St Patrick's University Hospital

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

ST PATRICK'S UNIVERSITY HOSPITAL

James's Street, Dublin 8

Date of Publication: 3rd April 2023

ID Number: AC0125

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
N/A

Inspection Team:
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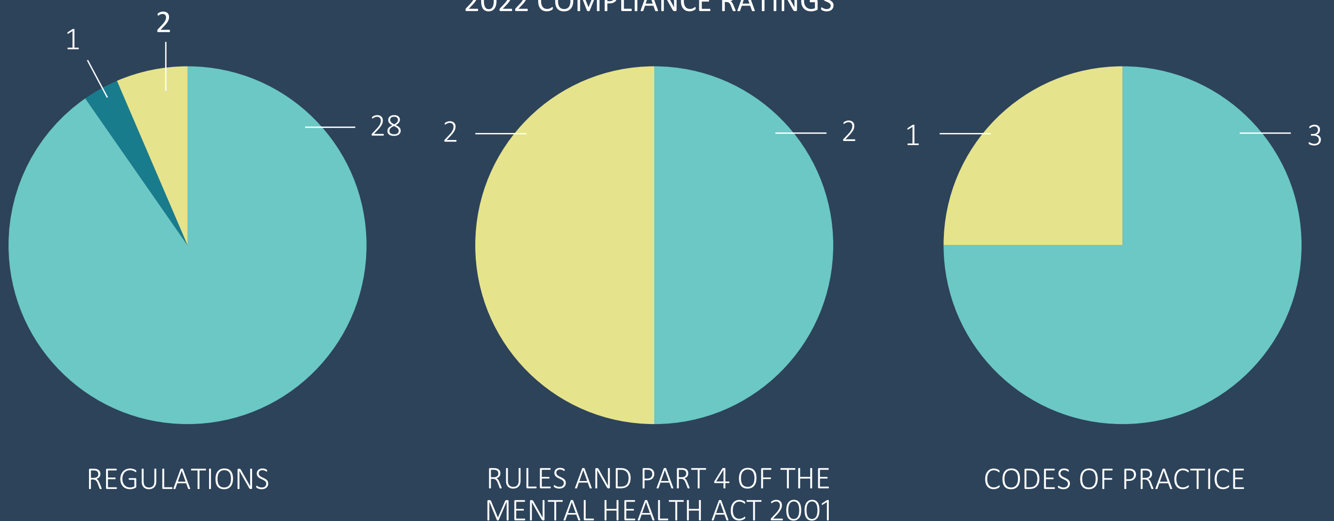
Inspection Date:
13 – 16 September 2022

Previous Inspection date:
24 – 27 August 2021

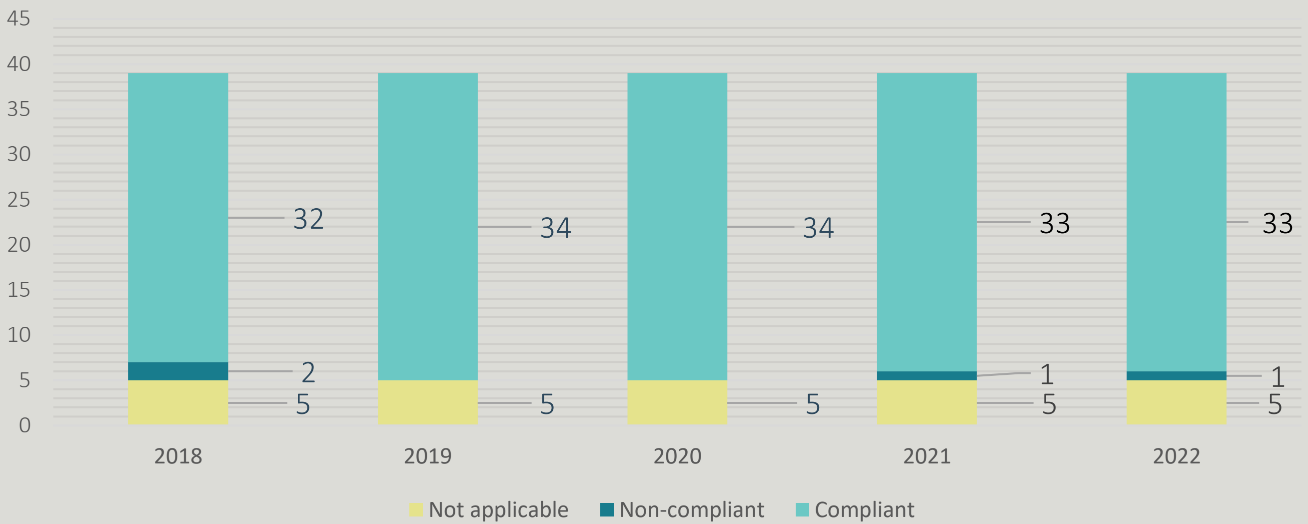
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2018 – 2022

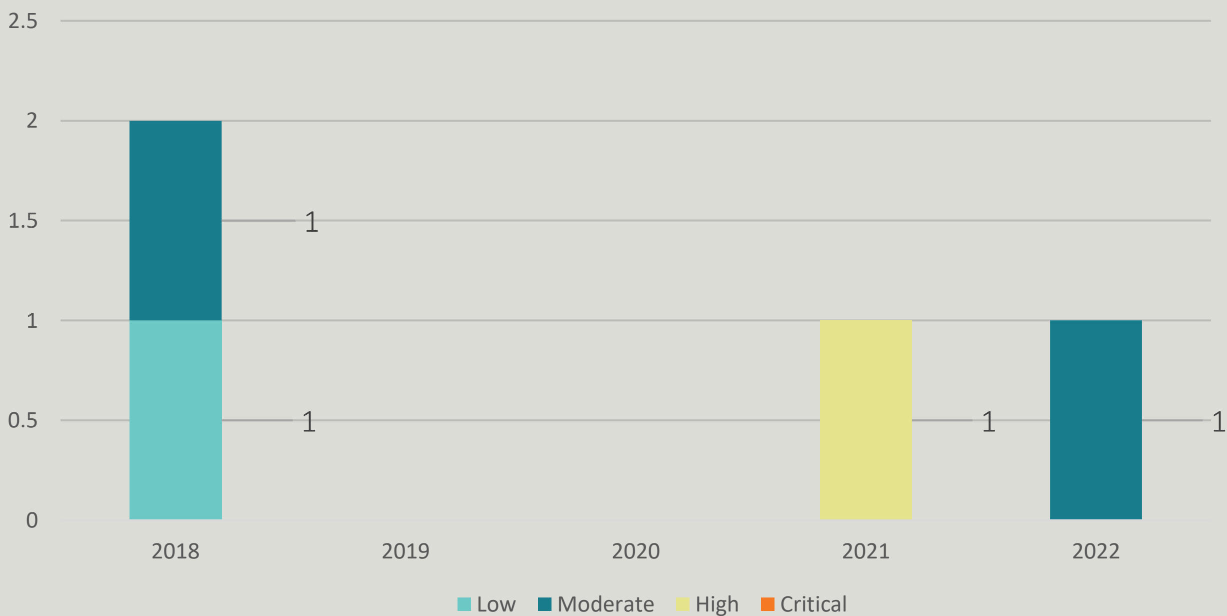
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2018 – 2022



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

The approved centre was an independent hospital and part of the St. Patrick's Mental Health Service (SPMHS) and located on Steeven's Lane in Dublin. The original hospital structure was an 18th century listed building. A variety of extensions had been developed over the years. The approved centre was registered to accommodate 241 residents. The approved centre comprised eight wards with fourteen consultant psychiatrist-led multi-disciplinary teams. There were specialist Eating Disorder team, Psychiatry of Later Life team and Addiction inpatient services as well as acute and general admissions. The approved centre did not admit children.

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

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm to the residents and that effective systems were in place to safeguard patients 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.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, stored and administered in a secure and safe manner.
- All staff had completed mandatory training.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to needs of residents in the following areas:

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The therapeutic programme included in-patient, out-patient, after care and relapse prevention programmes for residents with addiction issues and dual diagnosis of addiction and mental illness. There was a programme for eating disorder recovery and compassion focused therapy for residents diagnosed with an eating disorder. There were education and recovery programmes for people diagnosed with depressive illness, anxiety disorders, psychotic illness, and bipolar disorder. There were a suite of psychological therapies including dialectical behavioural therapy, acceptance and commitment therapy, pathways to wellness, cognitive behavioural therapy and a wellness recovery action planning.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

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

- There were a mix of single room and dormitories in the approved centre.
- 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.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However: Although the approved centre was generally clean and well maintained, at the time of inspection dirty windows and a number of damaged curtains were observed on Delaney Ward and Kilroot Ward.

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 provided access to a wide range of recreational e on weekdays and weekends. These included yoga, Tai Chi Ch'üan, meditation, art, crafts, pottery, music, bingo, mini golf, bingo, quizzes, pool, gardening, relaxation, pet visits, creative writing, board games, books, TV, movies, computer games, and painting. There was also a cafe and a gym for residents.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance, Leadership and Accountability

There were good governance structures and processes in place with an emphasis on service user involvement.

- St. Patrick's University Hospital was part of St. Patrick's Mental Health Services (SPMHS). The hospital was founded in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a Board of Governors consisting of both ex-officio and appointed members.
- The Senior Management Team (SMT) were accountable to the Board of Governors for the operation of the approved centre and a detailed clinical and corporate governance structure was in place.

- There was a clinical governance committee which was held weekly and a risk and safety committee which was held monthly. The clinical governance committee discussed quality indicators and outcome measures, clinical audit and quality improvements, and incidents/near misses.
- There was a very robust risk management process in place The Datix electronic database was used to record and monitor all risks within the approved centre and senior management formally reviewed the risk register every quarter
- The database was linked to the Electronic Health Record (EHR) for each resident and applicable risk information was populated in the relevant section of the resident's clinical file.
- An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre.
- Each head of discipline outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. All disciplines had formal and informal clinical supervision arrangements in place where appropriate. Annual staff training plans were completed to identify and address training needs.
- There was strong service user input to the service for example surveys, focus groups and a consultative forum and a project advisory service user forum. There was service user representation on interview panels for new appointments within the hospital. Community meetings, suggestion boxes, a complaints process, and an independent advocacy service also provided feedback to staff and management about the resident experience of service provision. There was strong emphasis on the experience of service users in academic research undertaken in SPMHS.
- Quality improvement initiatives included the admission pathway project, where end-to-end process mapping was used to ensure a seamless transition from first contact through admission to the appropriate ward. A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a local policy group which provided a multi-disciplinary approach to policy development, review, approval, and dissemination, and all policies were up to date at the time of inspection.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. St. Patrick's Mental Health Services launched a new family webinar series called 'Mental Health Recovery: A Family Perspective.' This was a monthly fourteen-part webinar series, which aimed to provide information for families and carers supporting a loved one with a mental health difficulty.

2. A nursing quality initiative working group was established to focus on activities designed to monitor, analyse, and improve the quality of nursing processes in order to improve the healthcare outcomes in the approved centre.

3. Pre-Admission Medicines Reconciliation: medicine reconciliation was completed for service users with planned admissions before they were admitted, with the aim of reducing medication errors and improving accuracy of prescribing.

4. Additional qualifications were available to enable two experienced pharmacy technicians in the service to carry out the final accuracy check on pre-approved prescriptions that had been clinically reviewed by a pharmacist.

5. The International Dysphagia Diet Standardization Initiative (IDDSI) framework had been implemented within the approved centre to ensure standardization of textured diet recommendations for service users transferring to and from acute hospitals. Training was facilitated with chefs, catering department, and nursing staff on the IDDSI framework.

6. St Patrick's Mental Health Services introduced a falls prevention initiative on Vanessa Ward (Psychiatry for Later Life Unit). The gym instructor used the Otago Exercise Programme to prevent falls in older adults and facilitated a programme including three sessions of resistance/mobility/balance training weekly. Additionally, two occupational therapy groups focusing on falls prevention were provided.

7. The Q Café in the approved centre received the Gold Medal Award. The Gold Medal Awards recognise and reward excellence in hospitality and catering operations across Ireland.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was an independent hospital and part of the St. Patrick's Mental Health Service (SPMHS). It was located on Steeven's Lane in Dublin. The original hospital structure was an 18th century listed building. A variety of extensions had been developed over the years. The approved centre was registered to accommodate 241 residents. The approved centre comprised eight wards: Dean Swift, including Special Care Unit (acute admissions), Stella (general adult-female only), Grattan (general admissions), Delaney (general admissions), Kilroot (general admissions), Vanessa (care of the elderly), Clara (eating disorders), and Temple (addictions service). Fourteen consultant psychiatrist-led multi-disciplinary teams provided care and treatment to residents. The approved centre did not admit children.

Residents had access to a large garden and therapy garden within the approved centre grounds. An art room, craft room, music room, library, pottery room, computer room, gym, information centre, restaurant, and a small shop were available to residents. Also, the approved centre recently opened a coffee shop in the main service user garden called the Well Bean Café. In general, the approved centre was well maintained and in good order throughout. However, two wards in the approved centre had dirty windows and several damaged curtains in bedrooms. From the reception area in the hospital to all the wards, the décor and furnishings provided a respectful and relaxed environment to service users. There was an exhibition space available to residents which provided a new artist's exhibition regularly.

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

Resident Profile	
Number of registered beds	***241***
Total number of residents	**220**
Number of detained patients	7
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	3
Number of patients on Section 26 leave for more than 2 weeks	N/A

3.2 Governance

St. Patrick's University Hospital was part of St. Patrick's Mental Health Services (SPMHS). The hospital was founded in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a Board of Governors consisting of both ex-officio and appointed members. The Senior Management Team (SMT) were accountable to the Board of Governors for the operation of the approved centre. A detailed clinical and corporate governance structure was in place. St. Patrick's University Hospital had

established governance structures in place and a number of senior management meetings took place within the approved centre on a regular basis. The SMT met fortnightly. Issues such as service development, recruitment, serious incidents, occupational health and safety, quality improvement, facilities, finance, and risk management, communications and fundraising, data protection, research and training were discussed at these meetings.

Governance was strengthened by a clinical governance committee which was held weekly and a risk and safety committee which was held monthly. The clinical governance committee discussed quality indicators and outcome measures, clinical audit and quality improvements, and incidents/near misses. The members completed an overview of the serious incidents reported within the approved centres and reviewed any issues identified as part of their risk management strategy. The risk and safety committee meeting discussed incidents/near misses, and risk management processes and review. The sub committees included the clinical finance group, the clinical council group, an infection control committee, a research ethics committee, a falls committee, a drugs and therapeutics committee, an editorial committee, a hospital development committee, and an advocacy sub-group. These met monthly and focused on specific aspects of service governance.

The approved centre had a standardised process for the management of risks and incidents. The person in the approved centre with responsibility for risk management was identified and known by staff. The Datix electronic database was used to record and monitor all risks within the approved centre. The database was linked to the Electronic Health Record (EHR) for each resident and applicable risk information was populated in the relevant section of the resident's clinical file. The risk management process in the approved centre included all categories of risk including business, facilities, health, and safety, financial, operational, compliance, legal and reputational. For each one of these risk areas, each relevant department had developed separate risk registers and maintenance of these registers was the responsibility of the relevant director. The Senior Management Team held overall responsibility for the monitoring and management of risks. Senior management formally reviewed the risk register every quarter and updated the register's content and control measures when necessary. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. The risk of COVID-19 was actively managed through the approved centre's risk management processes. Training in risk management had been provided to staff.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of staff were sufficient to meet the residents' needs. Health and Social care professionals, including medical, nursing, occupational therapy, psychology, social work, physiotherapy, dietetics and speech and language therapy were accessible to all residents. At the time of inspection all disciplines reported that their staffing numbers were currently in accordance with agreed numbers.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, dietetics, and psychology. The inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. All disciplines had formal and informal clinical supervision arrangements in place where appropriate. Annual staff training plans

were completed to identify and address training needs. Operational risks highlighted within these questionnaires included: recruitment and retention of staff, COVID-19 impacts which include the risk of Covid-19 outbreaks, and staff mandatory training. The identified risks were effectively mitigated, escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. A variety of methods were used to engage service users, past and present, in joint consultation of service provision– specifically surveys, focus groups and a consultative forum. Service user input into future developments in SPMHS was also facilitated using these methods and further supported by the project advisory service user forum. There was service user representation on interview panels for new appointments within the hospital. Community meetings, suggestion boxes, a complaints process, and an independent advocacy service also provided feedback to staff and management about the resident experience of service provision. There were clear processes in place to follow up on any issues identified by service users. There was strong emphasis on the experience of service users in academic research undertaken in SPMHS.

Quality improvement initiatives concentrated on the service user; an example being the admission pathway project, where end-to-end process mapping was used to ensure a seamless transition from first contact through admission to the appropriate ward. A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a local policy group which provided a multi-disciplinary approach to policy development, review, approval, and dissemination, and all policies were up to date at the time of inspection.

In response to the COVID-19 pandemic, the service developed and implemented a comprehensive COVID-19 management plan to help prevent the spread of the virus. Operational initiatives focused on maintaining a safe and effective service while observing public health requirements. These initiatives included the conversion of St. Patrick’s Hospital Lucan to a COVID-19 isolation facility, provision of home care packages, including provision of the full therapeutic milieu using on-line resources and the reorganisation of face-to-face therapeutic provision in the context of social distancing needs.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

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

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Restraint	As the approved centre did not use mechanical restraint, this rule 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.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Fifteen service user questionnaires were completed by the residents and returned to the inspection team. No residents requested to speak with the inspection team over the phone.

- Fourteen out of fifteen residents indicated that they had space for privacy and twelve out of fifteen indicated that their privacy and dignity was respected.
- Thirteen residents ticked that they 'always' felt safe in the approved centre, one indicated that they 'sometimes' felt safe and one indicated that they 'never' felt safe in the approved centre.
- Nine residents ticked that they 'always' felt they were able to discuss worries or concerns with staff as soon as they needed to, four indicated that they 'sometimes' could and two indicated that they 'never' could.
- Ten residents felt they were 'always' able to give feedback to staff or to make complaints when they were not satisfied with any part of their stay in the approved centre, three indicated that they 'sometimes' could and two indicated that they 'did not know how to make a complaint.'
- Twelve out of fifteen residents ticked to indicate that on admission to the approved centre a member of staff had explained what was happening in a way that they could understand.
- Eleven residents indicated that they understood their individual care plan, four residents indicated that they did not. Eleven residents indicated that they were 'always' involved in setting goals for their individual care plans, and four indicated that they were 'never' involved.

- Thirteen questionnaires indicated that residents knew who their multi-disciplinary team members were and two indicated they did not. Twelve out of fifteen residents indicated that they knew who their keyworker was.
- Twelve residents felt that there were enough activities during the day and three residents stated they did not.

There was a sense of overall satisfaction with the approved centre. On a scale of 1-10, with 1 being poor and 10 being excellent, residents scored 8 out of 10 for overall care and treatment.

Additional comments received on feedback questionnaires indicated that:

- A resident commented that staff were very pleasant, there was a good atmosphere, and all were very obliging and helpful.
- A resident commented that they felt the approved centre was well looked after but that there were not nearly enough seats for visitors or residents in the garden.
- A resident commented that more activities were needed in the special care unit and Dean Swift Ward.
- A resident commented: I have found my team provide excellent care that is tailored to my individual needs. I feel I can be completely transparent with them and work with them with ease, in particular my counsellor and psychologist.
- A resident commented that staff were approachable, attentive, and accommodating from the offset.
- A resident commented that there was a lack of communication with medical team and their family.
- A resident commented that there was no space for privacy in the bay area of the ward.

5.2 Advocacy

The approved centre had an advocacy service. 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:

- Chief Executive Officer
- Director of Services
- Programme Manager for Clinical Governance
- Clinical Director
- Nurse Practice Development Coordinator
- Head of Occupational Therapy
- Director of Psychology
- Head of Social Work
- Mental Health Act Administrator

Apologies were received on behalf of the Director of Nursing.

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 at least two resident identifiers to ensure that residents were readily identifiable by staff. The identifiers included the resident's name, date of birth, photograph, and medical record number (MRN).

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid.

There was a separate menu for the Eating Disorder Unit and for the rest of the approved centre. The Eating Disorder Unit and the rest of the approved centre had a separate menu for lunch and teas. Residents had two main meal choices and a separate vegetarian option and a choice of sides for each meal. Each meal had a dessert available. The food provided was wholesome and nutritious. A source of safe, fresh drinking water was available at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a series of written policies and procedures which detailed the processes for managing residents' personal property and possessions. *The Processing Service Users Property Policy* was last reviewed in May 2022. 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. The approved centre provided a safe in each resident's wardrobe, and monies and valuables were kept in a secure room.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. These activities included yoga, tai chi, meditation, art, crafts, pottery, music, bingo, mini golf, bingo, quizzes, pool, gardening, relaxation, pet visits, creative writing, board games, books, TV, movies, computer games, and painting. There was also a cafe and a gym for residents.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. There was an oratory on site. There were rooms available on each ward to allow for practicing religion if needed. Multi faith ministers could attend if required.

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 November 2021. Visiting times were appropriate and reasonable. Visits took place in the main hospital between 2-5 and 6-8. Visiting in the main hospital did not require pre-booking. For residents who were on observation level and could not leave the ward, visits had to be pre-booked for hourly visits on the ward. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Residents were facilitated to meet privately with visitors in an internal visiting room and the garden areas were available for visits. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in March 2020. Residents in the approved centre had access to mail, fax, Internet, and telephone for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in March 2020, and included all requirements related to:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

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

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

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

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in August 2021.

The clinical file of one resident who had died suddenly in the approved centre was examined on inspection. The sudden death was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

The therapeutic programme included in-patient, out-patient, after care and relapse prevention programmes for residents with addiction issues and dual diagnosis of addiction and mental illness. There was a programme for eating disorder recovery and compassion focused therapy for residents diagnosed with an eating disorder. There were education and recovery programmes for people diagnosed with depressive illness, anxiety disorders, psychotic illness, and bipolar disorder. There were a suite of psychological therapies including dialectical behavioural therapy, acceptance and commitment therapy, pathways to wellness, cognitive behavioural therapy and a wellness recovery action planning.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in June 2021. The clinical file of one resident who had been transferred from the approved centre in a non-emergency situation was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral, a list of current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in May 2022. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

Three clinical files were examined in relation to the provision of general health services during the inspection process. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. Residents on anti-psychotic medication received an annual assessment of their glucose regulation, blood lipids, electrocardiogram (ECG) heart function, and prolactin.

Residents could access national screening programmes that are available according to age and gender, including breast check, cervical screening, retina check-diabetics only, and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. The heating in bedroom and day areas was suitable and sufficient for residents' comfort and safety.

Appropriate signage and sensory aids were provided to support resident orientation needs. The approved centre had suitable lighting and it was free from offensive odours. Sufficient spaces were provided for residents to move about, including bedroom, communal and outdoor spaces. Hazards were minimized in the approved centre. Ligature points had been minimised to the lowest practicable level, based on risk assessment.

The approved centre had a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Generally, the approved centre was kept in a good state of repair inside and outside. However, at the time of inspection dirty windows and a number of damaged curtains were observed on Delaney Ward and Kilroot Ward.

The approved centre was non-compliant with this regulation due to the following reasons: the registered proprietor did not ensure that the premises were clean and maintained in good decorative condition, due to the following reasons:

a) The registered proprietor did not ensure that the premises were clean and maintained in good decorative condition, as there were dirty windows in two units, 22(1)(a).

b) The registered proprietor did not ensure that the premises were maintained in good decorative condition, as a number of curtains in two units were torn and creased, 22(1)(a).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, prescribing, storing and administration of medicine. The policy was last reviewed in July 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, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any (or no) allergies or sensitivities to medications, a record of medications administered to the resident and the administration route for all medications, clear records of the date of discontinuation for each medication, and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

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

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in July 2022 and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre. An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staff in the approved centre was sufficient to meet resident needs.

All healthcare staff had completed their training in Basic Life Support, Fire Safety, 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.

The following is a table showing the numbers and percentages of staff trained in the four different training topics:

Staff Training Table								
Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (236)	236	100%	236	100%	236	100%	236	100%
Consultant Psychiatrist (14)	14	100%	14	100%	14	100%	14	100%
Medical (22)	22	100%	22	100%	22	100%	22	100%
Occupational Therapist (6)	6	100%	6	100%	6	100%	6	100%

Social Worker (12)	12	100%	12	100%	12	100%	12	100%
Psychologist (32)	32	100%	32	100%	32	100%	32	100%
Other MDT (33)	33	100%	33	100%	33	100%	33	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in July 2022, and included:

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

All residents' health records were electronic and stored on an electronic database. 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. Records were appropriately secured from loss, destruction, tampering, or unauthorised access throughout the approved centre. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. The approved centre provided resources and facilities to support residents accessing the Mental Health Tribunals remotely, if required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in June 2021. It included the process for the management of complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre. There was a nominated individual responsible for dealing with all complaints available in the approved centre.

The complaints procedure and the nominated person’s contact details were publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints were handled promptly, appropriately, and sensitively. The nominated person was based in the approved centre and maintained a record of all minor and formal complaints relating to the approved centre. Residents who had made a complaint were not adversely affected by reason of the complaint having been made.

All complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded- these records were in electronic and hard copy format and were in addition to and distinct from a resident’s individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There was a comprehensive written policy and procedures in relation to risk management and incident management processes. The policy was last reviewed in March 2022. The policy included all of the policy related regulation requirements, including:

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

The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, corporate and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Risk management practices actively reduced identified risks to the lowest level of risk.

Individual risk assessments were completed prior to episodes of physical restraint, electro-convulsive therapy (ECT), and at resident admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points, were effectively mitigated.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated and recorded in a standardised format. All clinical incidents were reviewed.

The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. 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 for public liability, employer's liability, clinical indemnity, and property. There was an indemnity scheme statement available for inspection or on request by the Mental Health Commission.

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 prominently displayed 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)

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in place in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy was last reviewed in February 2022. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice. All staff involved in ECT had appropriate training and education in Basic Life Support techniques.

Evidence of Implementation: There was a dedicated ECT suite in the approved centre. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. A named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one involuntary patient who had received ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in their clinical file. The involuntary patient was deemed unable of consenting to receiving ECT. ECT was administered according to section 59(1)(b) of MHA 2001, as amended. Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent completed by two consultant psychiatrists for each ECT programme. The Form 16 was placed in the patient's clinical file and a copy of the Form 16 was sent to the MHC within five days.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that

proved ineffective before prescribing ECT, the discussion with the patient, and a current mental state examination. Cognitive assessments were completed and recorded by consultant psychiatrists before and after each ECT session. All pre-ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post-ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The signatures of the registered medical practitioners were completed on the ECT record after each ECT treatment and placed in the clinical file.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. It was documented that the responsible consultant psychiatrist had assessed each of the patients' capacity to consent to receive treatment. One patient was found to have capacity to consent to receiving treatment and the other patient was found to be unable to consent treatment.

In relation to the patient who was able to consent to treatment- the written record of consent was reviewed on inspection. The record included the following: medications prescribed, confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medication, details of the discussion with the patient in relation to the nature and purpose of medication and its potential benefits and risks, and any supports provided to the patient in making their decision.

In relation to the patient who was unable to consent to receiving treatment- A Form 17 *Administration of Medicine for More Than 3 Monthly Involuntary Patient (Adult) – Unable to Consent* was completed for the patient who was assessed as not having capacity to consent to treatment. The Form 17 documented: the names of the medications prescribed, a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications, and details of the discussion with the patient, and any supports provided to the patient in relation to the discussion and their decision-making. The form also included approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in January 2022. The policy covered:

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

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

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

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

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

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

The approved centre compliant with this Code of Practice.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in place in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was last reviewed in February 2022. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice. All staff involved in ECT had appropriate training and education in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private and large waiting area, adequately equipped treatment room, and an adequately equipped recovery room. Material and equipment for ECT, including emergency medicines, were in line with best international practice. ECT machines were regularly maintained and serviced. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. A named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed able to consent to receiving ECT. Consent was obtained in writing for each ECT treatment session, including anaesthesia. All consent was obtained by the consultant psychiatrist (CP), or registered medical practitioner (RMP) under supervision of the CP, prior to each ECT treatment session and recorded in clinical file. An ECT treatment pack was contained within the patient's clinical file.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, and a current mental state examination. Cognitive assessments were completed and recorded before and after each ECT session. The process was in line with best international practice by the consultant psychiatrist.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre-ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post-ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT was recorded.

The approved centre was compliant with this Code of Practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in August 2022, included all of the policy-related criteria for this code of practice.

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication, and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the resident's family member was involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged showed a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and the relevant members of the multi-disciplinary team (MDT). The discharge plan included a reference to early warning signs of relapse and risks.

A preliminary discharge summary had been sent to relevant personnel within 3 days, and a comprehensive discharge summary was issued within 14 days. The more detailed summary detailed diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, names, and contact details of key people to follow up. The discharge summary included details of risk issues such as signs of relapse.

The approved centre was compliant with this Code of Practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 22: Premises					
Reason ID : 10003227		**The registered proprietor did not ensure that the premises were clean and maintained in good decorative condition, as there were dirty windows in two units, 22(1)(a)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The windows were cleaned during and after the inspection process	Regular audit and monitoring by facilities staff	There are no barriers to achieving this	11/01/2023	Environmental Services Manager
Preventative Action	Staff from the facilities department will continue to monitor the cleanliness of windows across the approved centre and address any needs identified, There is a quarterly cleaning program in place with our window cleaning company, Grosvenor, which is being enhanced with a power washing procedure of the protective grills that are part of the window mechanism	The facilities department will continue to monitor the cleanliness of the windows and report any issues through line management and take any required remedial actions	There are no barriers to achieving this	11/01/2023	Environmental Services Manager
Reason ID : 10003228		**The registered proprietor did not ensure that the premises were maintained in good decorative condition, as a number of curtains in two units were torn and creased, 22(1)(a)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The curtains were replaced during the week of the inspection	A new process has been established where cleaning staff will complete an environmental assessment of the room/ bay bed area after the service users discharge and any areas that require remediation will be reported	There are no barriers to achieving this	11/01/2023	The Household Department under the guidance of the Contracts Manager

		to the appropriate department			
Preventative Action	A new process has been established where cleaning staff will complete an environmental assessment of the room/ bay bed area after the service users discharge and any areas that require remediation will be reported to the appropriate department	Continuous assessment	There are no barriers to achieving this	11/01/2023	The Household Department under the guidance of the Contracts Manager

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.

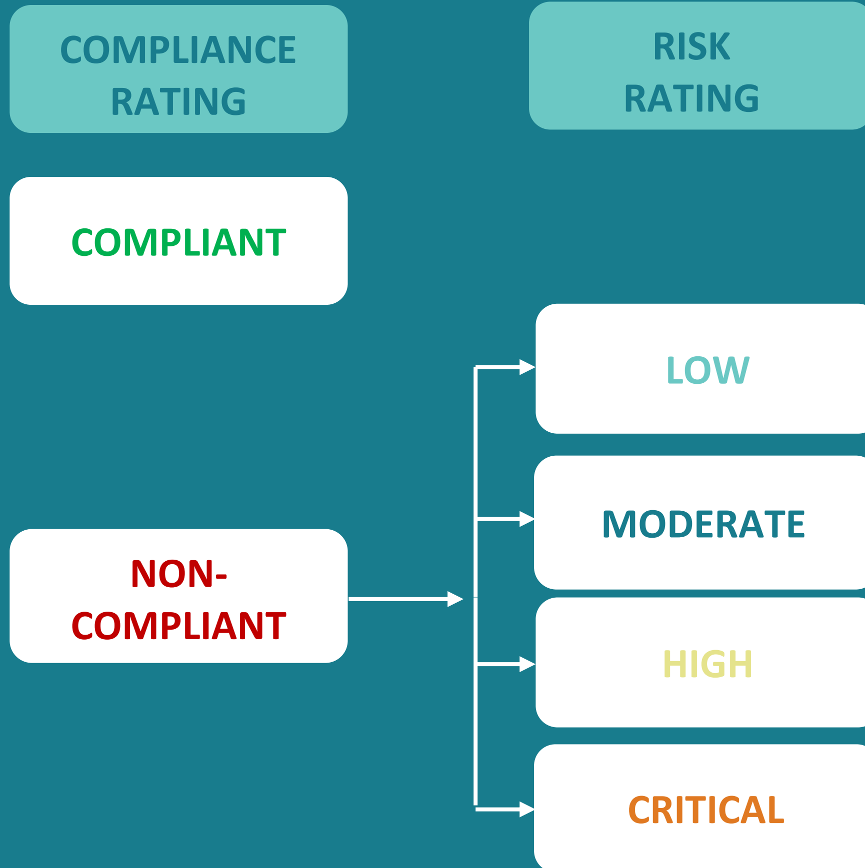
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation, and interview to assess compliance with the requirements.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