National Eating Disorders Recovery Centre

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mental health commission

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

National Eating Disorders Recovery Centre

62 Merrion Road, Ballsbridge, Dublin 4.

Date of Publication: 17 Feb 2023

ID Number: AC0310

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Other

Conditions Attached:
None

Most Recent Registration Date:
18 June 2021

Registered Proprietor:
Linmore Health Limited

Registered Proprietor Nominee:
Ms Carla Johnson, Director of Services

Inspection Team:
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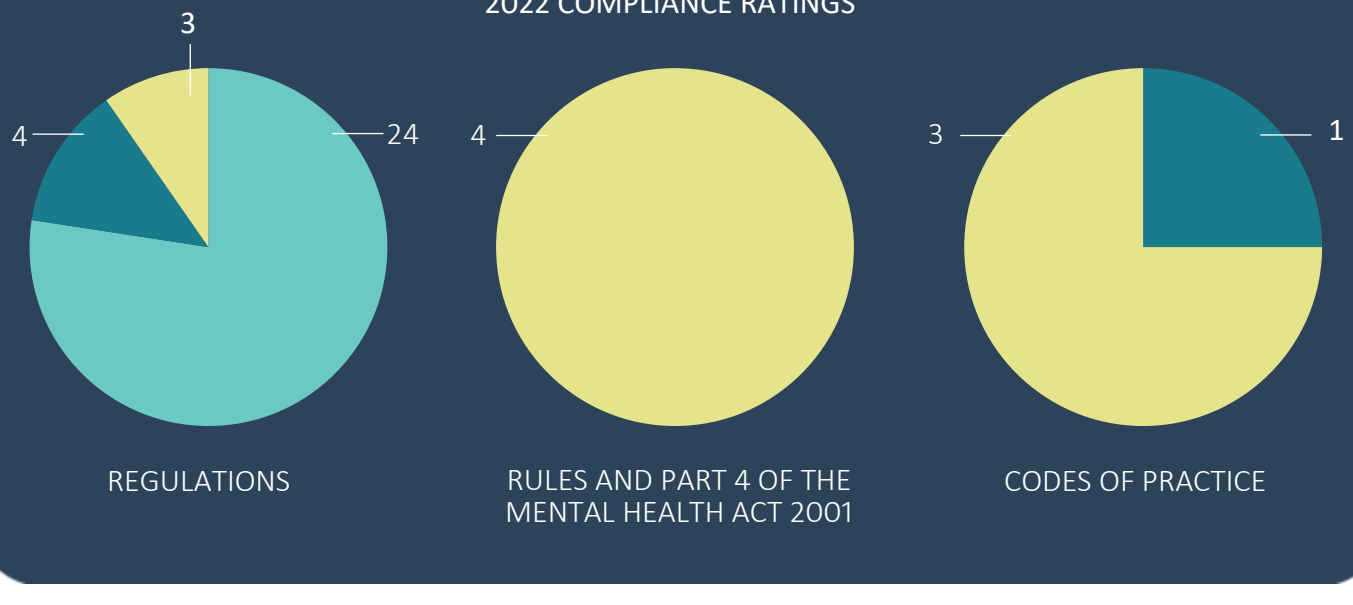
Dr Susan Finnerty MCRN009711

Inspection Date:
19 - 22 July 2022

Previous Inspection date:
09 - 11 November 2021

Inspection Type:
Announced Annual Inspection

2022 COMPLIANCE RATINGS

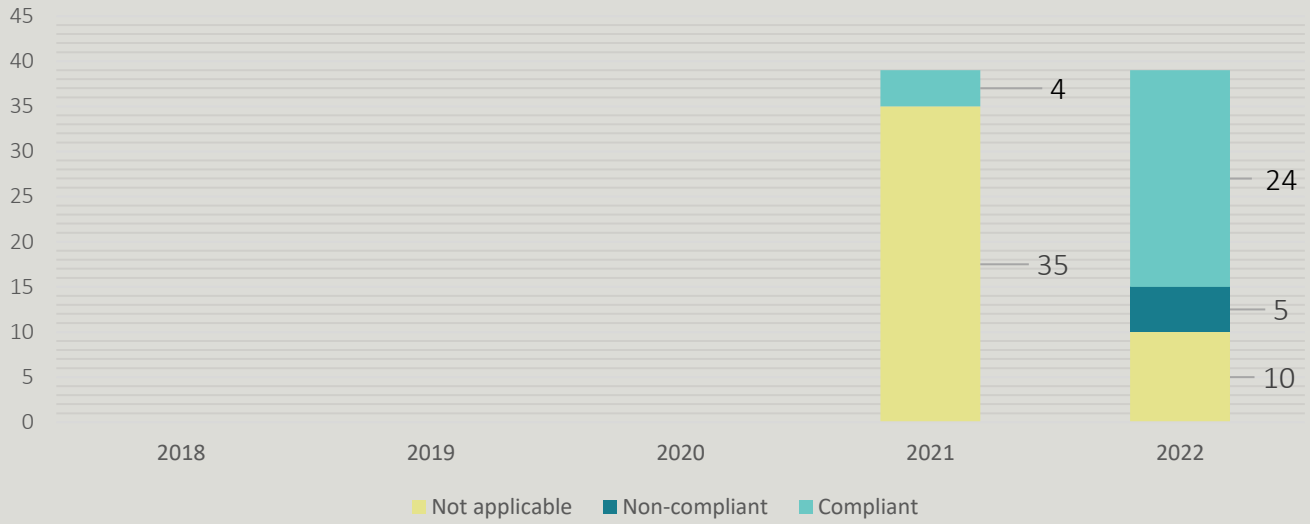


RATINGS SUMMARY 2018 – 2022

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

The approved centre opened in 2021.

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

The approved centre opened in 2021.

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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

National Eating Disorder Recovery Centre was an independent service specialising in the treatment of eating disorders. The inpatient treatment facility was registered for the care and treatment of adults with an eating disorder. The outpatient facility was providing assessment and treatment for both adolescents and adults at the time of inspection.

The centre was non-compliant with Regulation: 26 Staffing and this was rated as a critical risk.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	N/A	N/A	N/A	100%*	83%

*As the approved centre has no residents at the time of the inspection in 2021, only 4 regulations were applicable.

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

Enforcement Action	Date applied	Reasons	Outcome
Immediate Action Notice	27/07/2022	The approved centre was required to take immediate steps to address non-compliance with Regulation 26: Staffing.	The Mental Health Commission continues to engage with the service to monitor compliance with this matter.

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm to the residents in the following areas:

- 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.
- There was a minimisation of ligature points to the lowest practicable level.
- All staff had completed mandatory training.

However:

- The Nurse Staffing Rota indicated that there was not always an appropriate number and mix skill of staff on duty and in charge at all times. On Monday to Friday, night duty in the approved centre consisted of one nurse and one HCA. However, on Saturday and Sunday nights, there was one nurse only on duty.
- A qualified psychiatric nurse was not always on duty in the approved centre as required.
- Medication was not always prescribed or administered in a safe way and there was a potential risk of medication errors.

Appropriate care and treatment of residents

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

- There was a multi-disciplinary team (MLT) within the approved centre which consisted of two Consultant Psychiatrists, two Psychologist, Psychotherapist, Social Worker and Dietitian. There was a pathway for external referrals should residents require services that were not available in the approved centre such as Speech and Language Therapy and Occupational Therapy.
- 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.
- Residents had individual weekly sessions with the different professionals on the MDT and there was a weekly programme for residents with various therapeutic activities including dietetics and nutrition, psychotherapy, culinary skills, art therapy, restorative yoga, and cognitive behavioural therapy.

Respect for residents' privacy, dignity and autonomy

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

- There were 8 single bedrooms. There were two separate shower and toilet facilities located nearby.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

Responsiveness to residents' needs

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

- The approved centre had a residents' recreational diary and activities took place throughout the week. These activities included coffee mornings, yoga, and movie nights. There were outings to the community. The approved centre had a community meeting book where recreational activities and resident wishes were discussed. Board games, books, Lego, and other self-starting activities were also available in the unit.
- 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 choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance, Leadership and Accountability

We found that governance structures were in place.

- The approved centre was owned by a private company. The approved centre management team was composed of the Registered Proprietor (RP), the Clinical Director (CD), and the Director of Services (DOS). At the time of Inspection there was a vacancy for Assistant Director of Services. Management Team Governance meetings were held quarterly.
- A local management meeting and multi-disciplinary meetings took place weekly. There were monthly staff meetings chaired by the Director of Services or Clinical Nursing Manager. There was a formal system for staff supervision in place in the approved centre, that was carried out every six to eight weeks.
- The Director of Services had the overall responsibility for risk management. The National Eating Disorder Recovery Centre retained a local risk register which identified current risks. This was monitored and reviewed appropriately. There was a process in place for consultation with an independent Risk Manager.
- The approved centre had an online system, known as the EpicCare system for the recording of information such as resident information, assessments and individual care plans. Incident reporting was also on this system.
- The approved centre demonstrated adequate and appropriate processes to identify, assess, treat and monitor risk and incidents were reviewed to identify any trends or patterns occurring in the service.
- Residents and their families were encouraged to be involved in the development and review of their individual care plans. Residents in the approved centre were supported to provide service feedback through different pathways including a suggestion box, the complaints process and weekly community meetings which were documented.
- Advocacy services were available if a resident required them.
- Activities to support quality improvement in the approved centre included in-house training, staff supervision and team meeting reviews. The approved centre had recently completed an audit examining the criteria of their admission policy.

However:

- The nominated complaints officer was not included on the public display. Minor complaints had been dealt with and documented.
- At the time of Inspection, the numbers and skill mix of nursing staffing was not sufficient to meet the resident's needs. The Nurse Staffing Rota indicated that there was not always an appropriate number and mix skill of staff on duty and in charge at all times.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

The approved centre had adapted the Therapeutic Services to meet the needs of the residents, with the introduction of Movement Therapy Yoga.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

National Eating Disorder Recovery Centre was an independent therapeutic service specialising in the treatment of eating disorders. The National Eating Disorder Recovery Centre was located on Merrion Road, Ballsbridge, Dublin. It was a large two storey semi-detached house that had been renovated and refurbished for the purpose of providing both an inpatient and outpatient facility. The inpatient treatment facility was registered for the care and treatment of adults with an eating disorder.
The outpatient facility was providing assessment and treatment for both adolescents and adults at the time of inspection.

The approved centre was subdivided into two distinct areas. One had group rooms, consulting rooms, and facilities mainly for an outpatient service. The kitchen and dining facilities for the residential service were also located in this area. There was a nursing office centrally located that was for both the outpatient and inpatient service. The residential area was well proportioned, which encompassed of both living and recreational space on the ground floor, with two large sitting rooms that had been tastefully decorated. There was a quiet room that was also designated as a family visiting room. Located on the first floor of the approved centre was the sleeping accommodation which comprised of single bedrooms with rooms numbered two to eight located. Room eight which was larger in size was identified as the isolation/infection control room if required. There were two separate shower and toilet facilities located on the first-floor landing. A further two bedrooms, a shower room and toilet facilities were located on the second floor but were not commissioned for use at the time of the inspection.

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

Resident Profile	
Number of registered beds	***6***
Total number of residents	**5**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was owned by a private company. The approved centre management team was composed of the Registered Proprietor (RP), the Clinical Director (CD), and the Director of Services (DOS). At the time of Inspection there was a vacancy for Assistant Director of Services.

A local management meeting took place weekly to discuss issues relating to the approved centre that included residents care and treatment, admission and discharge, any risk or incidents identified the previous week, COVID-19, health and safety, and any other relevant clinical and operational matters.

Weekly multi-disciplinary meetings occurred to discuss the residents care and treatment and any relevant clinical information.

The approved centre has monthly staff meetings chaired by the Director of Services or Clinical Nursing Manager.

Management Team Governance Meetings were held quarterly which were attended by the Registered Proprietor, Clinical Director, Director of Services, Clinical Nurse Manager, Consultant Psychiatrist, Psychologists and Dietitian. These meetings had standing agenda items such as reportable incidents, risk register, COVID-19, audits, health and safety, fire safety, staff retention, therapeutic services, shared learning and residents' care.

The Registered Proprietor usually attended the approved centre three to four times a month to meet with the DOS, CD and staff informally. There was a formal system for staff supervision in place in the approved centre, that was carried out every six to eight weeks.

Governance questionnaires were provided to the Clinical Director, Registered Proprietor, Director of Services, Consultant Psychologists, Consultant Psychiatrists, Dietitian and Social Worker. Operational risks outlined in governance questionnaires included lack of administrative staff and nursing staffing shortage.

The Director of Services had the overall responsibility for risk management and was known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. National Eating Disorder Recovery Centre retained a local risk register which identified current risks. This was monitored and reviewed appropriately. There was a process in place for consultation with an independent Risk Manager.

The approved centre had an online system, known as the EpicCare system for the recording of information such as resident information, assessments, and individual care plans. Incidents was one part of the system which included the risk rating of incidents, accidents and near miss situations. The approved centre demonstrated adequate and appropriate processes to identify, assess, treat and monitor risk and incidents were reviewed to identify any trends or patterns occurring in the service. Examples of identified risks for the approved centre were the COVID-19 pandemic, staff leaving the service without notice and health and safety.

At the time of Inspection, the numbers and skill mix of nursing staffing was not sufficient to meet the resident's needs, some staff were registered general nurses. The approved centre had a Nursing Team of nine staff, six registered psychiatric nurses and three registered general nurses. There were two full time Heath Care Assistants (HCA) who worked Monday to Friday and part time HCA who worked the daytime on weekends. Daytime staffing in the approved centre consisted for one nurse and one HCA over seven days. The night-time staffing in the approved centre consisted for one nursing staff and one HCA Monday to Friday.

The night-time staffing on Saturday and Sunday nights consisted of lone working, with one staff nurse on duty. The Nurse Staffing Rota indicated that there was not always an appropriate number and mix skill of staff on duty and in charge at all times. Nursing Rotas from 11 April 2022 to 17 July 2022 indicated there were thirty nights where only a nursing staff member was on duty, with a General Registered Nurse on fifteen of the thirty nights.

There was a multi-disciplinary team within the approved centre which consisted of two Consultant Psychiatrists, two Psychologist, Psychotherapist, Social Worker and Dietitian. There was a pathway for external referrals should residents require services that were not available in the approved centre such as speech and language therapy and Occupational Therapy.

Residents and their families were encouraged to be involved in the development and review of their individual care plans. Residents in the approved centre were supported to provide service feedback through different pathways including a suggestion box, the complaints process and weekly community meetings which were documented. The complaints, compliments and feedback arrangements were publicly displayed; however, the nominated complaints officer was not included on the public display. Minor complaints had been dealt with and documented. Advocacy services were available if a resident required them.

Activities to support quality improvement in the approved centre included in-house training, staff supervision and team meeting reviews. The approved centre had recently completed an audit examining the criteria of their admission policy.

There was a contingency plan in place for the management of COVID-19 with infection prevention control policies and procedures. One bedroom had been identified and allocated for use in the event that a resident was suspected or confirmed COVID-19. This identified room was to remain vacant unless in use for specific infection prevention and control purposes.

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			
		2021		2022
Regulation 15: Individual Care Plans		N/A	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines		N/A	✗	High
Regulation 26: Staffing		N/A	✗	Critical
Regulation 31: Complaints Procedures		N/A	✗	Moderate
Code of Practice: Admission, Transfer, Discharge		N/A	✗	Low

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.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
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 the approved centre did not use physical restraint, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire.
- 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.

None of the residents completed a service user experience questionnaire. Four residents availed of the opportunity to speak with inspection team in person.

The verbal feedback indicated that the residents understood and were involved in their Individual Care Plans (ICP's). Residents stated that they were not offered a copy of their ICPs, however, they did sign them at their MDT meetings. Respondents said that most of the staff were easy to talk with.

Residents stated the food was of a high standard, although on weekends the standard was not always as good. Residents said the dinner choices had improved in the last week, that menus were not discussed at community meetings, and this was something they would like. Three respondents mentioned that meal support was good.

Residents stated that following members of the MDT leaving the service, there was an interruption in the therapeutic programme". Respondents acknowledged it was a challenge getting to know the new therapists in the middle of the twelve-week residential programme. Residents stated the therapeutic groups were more structured at the beginning of their treatment programme.

Residents said they would like a therapy dog in the approved centre.

Respondents stated there was lack of group activities, particularly on weekends.

Residents stated that not all nursing staff in the approved centre were registered psychiatric nurse, that some were registered general nurses.

Residents stated they knew the process for making a complaint, however they did not know who the complaints officer was in the approved centre.

5.2 Advocacy

The approved centre had access to advocacy services should a resident require them although there was no formal advocacy service for the approved centre from Peer Advocacy in Mental Health. The contact information for the Peer Advocacy in Mental Health was displayed publicly and was in the resident information booklet.
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:

- Director of Services
- Clinical Nursing Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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. Each resident had a personalised meal plan based on their specific nutritional needs. Residents had at least two choices for meals. The menus rotated monthly and resident choice was catered for where necessary. 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. Residents were regularly assessed by the approved centre's full-time dietician. The centre used the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) and Malnutrition Universal Screening Tool (MUST) nutritional assessment tools. Residents had access to a Speech and Language Therapist (SALT) by private referral 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 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. 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 October 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe keeping of the resident's monies, valuables, personal property, and possessions, as necessary. Each resident was provided with their own secure locker to store their valuables. Residents were encouraged not to bring unnecessary valuables into the approved centre.

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 recreational activities appropriate to the resident group profile on weekdays and during the weekend. The approved centre had a residents' recreational diary and activities took place throughout the week. These activities included coffee mornings, yoga, and movie nights. There were outings to the community. The approved centre had a community meeting book where recreational activities and resident wishes were discussed. Board games, books, Lego, and other self-starting activities were also available in the unit.

The approved centre was complaint 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. The centre had a contact list of all local religious organisations. Residents were informed on admission of access to religious services and were facilitated to attend whenever they wished to do so.

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 October 2020.

Visits took place daily outside of mealtimes and therapeutic timetable, and visiting times were appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Two rooms were identified where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The two visiting rooms were bright, spacious, and suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in October 2020.

Residents in the approved centre had access to mail, fax, e-mail, Internet, telephone or any device 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 Wi-Fi and were permitted to keep their mobile phones/devices following a risk assessment. 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

COMPLAINT

(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 had an approval date of October 2022, 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 were in attendance 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. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

As there had been no death of a resident in the approved centre since the last inspection, this regulation was assessed on the policy alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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. 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. ICPs identified 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. ICPs were reviewed weekly. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

At the time of inspection, the approved centre operated a dual recording system of both paper copy and a computer filing EpiCare system. The five-paper format ICPs reviewed did not have all the relevant information regarding MDT reviews, goals, resources or treatment; these were recorded separately on and a computer filing EpiCare system. This meant that the ICPs were not a composite set of documents.

The approved centre was not compliant with this regulation for the following reasons:

a) **The approved centre operated a dual recording system of both paper copy and a computer filing EpiCare system. The individual care plans (ICPs) were stored on the dual system which included paper documents and the computer filing system. The paper documents had minimal information on ICPs.**
b) **The EpiCare system contained multi-disciplinary team (MDT) reviews, goals, resources, and treatment. Due to having a dual system in operation this meant that the individual care plans were not a composite set of documents, were not stored in the resident's clinical file, were not identifiable and uninterrupted, and were not clearly differentiated from progress notes.**

c) **The five-paper format ICPs reviewed did not have all the relevant information regarding MDT reviews, goals, resources or treatment.**

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 had a comprehensive multi-disciplinary team (MDT) onsite, including three psychologists (one full-time and two part-time), and two consultant psychiatrists (one full-time and one part-time).

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Residents had individual sessions weekly with the different professionals on the MDT, and there was a weekly programme for residents with various therapeutic activities, including dietetics and nutrition, psychotherapy, culinary skills, art therapy, restorative yoga, and cognitive behavioural therapy.

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. Residents had access to Occupational Therapy via private referral when required.

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 April 2022.

Since there had been no transfers since the last inspection, this regulation was assessed on the policy requirement only.

The approved centre was complaint 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 Responding to a Medical Emergency Policy, which was last reviewed in March 2022. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

There were no residents in the approved centre for more than six months. Residents received appropriate general health care interventions in line with individual care plans. Residents had access to a visiting general practitioner (GP) when required. The approved centre had a full-time dietitian and residents had access to a speech and language therapist (SALT) by referral.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

The approved centre was complaint 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 December 2020.

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 (MDT).

Residents were provided with written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition.

Whenever starting any new medication, medication-related information was discussed with the resident. Any resident questions on already prescribed medication were facilitated in MDT meetings or by the nurses as required. The nurses printed information from medication websites and access to the website information was also discussed with residents so they could access the information themselves. Nurses discussed any side effects, risks, and any other relevant information. 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

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. Each resident had their own bedroom, and residents had access to three large sitting rooms and two relaxation rooms. They also had access to a courtyard garden.

There was suitable and sufficient heating in day areas and bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. 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, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in good a state of repair externally and internally. There was 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 provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. All resident bedrooms were appropriately sized to address the resident needs, and furnished to support resident independence and comfort.

The approved centre was compliant with this regulation.

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

NON-COMPLIANT

Risk Rating HIGH

(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, proscribing, storing and administration of medicine. The policy was last reviewed in March 2022, 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 MPARs contained a record of medication management processes, including the following: a record of any (or no) allergies or sensitivities to medications, clear records of the date of discontinuation for each medication, Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident. All entries in the MPARs were legible.

All the five MPARs inspected did not record a minimal interval for PRN ("pro re nata" or take as required) medications. One of the MPARs inspected was missing one record of a medication administered and did not have a code to indicate a reason for withholding the medication. The same MPAR did not record the route for one regular medication and the dose for one PRN medication.

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. There were no Scheduled 2 and 3 controlled drugs stored in the approved centre at the time of inspection, but a separate locked storage for controlled drugs was available in the clinical office.

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

a) All five of the Medication Prescription and Administration Records reviewed did not record a minimal interval for any PRN (take as required) medications, 23(1).

b) **One of the Medication Prescription and Administration Records reviewed was missing one record of a medication administered, and did not have a code to indicate a reason for withholding the medication, 23(1).**

c) **The same Medication Prescription and Administration Record did not record the route for one regular medication and the dose for one PRN medication, 23(1).**

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 implemented in December 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating CRITICAL

(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 December 2020, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was not sufficient to meet resident needs. not all staff were registered psychiatric nurses. Six held qualifications in psychiatric nursing, and three held qualifications in general and paediatric nursing. This meant that the approved centre did not always have a registered psychiatric nurse on duty.

There was a team of four Health Care Assistants (HCAs) in the approved centre.

An appropriately qualified staff member was always not on duty and in charge, as not all nursing staff were registered psychiatric nurses. On Monday to Friday, night duty in the approved centre consisted of one nurse and one HCA. However, on Saturday and Sunday nights, there was one nurse only on duty. Following the raising of this issue during inspection, the approved centre adopted a policy of having two staff members (one nurse and HCA) on duty on weekend nights.

All healthcare staff were trained in Fire Safety, Basic Life Support, the Management of Violence and Aggression, and 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.

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (9)	9	100%	9	100%	9	100%	9	100%
Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	9	100%
Occupational Therapist (0)	N/A	%	N/A	%	N/A	%	N/A	%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (3)	3	100%	3	100%	100	%	100	%
Other MDT (3)	3	100%	3	100%	3	100%	3	100%

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

a) **The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, as four members of the nursing team had general/paediatric nursing qualifications, but were not qualified in psychiatric nursing, 26(2).**

b) **The registered proprietor did not ensure that there was an appropriately qualified staff member on duty and in charge of the approved centre at all times, as there was one nurse only on duty on Saturday and Sunday nights, 26(3).**

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 March 2022, and included the following:

- 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 health and safety inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All 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 31: Complaints Procedures

NON-COMPLIANT

Risk Rating MODERATE

(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 October 2020, 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 complaint's procedure was provided to residents and their representatives at admission or soon thereafter. The complaints procedure was publicly displayed; however, the current nominated person's name and contact details were not included.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

The registered proprietor ensured that the quality of service, care, and treatment is not adversely affected by reason the complaint being made.

The approved centre was non-compliant with this regulation because the contact details for the nominated complaints manager had not been publicly displayed in the approved centre, 31(3).

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 October 2020, and included:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessment was also

completed prior to and during resident 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. 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. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 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.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating LOW

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 policy in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in April 2022, did not address the following policy-related criteria for this code of practice:

- Policy on privacy, confidentiality, and consent: although consent to treatment is mentioned, there is no clear, comprehensive information on confidentiality or privacy.

Transfer: The transfer policy, which was last reviewed in April 2022, did not address the following policy-related criteria for this code of practice:

- Procedure for involuntary transfer.

Discharge: The discharge policy, which was last reviewed in April 2022, included all of the relevant policy-related criteria for this code of practice.

Training and Education: There was no documentary evidence that all relevant staff had read and understood the admission, transfer, and discharge policies.
Monitoring: The approved centre had been open for under a year, so no annual audits had been completed on the implementation of and adherence to the admission, transfer, and discharge policy.

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/carer was involved in the admission process with the resident's consent.

Transfer: There had been no transfers from the approved centre since the approved centre opened.

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, a follow up plan, reference to early warning signs of relapse/risks, and documented communications with the relevant general practitioner, primary care team, or community mental health team (CMHT). A comprehensive discharge summary letter, discharge planning multi-disciplinary team (MDT) meeting, and discharge recovery plan was recorded and was sent forward to all relevant community health professionals within a reasonable timeframe. These included all relevant medical and physical information, possible risks, recovery plan, and supports for the resident.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the general practitioner, primary care team, or community mental health team 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. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was non-compliant with this code of practice because the registered proprietor did not ensure that all health professionals were familiar with the content of the admission, transfer and discharge policies and did not provide documentary evidence that relevant staff had read and understand the policies, 9.1.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10003064		**The approved centre operated a dual recording system of both paper copy and a computer filing EpiCare system. The individual care plans (ICPs) were stored on the dual system which included paper documents and the computer filing system. The paper documents had minimal information on ICPs.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All ICPs are in paper copy only and are updated in full by one member of the MDT at the MDT meeting on behalf of the rest of the MDT.	ICPs are reviewed on a weekly basis, CNM 3 to oversee this.	Achievable & realistic	11/01/2023	Clinical Nurse Manager 3, Key worker
Preventative Action	ICPs are reviewed on a weekly basis, CNM 3 to oversee this. Quarterly audits of ICP to be carried out.	ICPs are reviewed on a weekly basis, CNM 3 to oversee this.	Achievable & realistic	08/02/2023	Clinical Nurse Manager 3, Key worker
Reason ID : 10003065		**The EpiCare system contained multi-disciplinary team (MDT) reviews, goals, resources, and treatment. Due to having a dual system in operation this meant that the individual care plans were not a composite set of documents, were not stored in the resident's clinical file, were not identifiable and uninterrupted, and were not clearly differentiated from progress notes.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All ICPs are in paper copy only and are updated in full by one member of the MDT at the MDT meeting	Weekly reviews of the ICPs take place. Quarterly audits of ICPs.	Achievable and realistic	11/01/2023	Clinical Nurse Manager 3, Key worker

	on behalf of the rest of the MDT.				
Preventative Action	Weekly reviews of the ICPs take place. Quarterly audits of ICPs.	Weekly reviews of the ICPs take place. Quarterly audits of ICPs.	Achievable and realistic	08/02/2023	Clinical Nurse Manager 3, Key worker
Reason ID : 10003066		**The five-paper format ICPs reviewed did not have all the relevant information regarding MDT reviews, goals, resources or treatment**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All ICPs are in paper copy only and are updated in full by one member of the MDT at the MDT meeting on behalf of the rest of the MDT.	Weekly ICP reviews, Quarterly ICP audits	Achievable and realistic	11/01/2023	Clinical Nurse Manager 3, Key worker
Preventative Action	Weekly ICP reviews, Quarterly ICP audits	Weekly ICP reviews, Quarterly ICP audits	Achievable and realistic	08/02/2023	Clinical Nurse Manager 3, Key worker

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10003068		**All five of the Medication Prescription and Administration Records reviewed did not record a minimal interval for any PRN (take as required) medications, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All kardexs have a minimal interval for any PRN medications prescribed	Weekly review of kardexs Quarterly audits of kardexs	Achievable & realistic	14/12/2022	Clinical Nurse Manager 3
Preventative Action	Weekly review of kardexs Quarterly audits of kardexs	Weekly review of kardexs Quarterly audits of kardexs	Achievable & realistic	08/02/2023	Clinical Nurse Manager 3
Reason ID : 10003069		**One of the Medication Prescription and Administration Records reviewed was missing one record of a medication administered, and did not have a code to indicate a reason for withholding the medication, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All kardexs have been reviewed and ensured that no codes are missing	Weekly review of kardexs Quarterly audits of kardexs	Achievable & realistic	14/12/2022	Clinical Nurse Manager 3
Preventative Action	Weekly review of kardexs Quarterly audits of kardexs	Weekly review of kardexs Quarterly audits of kardexs	Achievable & realistic	08/02/2023	Clinical Nurse Manager 3
Reason ID : 10003070		**The same Medication Prescription and Administration Record did not record the route for one regular medication and the dose for one PRN medication, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All kardexs have a record of route and dose of medication	Weekly review of kardexs Quarterly audits of kardexs	Achievable & realistic	14/12/2022	Clinical Nurse Manager 3

Preventative Action	Weekly review of kardexs Quarterly audits of kardexs	Weekly review of kardexs Quarterly audits of kardexs	Achievable & realistic	08/02/2023	Clinical Nurse Manager 3

Regulation 26: Staffing					
Reason ID : 10003071		**The registered proprietor did not ensure that the numbers of staff and skill mix of staff were appropriate to the assessed needs of residents, as four members of the nursing team had general/paediatric nursing qualifications, but were not qualified in psychiatric nursing, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The proprietor has ensured that psychiatric nurses are on duty at all times in the centre.	Staff rosters and audits of same	Achievable and realistic	14/12/2022	Director of Services
Preventative Action	Staff rosters and audits of same	Staff rosters and audits of same	Achievable and realistic	14/12/2022	Director of Services
Reason ID : 10003072		**The registered proprietor did not ensure that there was an appropriately qualified staff member on duty and in charge of the approved centre at all times, as there was one nurse only on duty on Saturday and Sunday nights, 26(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Proprietor has ensured that a HCA is on duty with the Nurse regardless of minimal numbers of clients in the building at that time.	Staff roster Audits of roster	Achievable & realistic	14/12/2022	Director of Services
Preventative Action	Staff roster Audits of roster	Staff roster Audits of roster	Achievable & realistic	14/12/2022	Director of Services

Regulation 31: Complaints Procedures					
Reason ID : 10003067		**The contact details for the nominated complaints manager had not been publicly displayed in the approved centre, 31(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The details for the nominated complaints manager are displayed publicly in the approved centre.	Spot check of signs in place include contact details of complaints manager	Achievable & realistic	14/12/2022	Clinical Nurse Manager 3
Preventative Action	Spot check of signs in place include contact details of complaints manager	Spot check of signs in place include contact details of complaints manager	Achievable & realistic	11/01/2023	Clinical Nurse Manager 3

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10003063		**The registered proprietor did not ensure that all health professionals were familiar with the content of the admission, transfer and discharge policies and did not provide documentary evidence that relevant staff had read and understand the policies, 9.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Proprietor to ensure that all health professionals have signed that they have read and understood the admission, transfer and discharge policies.	At the end of relevant staff induction, CNM3 to complete paperwork with staff indicating that the content of the admission, transfer and discharge policies have been read, signed and understood.	This is both an achievable and realistic goal that has already been completed when highlighted by the MHC and going forward , the signing of same is included in new staff induction.	14/12/2022	Director of Services/ Clinical Nurse Manager 3
Preventative Action	Review of new staff induction forms by DOS & CNM3 that this is signed.	Audit of new staff induction forms.	Achievable & realistic	14/12/2022	Director of Services/ Clinical Nurse Manager 3

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.

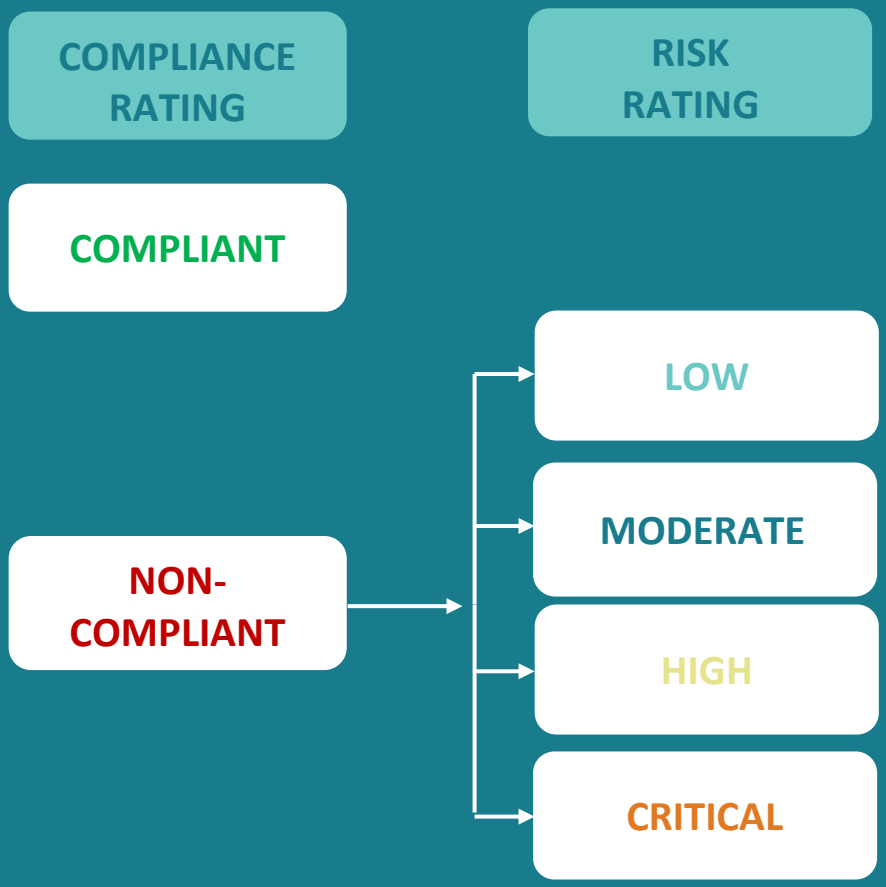
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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