St Gabriel's Ward, St Canice's Hospital

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

ST GABRIEL'S WARD, ST CANICE'S HOSPITAL

St Gabriel's Ward, St Canice's Hospital
Dublin Road, Kilkenny

Date of Publication: 06 Dec 2022

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2022 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
None

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, Acting Head of Services, CHO 5 Mental Health Services

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
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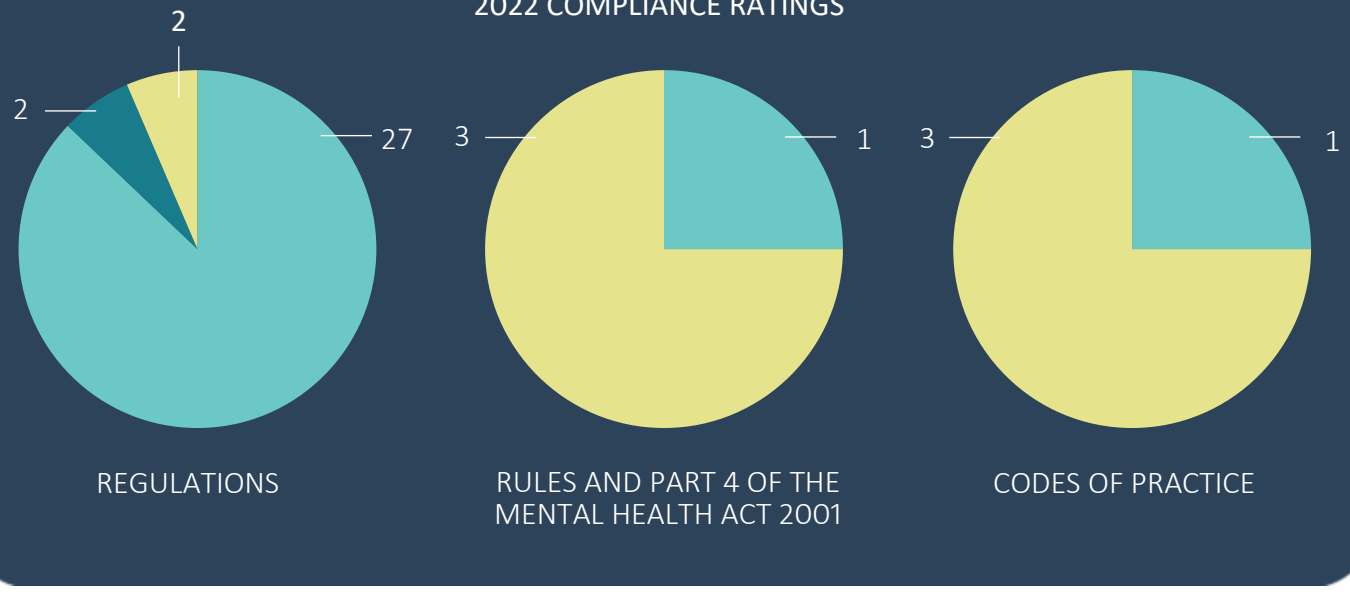
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
24 – 27 May 2022

Previous Inspection date:
29 June – 2 July 2021

Inspection Type:
Announced Annual Inspection

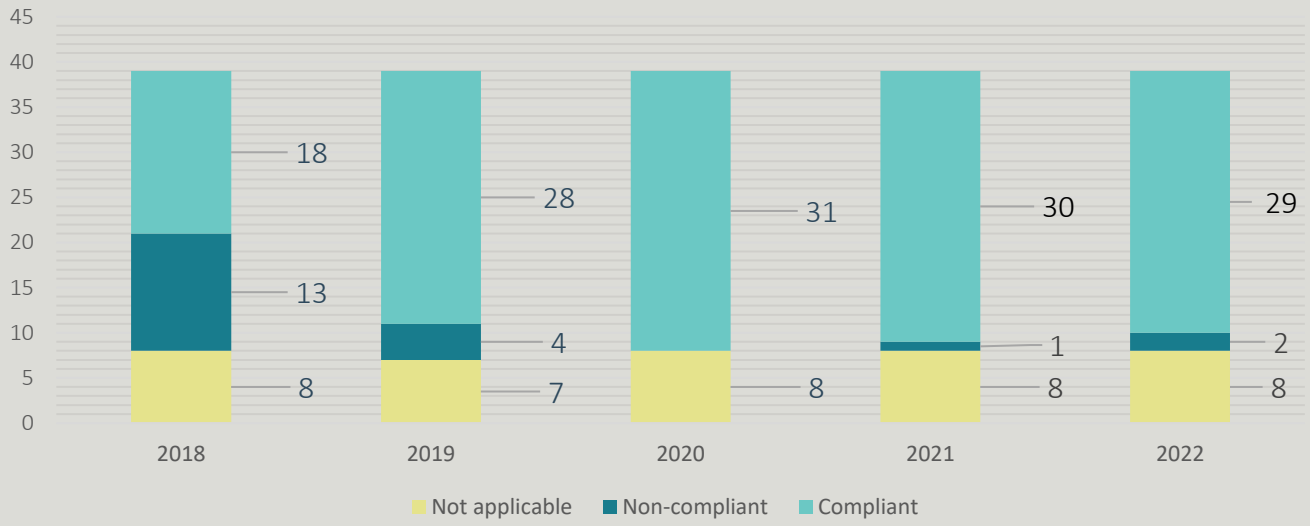
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

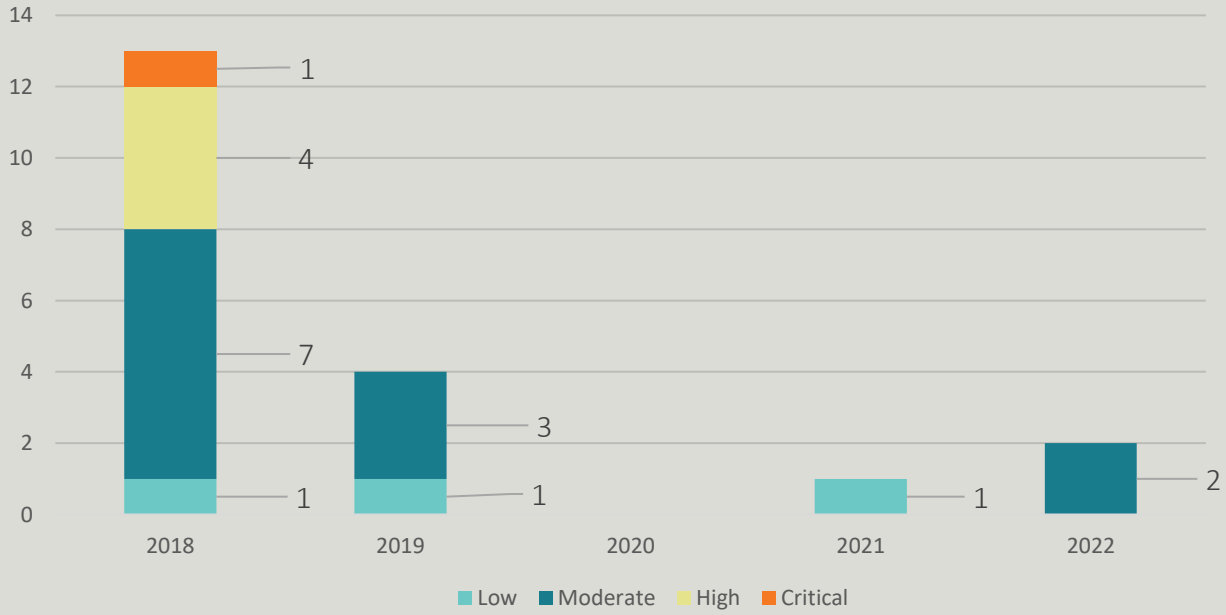
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 approved centre was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey building erected in the 1980s. The community mental health teams were co-located in separate facilities within the building. There were plans in place for the community mental health teams to move to a new premises which would free up space for the approved centre to incorporate a new occupational therapy area, and a resident's day room. The approved centre was registered to accommodate residents for Continuing Mental Health Care/Long Stay and Psychiatry of Later Life.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	58%	88%	100%	97%	94%

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 did not always operate safe practices which reduced risk of harm to the residents.

- 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.

However, radiators and associated pipework, which were very hot to touch, were not covered and presented a burn hazard.

Appropriate care and treatment of residents

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

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The approved centre had a combined Recreational and Therapeutic Group Programmes Timetable. Group therapies were facilitated by the centre's two occupational therapists (OTs) and therapeutic activities were co-produced with external providers including musicians and a horticulturist.
- Therapeutic activities included relaxation, exercise groups, horticultural groups, music groups, drama therapy and chair yoga. The OTs worked together with the social workers on a dementia-friendly environment and garden project. Therapeutic activities were also provided on a one-to-one basis where required.
- 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.

Respect for residents' privacy, dignity and autonomy

We found that facilities and processes respected residents' privacy and dignity within the limitations of multioccupancy bedrooms and that interactions respected residents' wishes.

- Sleeping accommodation was in single, two, three and four-bed rooms. Toilet and shower facilities were either en suite or communal.
- 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.

However, there were no plans to provide residents with single ensuite bedrooms.

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 wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. These activities included chair yoga, music groups, walks, shopping trips, baking, garden activities, and gardening groups. One-to-one activities were also arranged for residents where appropriate.
- The occupational therapists and social workers had established a working group with a view to making the environment in St Gabriel's Ward more dementia friendly for the residents.
- The social worker in the approved centre had introduced a booklet titled *Remembering Yesterday Living Today: Getting to know me in my own unique way;* this booklet was used as a tool for residents and their families to explore and present the resident's lifespan and life experiences. The booklet has a psychosocial approach which allowed staff to get to know the residents.
- 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, Leadership and Accountability

Governance structures and processes were in place but there were unidentified risks in the approved centre

- The approved centre was part of South-East Community Healthcare Organisation. St. Gabriel's ward was governed by the executive team from Carlow/Kilkenny/South Tipperary team.
- The EMT consisted of heads of discipline, the head of service, the area lead for mental health engagement and the general manager. The local Quality and Patient Safety Committee (QPSC) met monthly, and issues arising from these meetings were then tabled at the Quality and Safety Executive Committee (QSEC), which met monthly.
- The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed.
- The approved centre had an Emergency Plan and a COVID-19 Prevention and Outbreak Plan.
- An area-wide Training Committee had commenced since the last inspection to address staff training needs throughout Carlow/Kilkenny/South Tipperary.
- The Area Lead for Mental Health Engagement had engaged a representative (family member) from the local Mental Health Forum in Kilkenny to be involved in St. Gabriel's Ward on behalf of the residents. The representative had been attending the local QPSC meetings but role was vacant at the time of inspection and efforts were being made to fill this voluntary position.
- The person with responsibility for risk was identified and known by all staff. The approved centre had a risk register. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF).

However, not all health and safety risks were adequately documented within the risk register. During the inspection, radiators and associated pipework were observed to be extremely hot to touch. This represented a health and safety risk to the approved centre's resident cohort; this had not been previously identified as a risk.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A Falls Prevention Policy: falls information leaflets and post falls review documentation had been developed and rolled out to staff in the approved centre. The process included discussing any resident falls at the weekly multi-disciplinary meeting.

2. Work on the approved centre's dementia friendly garden had commenced and was directed by the multi-disciplinary team with the introduction of meandering pathways and raised garden beds. Funding had been received from public services innovation fund.

3. Therapeutic and recreational activities had been reintroduced to St. Gabriel's Ward which included weekly live music, Siel bleu (online exercises), chair-based yoga, art, gardening, and drama.

4. The occupational therapists and social workers had established a working group with a view to making the environment in St Gabriel's Ward more dementia friendly for the residents.

5. The social worker in the approved centre had introduced a booklet titled *Remembering Yesterday Living Today: Getting to know me in my own unique way;* this booklet was used as a tool for residents and their families to explore and present the resident's lifespan and life experiences. The booklet has a psychosocial approach which allowed staff to get to know the residents.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey, brick façade building erected in the 1980s. The community mental health teams were co-located in separate facilities within the building. There were plans in place for the community mental health teams to move to a new premises which would free up space for the approved centre to incorporate a new occupational therapy area, and a resident's day room.

The approved centre was comprised of a central nurses' office, sitting room, and day area with bedroom accommodation located on an adjacent corridor. Sleeping accommodation was in single, two, three and four-bed rooms. Toilet and shower facilities were either en suite or communal. The approved centre was registered to accommodate residents for Continuing Mental Health Care/Long Stay and Psychiatry of Later Life.

Residents had access to a large secure garden area under supervision. Work had commenced to provide residents and their families with a dementia-friendly garden space. A meandering pathway and raised garden beds had been completed since the last inspection, work was ongoing and plans were in place for a sensory garden. Overall, the unit was bright and clean and had a calm, dementia-friendly focus. At the time of inspection there were no plans to provide residents with single room accommodation.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**15**
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	9
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of South-East Community Healthcare Organisation which was divided into two executive management teams (EMT), namely Carlow/Kilkenny/South Tipperary and Waterford/Wexford. St. Gabriel's ward was governed by the executive team from Carlow/Kilkenny/South Tipperary team. The monthly EMT meetings had reconvened following a pause, due to the COVID-19 Pandemic, and an Operational Team Meeting had taken its place to discuss issues regarding the pandemic. The EMT consisted of heads of discipline, the head of service, the area lead for mental health engagement and the general

manager. Agenda items included: key performance indicators, the operational plan, mental health engagement, finance, resources, manpower, the budget, updates on staffing posts, and the COVID-19 pandemic. Minutes from this meeting were provided to the inspection team. The local Quality and Patient Safety Committee (QPSC) met monthly, and issues arising from these meetings were then tabled at the Quality and Safety Executive Committee (QSEC), which met monthly. Minutes from these meetings were also provided to the inspection team.

The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed. Clinical audits were provided to the inspection team where applicable.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre. The approved centre had a risk register; however, not all health and safety risks were adequately documented within the risk register. During the inspection, radiators and associated pipework were observed to be extremely hot to touch. This represented a health and safety risk to the approved centre's resident cohort; this had not been previously identified as a risk. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF). The approved centre had an Emergency Plan and a COVID-19 Prevention and Outbreak Plan.

At the time of inspection, the numbers and skill mix of clinical staff was sufficient to meet the residents' needs. The approved centre had two occupational therapists (One whole-time equivalent) and two part-time social workers (two days/week). A psychology post had been approved for the psychiatry of later life team (POLL) and a candidate was waiting to commence in the position. Residents in St. Gabriel's Ward had access to a psychologist by referral. An area-wide Training Committee had commenced since the last inspection to address staff training needs throughout Carlow/Kilkenny/South Tipperary.

The Area Lead for Mental Health Engagement had engaged a representative (family member) from the local Mental Health Forum in Kilkenny to be involved in St. Gabriel's Ward on behalf of the residents. The representative had been attending the local QPSC meetings in the past. The role was vacant at the time of inspection and efforts were being made to fill this voluntary position. Details of the SAGE (a support and advocacy service for older people) advocate were displayed in the approved centre.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2018 and 2022 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2018		2019		2020		2021		2022	
Regulation 22: Premises	✓		✓		✓		✗	Low	✗	Moderate
Regulation 32: Risk Management Procedures	✗	Moderate	✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As 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.
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 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:

- 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 and families could engage with the inspection team on any matter relating to their care whilst in the approved centre.

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

The inspection team received one completed resident feedback questionnaires (completed on behalf of a resident by a family member). Feedback suggested that the family member was always able to discuss worries or concerns with a member of staff as soon as they needed to. They felt that the resident's privacy and dignity was respected and that their family member was safe in St. Gabriel's Ward. The family member, however, didn't understand what an ICP was, nor did they know who the multi-disciplinary team (MDT) members caring for their loved one were. On a scale of 1-10 (1 being poor and 10 being excellent), the family member rated their experience of the care and treatment in St. Gabriel's Ward as being 10. An extra comment was included in the questionnaire: "The care given is excellent, the staff are friendly and caring, I am very happy with all".

The inspection team spoke to seven relatives via phone during the inspection. The relatives spoke very highly of the care and treatment provided in St. Gabriel's. One person said, "I couldn't be happier with the care they provide"; another stated, "I couldn't say enough good things about the staff"; another said, "it is a fantastic service, we are very lucky to have St. Gabriel's". All the relatives said the frontline staff were very kind and caring toward the residents. Relatives said the care was person-centred: "the staff get to know the residents as people, they know their interests and what makes them happy, and they use that to motivate and help the residents." All relatives said they were kept informed about all aspects of the resident's care and were informed of any incidents or any health concerns regarding their loved one. Many relatives said their only fear was that their loved one would be moved on from St. Gabriel's. Access to visits was identified by relatives as a possible area for improvement. An increase in visiting options on weekday evenings was identified, as the existing visiting times were during office hours. However, all relatives that identified visiting as an issue said the approved centre facilitated evening visits if they made a request.

5.2 Advocacy

The SAGE, support and advocacy service for older people was available for residents in the approved centre. There were no needs identified at the time of inspection.

6.0 Feedback Meeting

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

- Clinical Director
- Acting Area Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker - Deputy
- General Manager
- Compliance Officer
- Clinical Nurse Manager 3
- Assistant Director of Nursing
- Mental Health Act Administrator
- Support Services Manager

Apologies:

- Head of Service
- Area Lead for Mental Health Engagement

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used stickers to ensure that residents were readily identifiable by staff. The stickers included the resident's name, date of birth, medical record number (MRN), and address. The centre also used photographs as identifiers.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in April 2021. A resident's personal property and possessions were safeguarded when the approved centre assumes responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. The approved centre provided a safe in each resident's locker, and a locked press in the nurses' station for money and other valuables.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. A dedicated activities nurse facilitated activities in the approved centre. These activities included chair yoga, music groups, walks, shopping trips, baking, garden activities, and gardening groups. One-to-one activities were also arranged for residents where appropriate.

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 are facilitated within the approved centre insofar as is practicable. Resident were provided with virtual access to mass.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in August 2019.

Visiting times were by appointment, and there were no restrictions on the number or frequency of visits. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Residents were facilitated to meet privately with visitors in an internal visiting room. Visits were also facilitated in a garden area. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents in the approved centre had access to mail, fax, Internet and telephone for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Residents had access to their own phones where appropriate and use of a cordless phone in the approved centre, as well as Wi-Fi internet and mail access. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures 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.
- The consent requirements of a resident regarding searches.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out in the policy. As there were no searches undertaken since the last inspection, this regulation was assessed against the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in September 2020.

The clinical file of one resident who had died in the approved centre was examined on inspection. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs. 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 representatives, family, next of kin, and friends. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's 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

Each resident had an Individual Care Plan (ICP). Five ICPs were inspected. All IPCs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, and resources required.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The IPCs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

ICPs identified appropriate goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident, at least every six months for residents in this continuing care facility. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre had a combined Recreational and Therapeutic Group Programmes Timetable. Group therapies were facilitated by the centre's two occupational therapists (OTs), and therapeutic activities were co-produced with external providers including musicians and a horticulturist. Therapeutic activities included relaxation, exercise groups, horticultural groups, music groups, drama therapy and chair yoga. The OTs worked together with the social workers on a dementia-friendly environment and garden project. Therapeutic activities were also provided on a one-to-one basis where required.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in September 2019. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral, a copy of the resident's Medication Prescription and Administration Record (MPAR), and the 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 policy which included procedures for responding to medical emergencies. The policy was last reviewed in April 2021.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). This was located in the foyer outside the nurses' office in a clearly marked and alarmed wall-mounted box. Residents received appropriate general health care interventions in line with individual care plans.

Three clinical files were examined in relation to the provision of general health services during the inspection process. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference.

Residents on anti-psychotic medication received an annual assessment of their glucose regulation, blood lipids, electrocardiogram (ECG) heart function, and prolactin. Adequate arrangements were in place for residents on anti-psychotic medications to access general health services and for their referral to other health services as required.

Residents could access national screening programmes that are available according to age and gender, including but not limited to the following: breast check; cervical screening; retina check (diabetics only); bowel screening; and medication review.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in March 2021.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs. The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(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 in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. The approved centre provided a large sitting room, smaller sitting room, and garden area. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. The heating in bedroom and day areas was suitable and sufficient for residents' comfort and safety. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, however, were not adequately minimized in the approved centre. Radiators and their associated pipework were not covered and represented a burn hazard as they were very hot to touch. Ligature points had been minimised to the lowest practicable level, based on risk assessment. The approved centre was kept in good state of repair externally and internally on inspection. The approved centre had a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the overall approved centre environment was developed and maintained

with due regard to the safety and well-being of residents, because radiators and associated pipework were not covered and presented a burn hazard, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPRs contained a detailed record of appropriate medication management processes, including the following: a record of any (or no) allergies or sensitivities to medications, a record of medications administered to the resident and the administration route for all medications, clear records of the date of discontinuation for each medication, and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible and contained the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified, and Scheduled 2 and 3 controlled drugs were secured separately from mediations to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in March 2022.

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 policy and procedures in place relating to staffing. The policy was last reviewed in March 2022, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty at all times. The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. There were two dedicated part-time occupational therapists (one whole-time equivalent) and two part-time social workers (two days/week) in the approved centre. The social workers hours increased dependant on the residents' needs. Residents had access to a psychologist, a dietitian, a speech and language therapist (SALT) and a physiotherapist on referral. There was also access to tissue viability staff within the approved centre.

All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. Health care staff were also trained in Basic Life Support, Fire Safety and Children First. All disciplines had up to date training in the Management of Violence and Aggression except for nursing staff. Scheduled training had been postponed due to the COVID-19 pandemic. Documented evidence, including the reason for this postponement had been submitted to the inspection team.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (14)	14	100%	14	100%	8	60%	14	100%	14	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 (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (0)	0	0%	0	0%	0	0%	0	0%	0	0%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

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

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence, and kept in good order with no loose pages.

Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorized access. Documentation of 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 the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures were reviewed within the required three-year time frame, having due regard to any recommendations made by the Inspector or the Commission.

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. The approved centre provided resources and facilities to support residents accessing the Mental Health Tribunals remotely, if 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 policy and procedures in relation to the complaints process. The policy was last reviewed in June 2021, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives in the resident information booklet. Information about the complaints procedure, including how to contact the nominated person, is publicly displayed in the approved centre.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint can be made. There had been no complaints registered in the approved centre since the last inspection.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in April 2022.

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.

During the inspection, radiators and associated pipework were observed to be extremely hot to touch. This represented a health and safety risk to the centre's resident cohort. This risk had not been identified by staff prior to the inspection, and hence was not documented in the risk register.

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

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, 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 non-compliant with this regulation for the following reasons:

a) **Not all health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with the relevant legislation, as the hot radiators and pipework in the approved centre had not been identified as a risk, and they posed a health and safety risk to the residents, 32(1).**
b) **Not all health and safety risks were documented in the risk register as the hot radiator and pipework had not been included on the approved centre's risk register, 32(1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate 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 no conditions to registration attached. 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 clinical file of one resident who was mechanically restrained was reviewed on inspection. Mechanical restraint was undertaken due to the enduring risk of harm to the self or others and was only used to address an identified clinical need. Mechanical restraint was used only when less restrictive alternatives were deemed unsuitable. Mechanical restraint was ordered by a registered medical practitioner under the supervision of the consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf; the form was completed three-monthly.

The clinical file contained a contemporaneous record that 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 to be 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.

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 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 had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, and all other relevant information. A key worker system was in place, full physical examination carried out, and a family member or carer 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 had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, documented communications with the relevant general practitioner, primary care team, or community mental health team (CMHT), a follow-up plan, and reference to early warning signs of relapse and risks. The discharge meeting was attended by the resident or their representative, key worker, and relevant members of the multi-disciplinary team

(MDT). 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 the key worker. The preliminary discharge summary was sent to the general practitioner within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. 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: Corrective and Preventative Action Plan

Regulation 22: Premises					
Reason ID : 10002918		**The registered proprietor did not ensure that the overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, because radiators and associated pipework were not covered and presented a burn hazard, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Funding is secured to cover radiators and associated pipework in all resident access areas in order to prevent a burn risk to residents. This work has commenced and will be completed by October 2022.	Walk through review.	Achievable and realistic.	28/10/2022	Technical services.
Preventative Action	All radiators and associated pipe work in resident access areas will be covered to prevent a risk of burns to residents. A Risk Assessment Form has been completed and will remain open until the	Walk through review.	Achievable and realistic.	28/10/2022	Technical services.

	necessary works are completed.				

Regulation 32: Risk Management Procedures					
Reason ID : 10002921		**Not all health and safety risks were identified, assessed, treated, reported and monitored by the approved centre in accordance with the relevant legislation, as the hot radiators and pipework in the approved centre had not been identified as a risk, and they posed a health and safety risk to the residents, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A Risk Assessment Form has been completed highlighting the risk of burns to residents from hot radiators and the associated pipework. This risk is placed on the units risk register. Funding is secured to cover radiators and associated pipework in all resident access areas. This work will be completed by October 2022	Walk through review.	Achievable and realistic.	28/10/2022	Technical Services.
Preventative Action	All radiators and associated pipework in resident access areas will be covered	Walk through review.	Achievable and realistic.	28/10/2022	Technical services.

	to prevent a risk of burns to residents.				
Reason ID : 10002922		**Not all health and safety risks were documented in the risk register as the hot radiator and pipework had not been included on the approved centre's risk register, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A Risk Assessment Form has been completed highlighting the risk of burns from hot radiators and associated pipework. This risk will remain on the units risk register until remedial works are completed. The necessary works have commenced and will be completed by October 2022.	Walk through review.	Achievable and realistic.	28/10/2022	ADON Technical services.
Preventative Action	All radiators and associated pipework in resident access areas will be covered to prevent a risk of burns to residents	Walk through review.	Achievable and realistic.	28/10/2022	Technical services

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

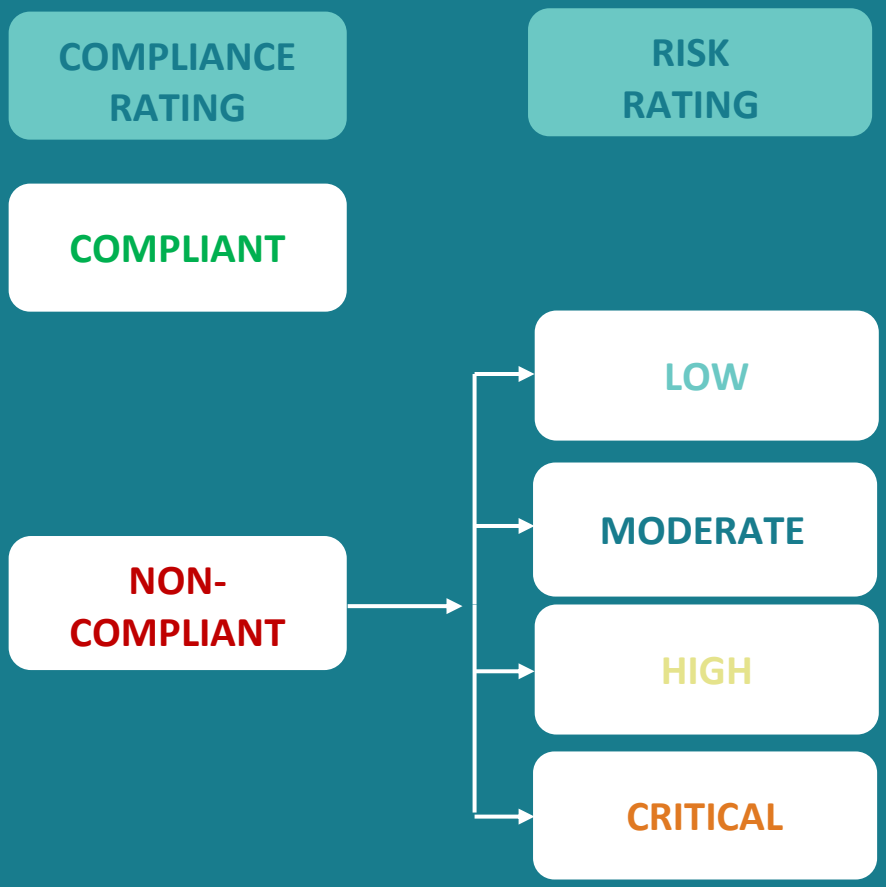
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.