Cois Dalua

Annual Inspection
Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

COIS DALUA

Meelin, Knockduff Upper, Newmarket, Co. Cork

Date of Publication:
1 February 2023

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2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay
Mental health rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
1 June 2021

Registered Proprietor:
Nua Healthcare Services

Registered Proprietor Nominee:
Mr Noel Dunne, Chief Executive

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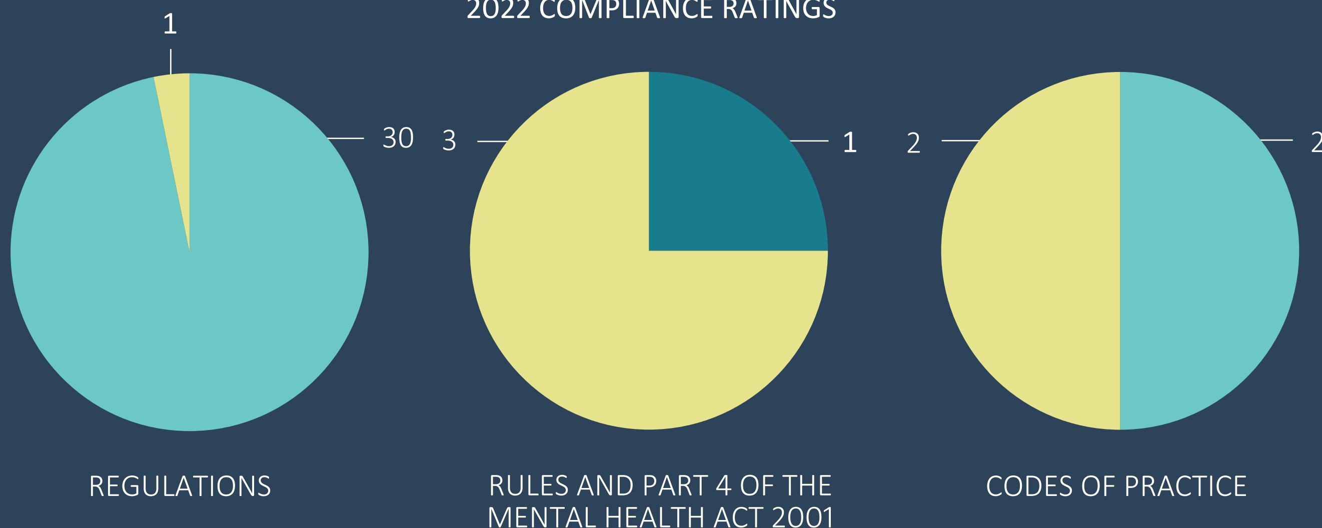
Inspection Date:
5 – 8 July 2022

Previous Inspection date:
7 – 9 September 2021

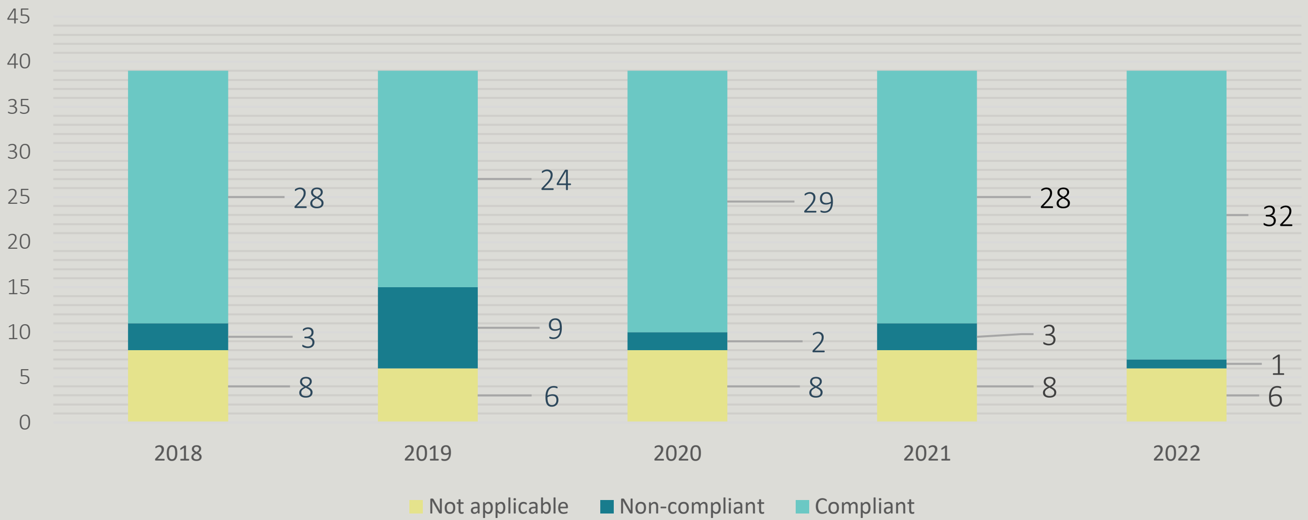
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2018 – 2022

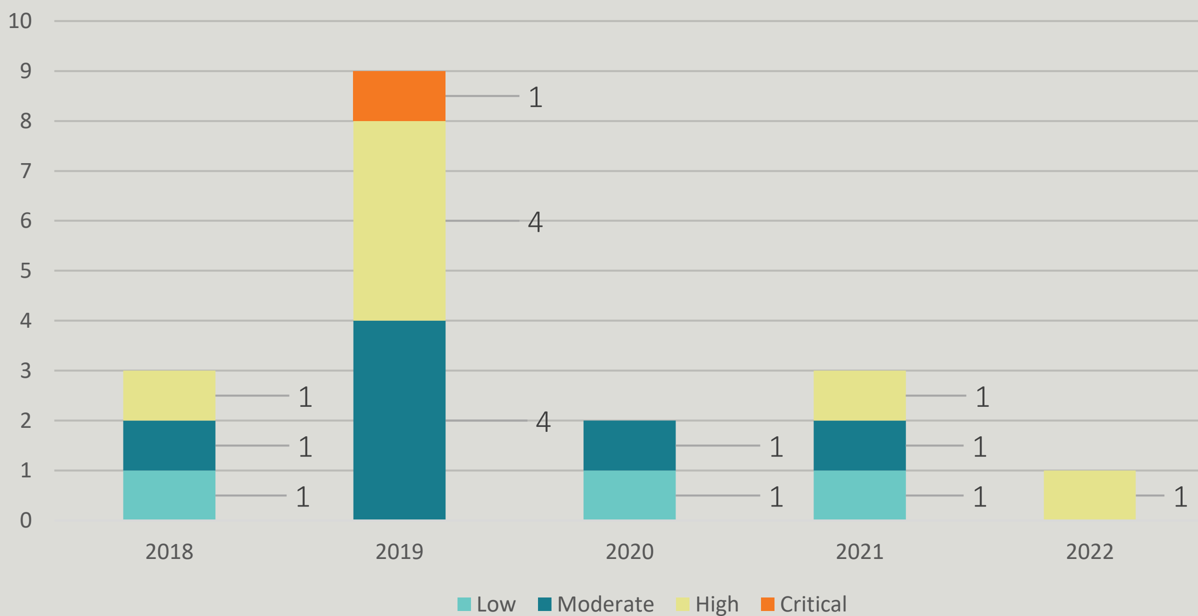
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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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

Cois Dalua was a 16 bed privately operated approved centre run by Nua Healthcare. It was located in Meelin, approximately eight kilometres from Newmarket, Co. Cork. It provided continuing care and rehabilitation. As well as 10 single en suite bedrooms it had 6 self-contained apartments and was under the care of one clinical team.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	90%	73%	94%	90%	97%

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.
- Staff had completed mandatory training.

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 delivered included: Music Therapy, relaxation and gardening groups, access to well-equipped gym, sensory room, and massage available for residents. Groups includes breakfast club, kick start recovery programme, walking groups, music therapy, yoga and psycho-education.
- A behavioural specialist worked one day on site and a dietitian and speech, physio and language therapists were employed within Nua and there was a referral process for residents with identified needs.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents’ privacy, dignity and autonomy

We found that facilities and processes respected residents’ privacy and dignity and that interactions respected residents’ wishes in the following:

- All bedrooms were single rooms with en suite bathroom and toilet.

- 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.
- The Approved Centre had introduced an open-door policy since the last inspection and residents now had free access to the building via keypad operated doors, unless risk assessed unsafe to do so. Residents were provided an information booklet regarding the policy.

Responsiveness to residents' needs

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

- There were TVs, board games, a movie night, and three separate outdoor garden spaces with a swing, badminton and football goal nets. There was also an activity garden for one resident with his own shed for his tools. All residents had a community outing day for themselves once a week.
- 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

There were governance structures and processes in place.

- The approved centre was under Nua Healthcare's overall governance structure.
- There was a weekly governance meeting, which was attended by local and area management and Nua Healthcare's senior management. There was also a quality and safety meeting fortnightly and a monthly clinical governance meeting which took place between senior management, executive management team and the board.
- A local management meeting took place weekly to discuss issues relating to the approved centre. There was also a weekly multi-disciplinary meeting to discuss the residents' care and any relevant clinical information. A service planning meeting took place monthly and was attended by the Multi-Disciplinary Team (MDT), Clinical Director and Director of Nursing or Assistant Director of Nursing. The approved centre had weekly staff meetings chaired by the Director of Nursing.
- The Director of Operations had overall responsibility for risk management; however responsibilities were delegated to the Director of Nursing onsite. Cois Dalua retained a local risk register which

identified current risks. Escalations of risks were referred to the Executive Management Team where appropriate. The centre had an Automated Incident Report System (AIRS) to record accidents, incidents and near miss situations.

- There was a formal system of performance appraisals for staff in the approved centre that was carried out annually or as required. All disciplines were up to date with mandatory training.
- Audits were completed by independent auditors within the Quality and Safety Department every three months. Additional quality audits were carried out processes such as a food safety, complaints, privacy and provision of information.
- Resident community meetings were undertaken monthly and documented. Minor complaints had been dealt with and documented. Formal complaints were dealt with by the designated complaints officer who was not based in the approved centre. Advocacy services were available if a resident required them.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Music Therapy – weekly open group sessions co-facilitated by Music Therapist and Occupational Therapy team.

2. Family peer support group – to support families of service users to enhance their understanding of mental health issues and how they can set boundaries for their own well-being.

3. Creation of mental health factsheets –The aim of the factsheets is to assist family members and friends at better understanding the residents' condition and support them in more adaptive ways.

4. Development of a psychoeducation programme - to address the various needs and difficulties of the residents that are commonly found in schizophrenia to promote insight and awareness into mental illness and mental health needs.

5. Development of visual aids/supports/reminders on residents' noticeboard- the aim is to support resident with memory encoding and to encourage the implementation of new coping strategies and skills.

6. Development of feedback forms for service users and staff members to complete following their engagement in a therapeutic programme and suggestions on how to improve it.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Cois Dalua was a 16 bed privately operated approved centre run by Nua Healthcare. It was located in a small rural village called Meelin, approximately eight kilometres from Newmarket, Co. Cork.

Accommodation consisted of four single en suite bedrooms and four self-contained apartments in the old building. A new extension had a further six en suite bedrooms and two self-contained apartments. The approved centre was located in its own grounds and was surrounded by fencing with a keypad-controlled gate accessible by the residents when required.

Communal areas included a day room, a TV lounge, two dining rooms, indoor gym, a therapy room, a sensory room, and two training kitchens. Outdoor facilities included smoking and garden areas both at the main building and extension, and a sensory garden which could be accessed by all residents. The two sides of the building were separated by an internal door with a keypad-controlled lock.

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**13**
Number of detained patients	0
Number of wards of court	4
Number of children	0
Number of residents in the approved centre for more than 6 months	12
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under Nua Healthcare's overall governance structure. The approved centre had a local weekly governance matrix that included adverse events, near miss situations and any other relevant clinical and operational risks.

The local governance matrix was consolidated into a weekly governance meeting, which was attended by local and area management and Nua Healthcare's senior management. There was also a quality and safety meeting fortnightly that was attended by senior management and executive management team, heads of quality and safety, data protection officer, registration officer, local and area management representatives, and any other relevant disciplines. These meetings had standing agenda items such as reportable incidents, corporate risk register, COVID-19, audits, fire safety and staff retention. Resident admissions, discharges and

transfers were discussed weekly in the national level Admission Transfer Discharge- attended by the admissions, transfers and discharge team and local Clinical Director and Director of Nursing.

There was a monthly clinical governance meeting which took place between senior management, executive management team and the board. The information for this meeting was filtered from the governance and quality and safety meetings that happened weekly and fortnightly.

A local management meeting took place weekly to discuss issues relating to the approved centre. There was also a weekly multi-disciplinary meeting to discuss the residents' care and any relevant clinical information. Each resident's care was reviewed on minimum fortnightly and more often if required. A service planning meeting took place monthly and was attended by the Multi-Disciplinary Team (MDT), Clinical Director and Director of Nursing or Assistant Director of Nursing. The approved centre had weekly staff meetings chaired by the Director of Nursing or Assistant Director of Nursing and Nua Healthcare organised quarterly national staffing meetings to discuss any feedback or queries from staff.

Governance questionnaires were submitted by the CEO (Chief Executive Officer), Clinical Director, Director of Nursing, Assistant Director of Nursing, Director of Operations, Clinical Psychologist, Occupational Therapist and Behavioural Specialist. These indicated that there were clear reporting systems for all disciplines.

The Director of Operations had overall responsibility for risk management; however responsibilities were delegated to the Director of Nursing onsite. Cois Dalua retained a local risk register which identified current risks. This was monitored and reviewed appropriately. Escalations of risks were referred to the Executive Management Team (EMT) where appropriate. The centre had an Automated Incident Report System (AIRS) to record accidents, incidents and near miss situations. The approved centre demonstrated adequate and appropriate processes to identify, assess, treat, and monitor risks. All local and senior management received training in risk management.

There was a formal system of performance appraisals for staff in the approved centre that was carried out annually or as required. Staffing shortages were acknowledged and were mitigated with international recruitment and the use of overtime. All disciplines were up to date with mandatory training.

Audits were completed by independent auditors within the Quality and Safety Department every three months. Additional quality audits were carried out bi-annually for items such as a food safety, Automated External Defibrillator, (AED's) and complaints, and annual audit for areas such as privacy and provision of information.

One apartment was kept empty for the purpose of Covid-Isolation. All staff received infection control and Covid training as part of their induction program.

Resident community meetings were undertaken monthly, and this was documented. The complaints, compliments and feedback arrangements were publicly displayed. Minor complaints had been dealt with and documented. Formal complaints were dealt with by the designated complaints officer who was not based in the approved centre. Advocacy services were available if a resident required them. The Approved Centre had introduced an open-door policy since the last inspection and residents now had free access to the building via keypad operated doors unless risk assessed unsafe to do so and residents were provided an information booklet regarding the policy.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) in these areas between 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	
Rules Governing the Use of Mechanical Means of Bodily Restraint		N/A		N/A		N/A		N/A	X	High

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

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

One resident completed an interview with members of the inspection team and one resident partially completed service user experience questionnaire. Both residents agreed that there were enough activities in the centre. The residents reported that staff were easy to talk to and they were happy with how staff talked to them. The verbal feedback also stated that the resident was involved in their own care planning. In the feedback questionnaire returned, the resident reported feeling safe and that their privacy and dignity were respected. They also felt that they could communicate freely with their family and friends.

The service user experience questionnaire asked those completing to score on a scale of 1 – 10 the overall care and treatment in the approved centre, 1 being poor and 10 being excellent. The one questionnaire returned scored the service 10. The person who gave verbal feedback to the inspectors did not identify any improvements but reported that everything in the approved centre was beautiful.

At the time of the inspection there was no peer advocacy support with the approved centre, but there was an external advocacy service, with a referral process in place for residents who required this service.

5.2 Advocacy

The approved centre had access to advocacy services should an individual require them. 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 Psychologist
- Senior Social Worker
- Occupational Therapist
- Behaviour Specialist
- Clinical Director
- Assistant Director of Nursing
- Area Director of Operations
- Team Lead
- Head of Quality & Safety
- Area Chief Operating Officer
- Director of Services
- Mental Health Act Administrator

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers, appropriate to the resident group profile, and individual resident's needs. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other healthcare 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. Food was cooked in the approved centre daily by catering staff. Food menus showed one option for meals though a second option was available. Residents' food choices were catered for where possible. Most of the residents were long stay resident and catering staff were aware of their food preferences. A source of safe, fresh drinking water was available at all times in easily accessible communal areas 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. Residents had access to a Nua Care dietitian through Microsoft Teams when required.

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 Commwardies 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, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. A stock of new male and female emergency clothing was stored by the approved centre. No residents wore nightclothes during the day at the time of the inspection.

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 written policies and procedures in relation to residents’ personal property and possessions. The policy was last reviewed in July 2020.

The registered proprietor ensured that each resident retained 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.

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.

There were individual lockers located in a secure room for residents to store their monies and valuables. This meant provision was made by the approved centre for the safe-keeping of all residents personal property and possessions.

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 on weekdays and during the week. There was a weekly timetable printed on the noticeboard. All residents had a community outing day for themselves once a week. This allowed the resident to choose which locations they wanted to visit and what activities they wanted to attend to that week.

The approved centre had two large communal living rooms, both with sofas, TV, and board games. There were three separate outdoor garden spaces with a swing, badminton and football goal nets. There was also an activity garden for one resident with his own shed for his tools.

There was a wide variety of activities including Music Therapy, relaxation and gardening groups, access to well-equipped gym, sensory room, and massage available for residents. The Approved Centre had 5 vehicles that staff utilised to take residents out for community visits to local cafes, shops and other locations depending on the residents' preferences.

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 practicable. Residents had access to churches and minister in the local area for religious services following a risk assessment. Residents also had access to services through the radio and television.

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 written policies and procedures in relation to visits. The policy was last reviewed in July 2021. Visiting times were appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The approved centre had a relaxation room where residents could meet their visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The relaxation room 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 July 2021.

At time of inspection, there were no restrictions on communication for any resident. Residents in the approved centre had access to mail, fax, Internet including e-mail, and their own phone and laptop, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health.

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 policies and procedures on the conducting of searches. The policy was last reviewed in July 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 clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff attended at all times during the searches, and due regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both staff members

who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in December 2021. As there had been no resident deaths in the approved centre since the last inspection, this regulation was assessed for compliance against the policy requirements only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

ICPs identified appropriate goals for the residents. The ICP identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICP identified the resources required to provide the care and treatment identified.

All ICPs were reviewed in a timely manner with collaboration with the resident, their family or carer, and the multi-disciplinary team (MDT) of the resident. 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.

There were two full time Occupational Therapists (OT's) on site three days a week. The OTs offered individual and group work. Groups includes breakfast club, kick start recovery programme, walking groups, music therapy, movie night and yoga. Psycho-education was delivered on an individual and group with the individual psycho-education being underpinned by residents' needs – covering topics such as budgeting and public transport.

The social worker (SW) was full time and worked three days in the approved centre. The SW was involved in delivering individual and group work, such as groups mentioned above and also gardening, social farming, and dog walking. The behavioural specialist (BS) worked one day on site and was involved in individual care planning (ICP), weekly sessions and direct sessions with residents, and was mainly involved in incidents or with behavioural challenges. The dietitian and speech, physio and language therapists were employed within Nua and there was a referral process for residents with identified needs.

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 July 2021. 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 detailed letter of referral listing current medications.

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 July 2021. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED), which was kept in the nurses' office. 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. 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. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status-diet and physical activity including sedentary lifestyle, a medication review, 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 to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including breast check, cervical screening, retina check (diabetics only) 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 policy and procedures relating to the provision of information to residents. The policy was last reviewed in July 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 residents' needs.

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, and the complaints procedure. Residents were provided with details of their multi-disciplinary team. The approved centre provided a separate and easy to read residents' rights booklet.

Residents were provided with written and verbal information on diagnosis. 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, and the way in which staff addressed and communicated with residents was respectful. Residents were called by their preferred names. Staff appearance and dress were appropriate. 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, unless there was 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. Residents were facilitated to make private 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

The approved centre was clean, hygienic, and free from offensive odours. Residents had access to personal space and to appropriately sized communal rooms. Residents were either accommodated in single rooms with en suite facility or in one bedroom apartments. There were sufficient toilets and showers for residents in the approved centre. There was suitable and sufficient heating within the approved centre, and it was well ventilated.

The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs.

Hazards were minimised in the approved centre. Ligature points were minimised to the lowest practicable level based on risk assessment. Sufficient indoor and outdoor spaces were provided for residents to move about. Residents in both the main building and the extension had access to well-maintained gardens. Residents also had access to a separate sensory garden. The approved centre provided suitable furnishings to support resident independence and comfort. Current national infection guidelines were followed, with extra precautions taken in line with COVID-19 pandemic guidelines.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in July 2021 and 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. Five MPARs 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 the minimum dose intervals. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible. Medication was reviewed and this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit unless it required refrigeration.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in December 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the use of CCTV. The policy was last reviewed in July 2020. The policy included the purpose and function of using CCTV for observing residents in the approved centre.

There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. The approved centre's use of CCTV was also detailed in the resident information booklet. CCTV cameras used to observe residents were not capable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre's use of CCTV.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

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 staffing policy and procedures in place in relation to the recruitment, selection and Garda vetting requirements. The staffing policy was last reviewed in June 2021.

The number and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times, and this was documented. 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.

All staff were trained in basic life support, fire safety, management of violence and aggression and the Mental Health Act 2001.

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (21)	21	100%	21	100%	21	100%	21	100%
Consultant Psychiatrist (1)	1	100%	1	100%	1	100%	1	100%
Medical (1)	1	100%	1	100%	1	100%	1	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%
Other (38)	38	100%	38	100%	38	100%	38	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 in relation to the maintenance of records. The policy was last reviewed in July 2021. The clinical files of seven residents were inspected in relation to the approved centre's maintenance of records processes. All residents' records were secure, up-to-date, and in good order with no loose pages. All resident records were reflective of the residents' status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented electronic and hard copy 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 requiring a three-yearly review were reviewed appropriately.

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 to support the Mental Health Tribunal process, with a designated Tribunal Room located in the extension area. The approved centre provided adequate resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend a Mental Health Tribunal as required. Resources and facilities were provided by the approved centre to support patients accessing Mental Health Tribunals remotely.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission. This information was available within the resident information booklet. 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 and non-minor complaints were documented in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept separate from the resident’s individual care plan.

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. The policy was last reviewed in December 2021 and addressed all policy related regulatory requirements. 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, corporate and health and safety risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed, or effectively mitigated.

Individual risk assessments were completed during admission and at discharge and in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Requirements for the protection of children 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. The information provided was anonymous at the resident level. There was an emergency plan in place that 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 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 on the entrance hall wall. Where changes had arisen in relation to the information detailed in the certificate of registration, this was communicated to the Mental Health Commission (MHC).

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

NON-COMPLIANT

Risk Rating HIGH

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: Two episodes in total of the mechanical restraint of two different residents under Part 5 of the Rules were reviewed during the inspection process. In both episodes mechanical restraint for enduring risk of harm to self or others was only used to address an identified clinical need, and mechanical restraint was used only when less restrictive alternatives were unsuitable.

The mechanical restraint was not ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on his or her behalf in either of the two mechanical restraint episodes inspected.

The clinical files of the two different residents who received mechanical restraint contained a contemporaneous record of the mechanical restraint episodes. In both episodes of mechanical restraint the contemporaneous record documented that there was an enduring risk of harm to self or others, that less restrictive alternatives were implemented without success. It included the type of mechanical restraint and that mechanical restraint was only to be used when the resident was being transported by car, the situation in which mechanical restraint was being applied and the duration of the order.

The clinical file which contained the contemporaneous record did not specify the duration of the mechanical restraint order and it did not specify the review date in either of the two mechanical restraint episodes inspected.

The approved centre was non-compliant with this rule for the following reasons:

a) **The mechanical restraint was not ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on his or her behalf in two mechanical restraint episodes, 21(3).**

b) **The clinical file which contained the contemporaneous record did not specify the duration of the mechanical restraint order in two mechanical restraint episodes, 21(5)(e).**
c) **The clinical file which contained the contemporaneous record did not specify the review dates of the mechanical restraint order in two mechanical restraint episodes, 21(5)(g).**

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.

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in July 2021**.** The policy covered:

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

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

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

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. Physical restraint was only used in rare and exceptional circumstances when the residents posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of each of the residents. Staff had first considered all other interventions to manage each resident's unsafe behaviour.

Cultural awareness and gender sensitivity were demonstrated in these three separate episodes of physical restraint. Residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered medical practitioner (RMP), and a designated staff member was responsible for leading the physical restraint of each resident and for monitoring the head and airway of each of the residents. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the residents within three hours of the start of each of the three individual episodes of physical restraint.

The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical files. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in each of the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episodes. The residents were afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical files no later than two working days after the episodes.

The approved centre 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 a written policy in relation to admission, transfer, and discharge. The policy was last reviewed in July 2021. The policy 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. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication, and current mental health state. A risk assessment and full physical examination had been completed in all three cases. A key working system was in place for the three residents. With consent, each of the three individual residents' family member was involved in the admission process.

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

Discharge: The clinical file of one resident who had been discharged was inspected. The discharge was co-ordinated by a keyworker. A discharge meeting was held and attended by the resident and their specific key worker, relevant members of the multi-disciplinary team and the resident's family. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was issued to primary care within three days of discharge. A comprehensive discharge summary was issued to relevant health care professionals within 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, and names and

contact details of key people for follow-up. The discharge summary included risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Rules Governing the Use of Mechanical Means of Bodily Restraint					
Reason ID : 10003043	**The mechanical restraint was not ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on his or her behalf in two mechanical restraint episodes, 21(3).**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In response to the non-compliance, a review was completed of Regulation 32 and Regulation 33 Policies. These were updated with a Mechanical Restraint Pathway to ensure there are clear guidelines for the introduction of a planned mechanical restraint. To enable this a mechanical restraint form was implemented to ensure the process was completed in order and reviewed as necessary.	The Mechanical Restraint Pathway Form ensures the introduction of any planned mechanical restraint is reviewed in a timely manner and will be reviewed by the Multi-Disciplinary Team to ensure there is a pathway to the least restrictive method.	The action has been achieved, policy updates and Mechanical Restraint Pathway Form completed, have been reviewed, approved and is in place.	01/08/2022	Clinical Director, Director of Nursing, Quality & Safety Manager
Preventative Action	All actions have been completed, reviewed and approved by the Clinical Director, Director of Nursing	The Mechanical Restraint Pathway Form ensures the introduction of any planned mechanical	The Action has been achieved, policies are updated and the Mechanical Restraint Pathway Form is completed. They have been	01/08/2022	Clinical Director, Director of Nursing, Quality & Safety Manager

	and Quality & Safety Manager.	restraint is reviewed in a timely manner and will be reviewed by the Multi-Disciplinary Team to ensure there is a pathway to the least restrictive method.	reviewed, approved and in place.		
Reason ID : 10003044		**The clinical file which contained the contemporaneous record did not specify the duration of the mechanical restraint order in two mechanical restraint episodes, 21(5)(e).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In response to this non-compliance, a Mechanical Restraint Pathway Form was completed, reviewed, approved and implemented. This will now be used in line with the updated policies for Regulation 32 and Regulation 33. This form clearly shows the duration and the review process.	The Mechanical Restraint Pathway Form ensures the introduction of any planned mechanical restraint identifies the duration and that it is reviewed in a timely manner. This will be reviewed by the Multi-Disciplinary Team to ensure there is a pathway to the least restrictive method.	The action has been achieved, policies have been updated and the Mechanical Restraint Pathway Form is completed. These have been reviewed, approved and in place.	01/08/2022	Clinical Director, Director of Nursing & Quality & Safety Manager
Preventative Action	All actions have been completed, reviewed and approved by the Clinical Director, Director of Nursing & Quality & Safety Manager.	The Mechanical Restraint Pathway Form ensures the introduction of any planned mechanical restraint identifies the duration and that it is reviewed in a	The action has been achieved, the policies are updated, and the Mechanical Restraint Pathway Form is completed. These have been reviewed, approved and are in place.	01/08/2022	Clinical Director, Director of Nursing & Quality & Safety Manager.

		timely manner. It will be reviewed by the Multi-Disciplinary Team to ensure there is a pathway to the least restrictive method.			
Reason ID : 10003045		**The clinical file which contained the contemporaneous record did not specify the review dates of the mechanical restraint order in two mechanical restraint episodes, 21(5)(g).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In response to this non-compliance, a Mechanical Restraint Pathway Form was completed, reviewed and implemented. This will now be used in line with the updated policies for Regulation 32 and Regulation 33. This form clearly shows the duration and the review process.	The Mechanical Restraint Pathway Form ensures the introduction of any planned mechanical restraints identifies the duration and that it is reviewed in a timely manner. This will be reviewed by the Multi-Disciplinary Team to ensure there is a pathway to the least restrictive method.	The action has been achieved, policies are updated and the Mechanical Pathway Form is completed. These have been reviewed, approved and are in place.	01/08/2022	Clinical Director, Director of Nursing and Quality and Safety Manager.
Preventative Action	All actions have been completed, reviewed and approved by the Clinical Director, Director of Nursing and Quality and Safety Manager.	The Mechanical Restraint Pathway Form ensures the introduction of any planned mechanical restraint identifies the duration and that it is reviewed in a timely manner. These	The action has been achieved, policies are updated and the Mechanical Restraint Pathway Form is completed. These have been reviewed, approved and are in place.	01/08/2022	Clinical Director, Director of Nursing and Quality and Safety Manager.

		will be reviewed by the Multi-Disciplinary Team to ensure there is a pathway to the least restrictive method.			

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.

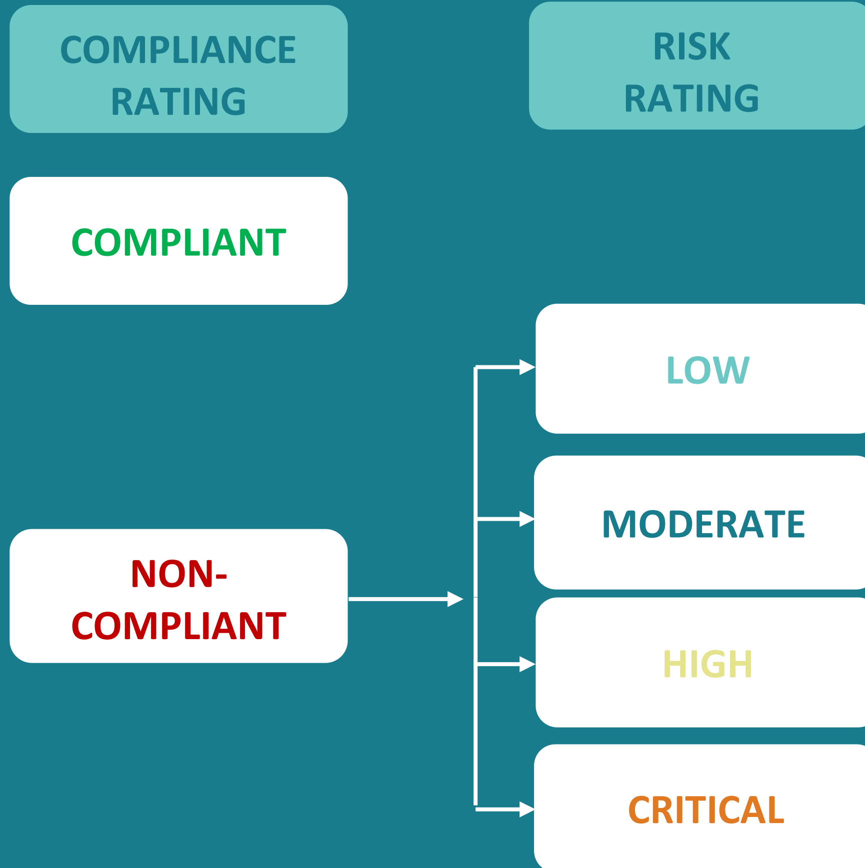
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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