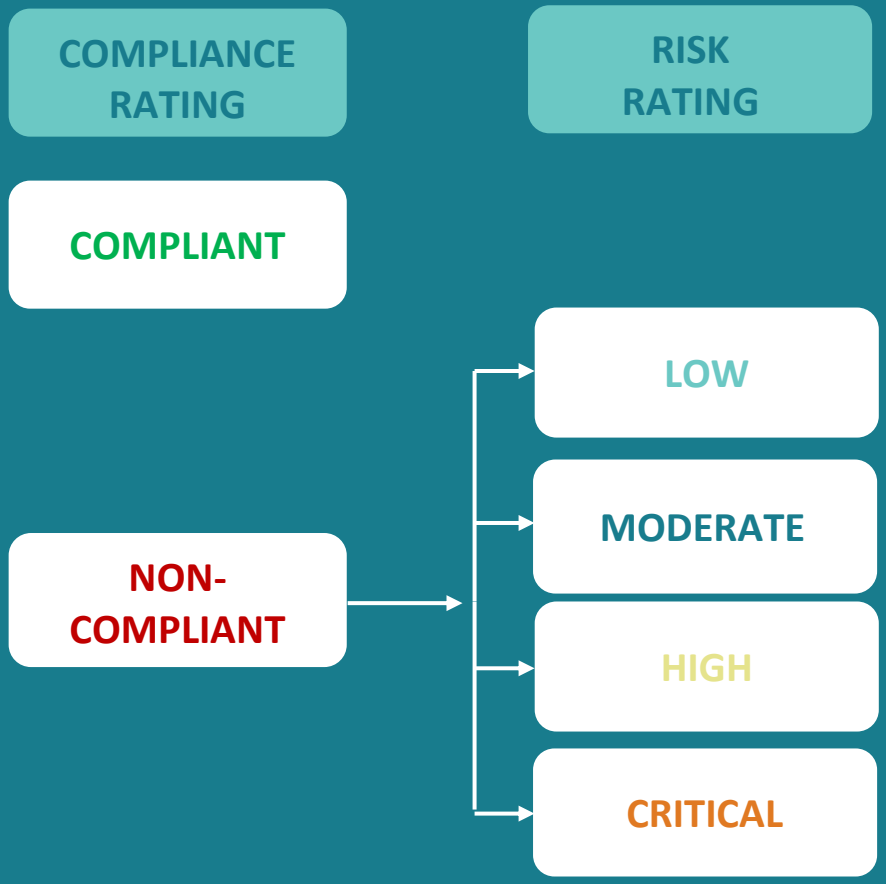
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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