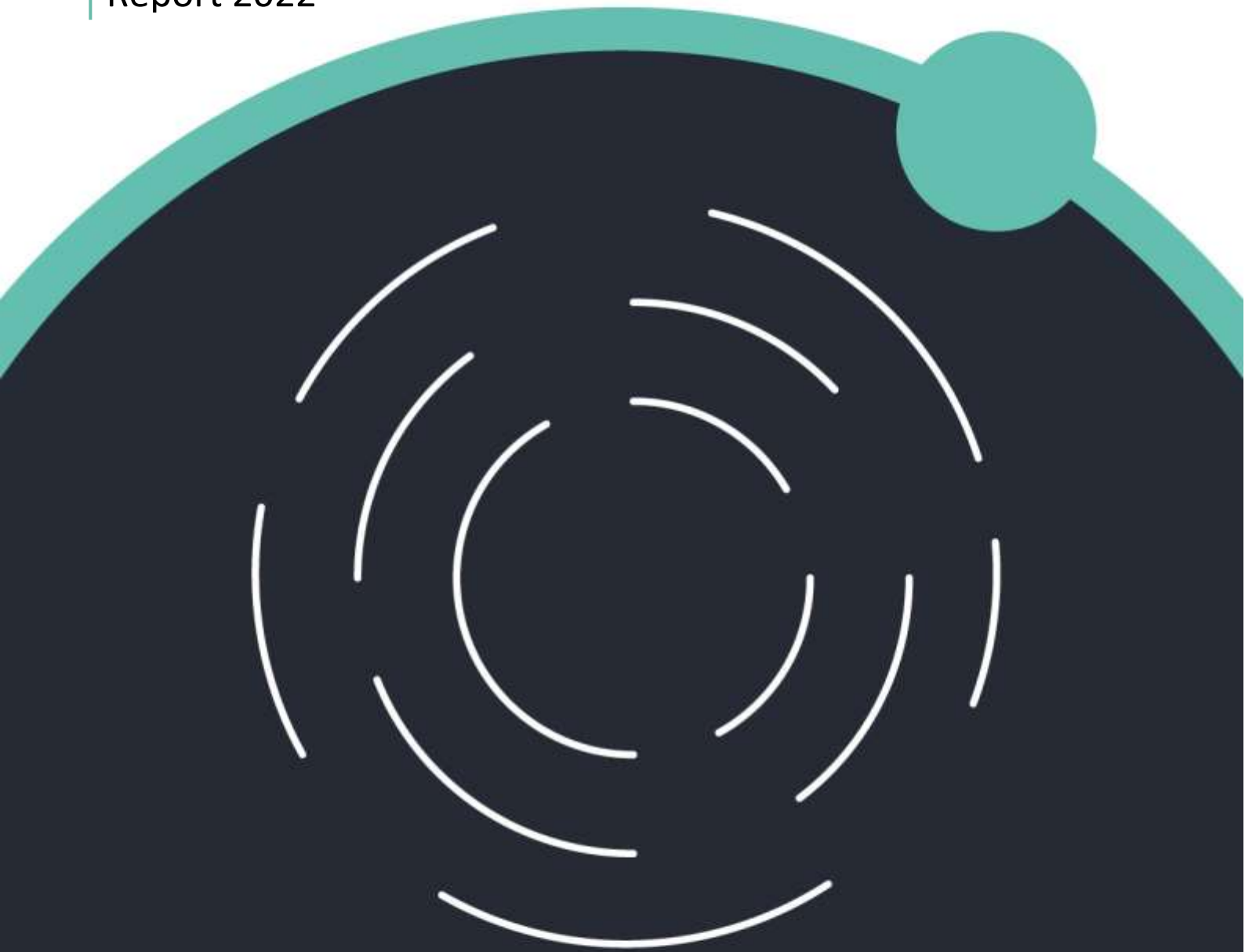
# St Patrick's Hospital, Lucan

Annual Inspection Report 2022



*Promoting Quality, Safety and Human Rights in Mental Health*

# ST PATRICK'S HOSPITAL, LUCAN

Lucan, Dublin

**Date of Publication:** 3rd April 2023

ID Number: AC0127

## 2022 Approved Centre Inspection Report (Mental Health Act 2001)

**Approved Centre Type:**
Acute adult mental health care
Continuing mental health care / long stay
Psychiatry of later life
Mental health rehabilitation

**Conditions Attached:**
None

**Most Recent Registration Date:**
25 May 2022

**Registered Proprietor:**
Mr Paul Gilligan, Chief Executive Officer

**Registered Proprietor Nominee:**
N/A

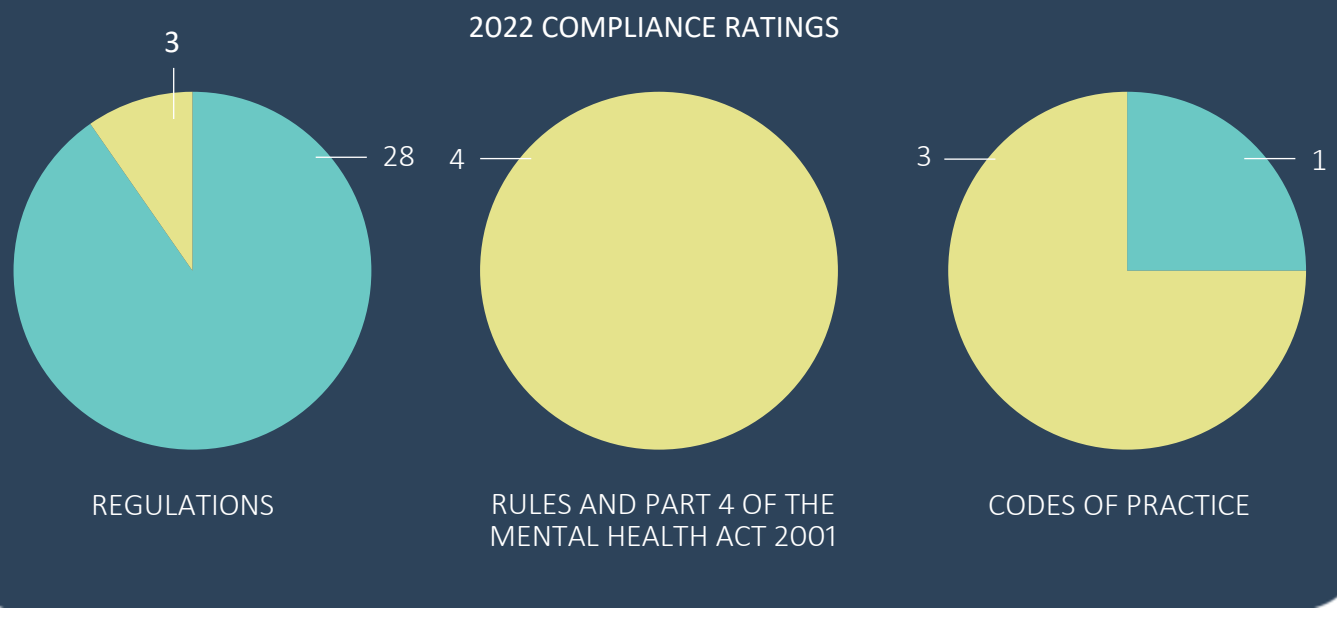
**Inspection Team:**
Megan Barry Sheehy, Lead Inspector
Kirsi Salo
Martin Mc McMenamin

**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Inspection Date:**
4 – 7 September 2022

**Previous Inspection date:**
14 – 17 September 2021

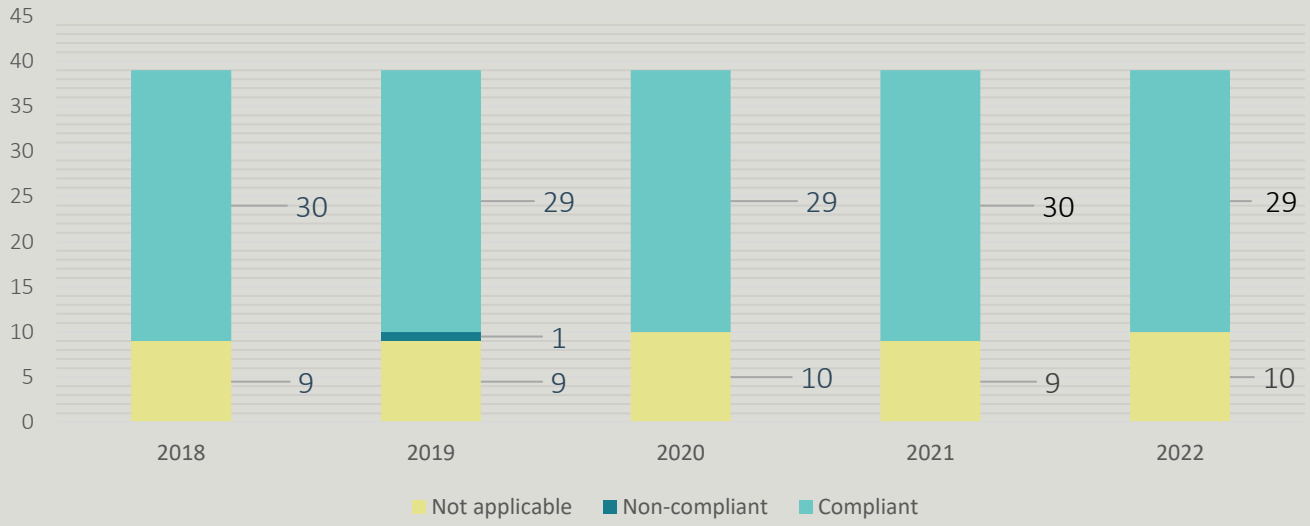
**Inspection Type:**
Announced Annual Inspection



## RATINGS SUMMARY 2018 – 2022

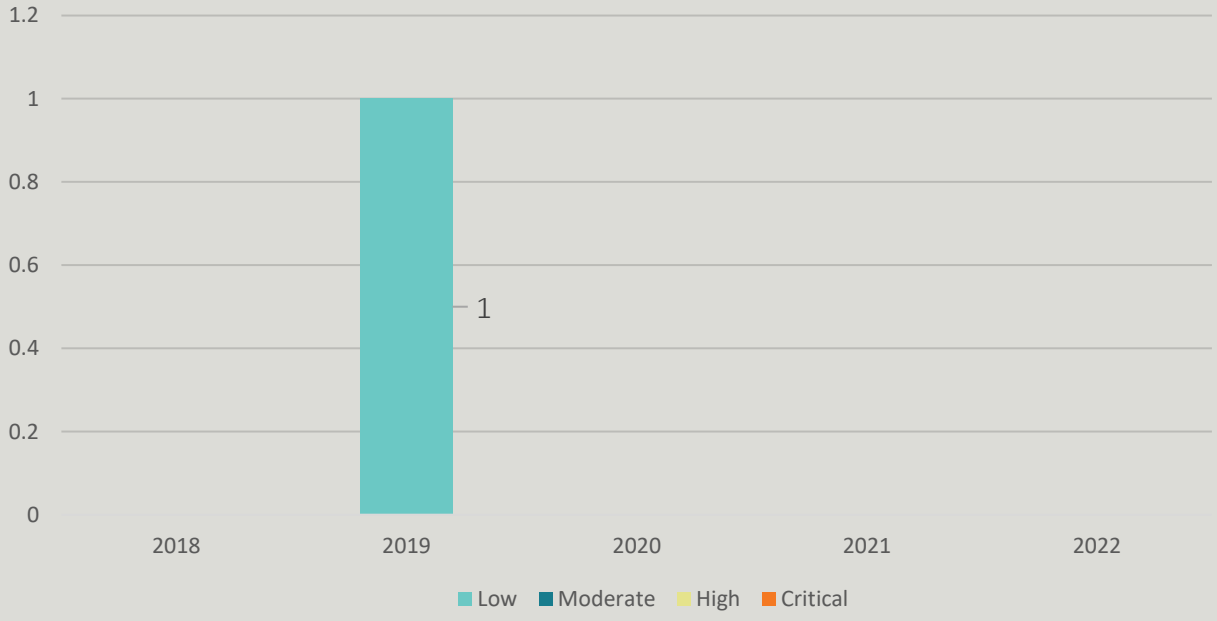
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

### CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022




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

### CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2018 – 2022



# Contents

# 1.0 Inspector of Mental Health Services – Review of Findings

## Inspector of Mental Health Services — Dr Susan Finnerty

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

## In brief

St. Patrick's Hospital Lucan was located within large grounds in Lucan, Co. Dublin. The approved centre was part of St. Patrick's Mental Health Services and shared management structures with this larger service. The approved centre had three consulting psychiatrist each with multi-disciplinary teams. The approved centre was closed to admissions and was providing care to residents from St. Patrick's University Hospital, who were isolating as a result of COVID-19. There were no residents in the approved centre at the time of inspection however, the approved centre had accommodated residents since the last inspection.

| Compliance Summary | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| % Compliance | 100% | 97% | 100% | 100% | 100% |

## Conditions to registration

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

## Ongoing escalation and enforcement actions at time of inspection

None.

## Escalation and enforcement actions commenced following this inspection

None.

## Safety in the approved centre

**We found that the approved centre operated safe practices which reduced risk of harm to the residents and that effective systems were in place to safeguard patients 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.

## 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.
- There was a comprehensive schedule of therapeutic programs available to all residents. The approved centre was used as a COVID-19 isolation site at the time of the inspection. Residents were provided with an electronic tablet and had virtual access to therapeutic programs and to individual meetings with their multi-disciplinary team (MDT).
- The approved centre provided Addiction, Anxiety, Bipolar, Eating Disorders and Depression focused groups. Other therapeutic groups included: Pillars of Wellness, Compassion Focused Therapy, Dialectic Behavioural Therapy, SAGE psychology skills, Radical Openness and Trauma Recovery, Access to Recovery, Acceptance and Commitment to Therapy, Transitions in Recovery, Pathways to Wellness and Psychosis Recovery.

## 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:**

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

## Responsiveness to residents' needs

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

- Residents admitted were provided activity packs containing playing cards, colouring pencils, markers, mindful colouring sheets, crossword puzzles, word search and sudoku puzzles., watercolours and acrylic paints, jigsaw puzzles, 3D puzzles, Airfix kits, Lego kits, knitting/ crocheting materials, could attend and participate virtually to an activity programme which included the following: relaxation, mindful yoga, creative writing, mindfulness, virtual quiz and bingo, loving kindness meditation and yoga nidra.
- 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

**We found robust governance system in place in the approved centre.**

- St. Patrick's Hospital Lucan was part of St. Patrick's Mental Health Services. The approved centre was established in 1746 and was governed by charter through a board of governors. The senior management team (SMT) were accountable to the board for the direct operation of the approved centre.
- A detailed clinical and corporate governance structure was in place. Governance processes made provision for the involvement of service users.
- The senior management team (SMT) met fortnightly and were attended by representatives of various disciplines within the approved centre. The SMT meeting minutes evidenced a robust governance process with outcomes and actions documented.

- The approved centre had a risk manager. The approved centre had a local risk register. There was evidence that the risk register was reviewed and updated at SMT meetings.
- All incidents had been appropriately reported and were reviewed for patterns and trends by the risk manager.
- The process for making a complaint was publicly displayed and available to residents and family members.
- Complaint and suggestion boxes were available in communal areas throughout the approved centre No formal complaints had been made since the previous inspection.
- A representative from Peer Advocacy in Mental Health was available to the residents of the approved centre.

# 2.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

1. Webinars had been provided for families and advocates around information and advocacy for family recovery.

2. The approved centre had completed a medicine reconciliation in advance of planned admission to ensure full information is provided to prescribers.

3. Team Pharmacists had been attending multi-disciplinary team (MDT) meetings to provide advice on optimisation of medication selection.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

St. Patrick's Hospital Lucan was located within large grounds in Lucan, Co. Dublin. The approved centre was part of St. Patrick's Mental Health Services and shared management structures with this larger service. The approved centre had three consulting psychiatrist each with multi-disciplinary teams.

As part of the St. Patrick's Mental Health Services Pandemic Plan, the approved centre was closed to admissions and instead was providing care to residents from St. Patrick's University Hospital, who were isolating as a result of COVID-19. When residents had completed the necessary isolation period they were transferred back to St. Patrick's University Hospital. St. Patrick's Hospital Lucan had provided COVID-19 care in this manner since March 2020 and continued to provide such care at the time of inspection. There were no residents in the approved centre at the time of inspection however, the approved centre did accommodate residents since the last inspection.

The approved centre was a renovated 19th century Georgian house consisting of a basement, ground floor and first floor. The resident areas were on the ground floor. The ground floor consisted of dining room, art room, therapy room, sitting room, and occupational therapy kitchen. Three double bedrooms and forty-six single rooms were available to accommodate residents. All bedrooms had en suite toilet and shower facilities. A large exterior garden and a smaller courtyard garden were available to residents.

Health and social care professionals delivered services to residents by technology mediated interventions (TMI) when residents were isolating. The multi-disciplinary team that admitted the resident to St. Patrick's University Hospital continued to provide their care and treatment when they resident in St Patrick's University Hospital, Lucan.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | ***52*** |
| **Total number of residents** | **0** |
| Number of detained patients | 0 |
| Number of wards of court | 0 |
| Number of children | 0 |
| Number of residents in the approved centre for more than 6 months | 0 |
| Number of patients on Section 26 leave for more than 2 weeks | |

## 3.2 Governance

St. Patrick's Hospital Lucan was part of St. Patrick's Mental Health Services. The approved centre was formed in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a board of governors. The senior management team were accountable to the board for the direct operation of the approved centre. A detailed clinical and corporate governance structure was in place. This provided clarity in relation to areas of responsibility within the approved centre. Governance processes made provision for the involvement of service users and their representatives where appropriate.

The senior management team (SMT) met fortnightly. These meetings were attended by representatives of various disciplines within the approved centre. The minutes from these meetings were provided to the inspection team and outlined an active governance process involving senior management. Issues such as service development, health and safety, facilities, and risk management were discussed at these meetings. There was evidence that the risk register was reviewed and updated at SMT meetings. The SMT meeting minutes evidenced a robust governance process with outcomes and actions documented.

There were key personnel with responsibility for risk management working in the approved centre. The approved centre had a risk manager. The person with overall responsibility for risk was identified and known by staff. The approved centre had a local risk register. The risk register contained health and safety risks, clinical risks, and corporate risks. All incidents had been appropriately reported and were reviewed for patterns and trends by the risk manager.

There was an organisational chart defining key positions and lines of responsibility. The approved centre was adequately staffed. Core staff included nursing staff, psychologists, social workers, occupational therapists, pharmacist, and medical staff. Each head of discipline outlined clear strategic goals for the service and the systems that were in place to monitor goal attainment. Clinical supervision was provided for medical staff and the health and social care professionals.

The process for making a complaint was publicly displayed and available to residents and family members. The details of the complaints officer were displayed in communal spaces throughout the approved centre, in an information booklet in each resident's bedroom and on the approved centre's website. Complaint and suggestion boxes were available in communal areas throughout the approved centre and these were used by residents, families, representatives or advocates. No formal complaints had been made since the previous inspection. Minor complaints were documented with clear actions and outcomes detailed.

A representative from Peer Advocacy in Mental Health was available to the residents of the approved centre.

At the time of inspection, St. Patrick's Hospital Lucan remained a COVID-19 isolation facility to ensure safe and effective services for its residents throughout all of St. Patrick's Mental Health Services. There was no plan at senior management level to review this in 2022. There were no residents at the time of inspection.

## 3.3 Reporting on the National Clinical Guidelines

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

# 4.0 Compliance

## 4.1 Non-compliant areas on this inspection

There were no areas of non-compliance on this inspection. As there were no residents in the approved centre at the time of inspection information was gathered through looking at clinical files retrospectively.

## 4.2 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice | Details |
|---|---|
| Regulation 17: Children's Education | As the approved centre did not admit children, this regulation was not applicable. |
| Regulation 25: Use of Closed Circuit Television | As CCTV was not in use in the approved centre, this regulation was not applicable. |
| Regulation 30: Mental Health Tribunals | As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable. |
| Rules Governing the Use of Electro-Convulsive Therapy | As the approved centre did not provide an ECT service, this rule was not applicable. |
| Rules Governing the Use of Seclusion | As the approved centre did not use seclusion, this rule was not applicable. |
| Rules Governing the Use of Mechanical Means of Bodily Restraint | As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable. |
| Part 4 of the Mental Health Act 2001: Consent to Treatment | As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As the approved centre did not admit children, this code of practice was not applicable. |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients | As the approved centre did not provide an ECT service, this code of practice was not applicable. |
| Code of Practice on the Use of Physical Restraint | As no resident was physically restrained since the last inspection, 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 had changed due to pandemic events and infection control measures. At the time of the inspection there were no residents in the approved centre so no resident feedback was received. It was communicated to the approved centre that the inspectors were open to receiving feedback.

## 5.2 Advocacy

The approved centre had an advocacy service available to the residents. However, no resident had engaged with the service since the last inspection. As a result, 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:

- Executive Clinical Director
- Registered Proprietor
- General Manager
- Area Director of Nursing
- Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker
- Principal Psychologist
- Programme Manager for Clinical Governance
- Clinical Nurse Manager

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

# 7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

## Regulation 4: Identification of Residents

**COMPLIANT**

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

### INSPECTION FINDINGS

There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. The identifiers were checked 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. The chef was on duty at all times and was responsive to emerging needs of the resident population. Residents had at least two choices for meals. A source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre, through water dispensers and bottled water.

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

**The approved centre was compliant with this regulation.**

## Regulation 6: Food Safety

**COMPLIANT**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 7: Clothing

**COMPLIANT**

The registered proprietor shall ensure that:

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

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

### INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and it took account of their preferences, dignity, bodily integrity, and religious and cultural practices. There was a stock of emergency clothing kept in the approved centre.

**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 an operational policy and procedures relating to residents' personal property and possessions, which was last reviewed in September 2019. There were no residents in the approved centre at the time of the inspection. Secure facilities including safes were provided for the safekeeping of residents' monies, valuables, personal property, and possessions, as necessary.

**The approved centre was compliant with this regulation.**

## Regulation 9: Recreational Activities

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre provided access to recreational activities on weekdays and weekends appropriate to the resident group profile. The approved centre was being used as a COVID-19 isolation Unit which meant a structured recreational programme was not possible.

Residents admitted were provided activity packs containing playing cards, colouring pencils, markers, mindful colouring sheets, crossword puzzles, word search and sudoku puzzles. Additionally, where appropriate, watercolours and acrylic paints, jigsaw puzzles, 3D puzzles, Airfix kits, Lego kits, knitting/ crocheting materials, books and portable DVD players and DVDs were provided. Residents had access to TV and to a delivered daily newspaper. Residents could attend and participate virtually to an activity programme which included the following: relaxation, mindful yoga, creative writing, mindfulness, virtual quiz and bingo, loving kindness meditation and yoga nidra. Residents received the virtual program and links via email and were provided with an electronic tablet.

**The approved centre was compliant with this regulation.**

## Regulation 10: Religion

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 11: Visits

**COMPLIANT**

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2021. Visiting times were appropriate and reasonable.

The approved centre had separate visiting areas where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Visiting rooms were appropriate for child visitors, and included children's books and a pop up children's tent.

**The approved centre was compliant with this regulation.**

## Regulation 12: Communication

**COMPLIANT**

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy on service user access to communication facilities was last reviewed in March 2020. Residents had access to postal mail, telephone and Wi-fi enabled internet - unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication 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 operational policy and procedures on the conducting of searches. The policy was last reviewed in March 2020. It included all of the policy regulation requirements including:

- 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.

No searches had taken place since the last inspection and the approved centre was therefore assessed for compliance on the basis of policy alone.

**The approved centre was compliant with this regulation.**

## Regulation 14: Care of the Dying

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

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

No resident had died in the approved centre since the last inspection and the approved centre was therefore assessed for compliance on the basis of policy alone.

**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 -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

Five individual care plans (ICPs) were reviewed on inspection of residents who had been in the approved centre since the last inspection. The approved centre used an electronic eSwift system for all clinical documentation. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. All ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICP was reviewed by the MDT weekly, in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

**The approved centre was compliant with this regulation.**

## Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

There was a comprehensive schedule of therapeutic programs available to all residents. The approved centre was used as a COVID-19 isolation site at the time of the inspection. Residents were provided with an electronic tablet and had virtual access to therapeutic programs and to individual meetings with their multi-disciplinary team (MDT).

The approved centre provided a number of workshops and therapeutic groups- including Addiction, Anxiety, Bipolar, Eating Disorders and Depression focused groups. There was also a wide variety of other therapeutic groups available, including but not limited to- Pillars of Wellness, Compassion focused Therapy, Dialectic Behavioural Therapy, SAGE psychology skills, Radical Openness and Trauma Recovery, Access to Recovery, Acceptance and Commitment to Therapy, Transitions in Recovery, Pathways to Wellness and Psychosis Recovery.

The approved centre had comprehensive multi-disciplinary services available for residents, including occupational therapists, clinical psychologists, social workers, pharmacists, dual diagnosis therapists, cognitive behavioural therapists, addiction therapists, clinical nurse specialists, consultant psychiatrists, family therapists, dieticians and non-consultant hospital doctors.

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 an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in January 2022.

The clinical file of one resident who had been transferred from the approved centre in an emergency situation was examined. Communications between the approved centre and the receiving facility were documented and followed up with a written referral. Full, complete, and relevant written information about the resident was transferred to the receiving hospital when they moved there. The transfer documentation included a letter of referral including a list of current medication, 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 medical emergency policy. The medical emergency policy was last reviewed in January 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to two Automated External Defibrillators, (AEDs). There were no residents in the approved centre at the time of the inspection and no resident had been in the approved centre for more than six months since the last inspection.

**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 two written operational policies and procedures on the provision of information to residents. Each policy was last reviewed in March 2020. The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. It contained details of housekeeping arrangements, including arrangements for personal property and mealtimes, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies, and residents' rights.

Residents were provided with the details of their multi-disciplinary team (MDT). Residents were provided with written and verbal information on their diagnosis unless, in the treating psychiatrist's view, disclosing such information might be damaging to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

**The approved centre was compliant with this regulation.**

## Regulation 21: Privacy

**COMPLIANT**

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

### INSPECTION FINDINGS

All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass.

All bathrooms, showers, and toilets had locks on the inside of the door unless there was an identified risk to a resident. There were three shared double rooms in the approved centre. Two of the rooms were not in use and the third room was for single occupancy only due to COVID-19 precautions. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information.

**The approved centre was compliant with this regulation.**

## Regulation 22: Premises

**COMPLIANT**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre was adequately lit, heated, and ventilated. It was clean, hygienic and free from offensive odours. Appropriate signage and sensory aids were provided to help residents orientation needs. Hazards were minimised. There were enough toilets and showers for residents in the approved centre. Resident bedrooms were appropriately sized. Residents had access to sufficient indoor and outdoor space.

The lighting in the approved centre was sufficiently bright and positioned to facilitate reading and other activities. Ligature points were minimised to the lowest practicable level based on risk assessment. The approved centre was kept in a good state of repair inside and outside. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained.

Suitable furnishings were provided to support resident independence and comfort- there were many large sitting rooms with foyer areas for residents to relax. There was at least one assisted toilet per floor. Assisted devices and equipment were provided to address resident need, when required.

**The approved centre was compliant with this regulation.**

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

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had two written policies and procedures on the ordering, prescribing, storing and administration of medicines. Each policy was last reviewed in July 2022. Combined, the policies included:

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

Five Medication Prescription and Administration Record (MPAR) of residents who were in the approved centre since the last inspection were reviewed. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies, the administration route for the medication, a record of all medications administered to the resident.

The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the electronic signature of the medical practitioner for each entry. All entries in the MPARs were legible. No resident was in the approved centre for over six months.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacy technician who supported the service. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

**The approved centre was compliant with this regulation.**

## Regulation 24: Health and Safety

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety. The policy was last reviewed in 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 staffing policy and procedures in place in relation to the recruitment, selection and Garda vetting requirements. The policy was last reviewed in June 2022.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. All staff were trained in Basic Life Support and Fire Safety, the Management of Violence and Aggression and in the Mental Health Act 2001.The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

| Profession | Basic Life Support | | Fire Safety | | Management Of Violence and Aggression | | Mental Health Act 2001 | |
|---|---|---|---|---|---|---|---|---|
| Nursing (22) | 22 | 100% | 22 | 100% | 22 | 100% | 22 | 100% |
| Consultant Psychiatrist (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| Medical (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| Occupational Therapist (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| Social Worker (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |
| Psychologist (4) | 4 | 100% | 4 | 100% | 4 | 100% | 4 | 100% |
| Other MDT ( Pharmacy 2 and CBT 1 ) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 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 series of written operational policies and procedures in relation to the maintenance of records. One policy was last reviewed in May 2022, two policies were last reviewed in June 2022 and the fourth policy was last reviewed in July 2022.

Resident records were secure, up-to-date, and in good order. All resident records were stored electronically on the eSwift system. Resident records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

**The approved centre was compliant with this regulation.**

## Regulation 28: Register of Residents

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had an 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 requiring a three-yearly review were reviewed appropriately.

**The approved centre was compliant with this regulation.**

## Regulation 31: Complaints Procedures

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in May 2022 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon thereafter. This information was available within the resident information booklet and notice boards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor and formal complaints were documented and details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's ICP.

**The approved centre was compliant with this regulation.**

## Regulation 32: Risk Management Procedures

**COMPLIANT**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

### INSPECTION FINDINGS

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

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

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

The information provided was anonymous at the resident level. There was an emergency plan in place that incorporated evacuation procedures.

**The approved centre was compliant with this regulation.**

## Regulation 33: Insurance

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 34: Certificate of Registration

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

# 8.0 Inspection Findings – Rules

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

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

# 9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

# 10.0 Inspection Findings – Codes of Practice

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

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

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

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

## Admission, Transfer and Discharge

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in August 2022, the transfer policy was last reviewed in February 2022, and the discharge policy was last reviewed in April 2021. All policies combined included all of the policy related criteria of the code of practice.

**Training and Education:** Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

**Evidence of Implementation:**

**Admission:** The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. An admission assessment had been completed. The resident's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, current mental health state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination.

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

**Discharge:** The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge meeting was held and attended by the resident and their key worker, and relevant members of the multi-disciplinary team (MDT). A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, and a comprehensive risk assessment and risk management plan. Family members were not involved in the discharge process as the resident did not want them to be and this was documented in the clinical file.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to relevant healthcare professionals within three days. A comprehensive discharge summary letter was issued within 14 days of discharge. The discharge summary letter included details of

diagnosis, prognosis, medication, mental state at discharge, outstanding health and social issues, follow-up arrangements, and names and contact details of key people for follow-up. The discharge summary included risk issues such as signs of relapse.

**The approved centre was compliant with this code of practice.**

# Appendix 1 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.

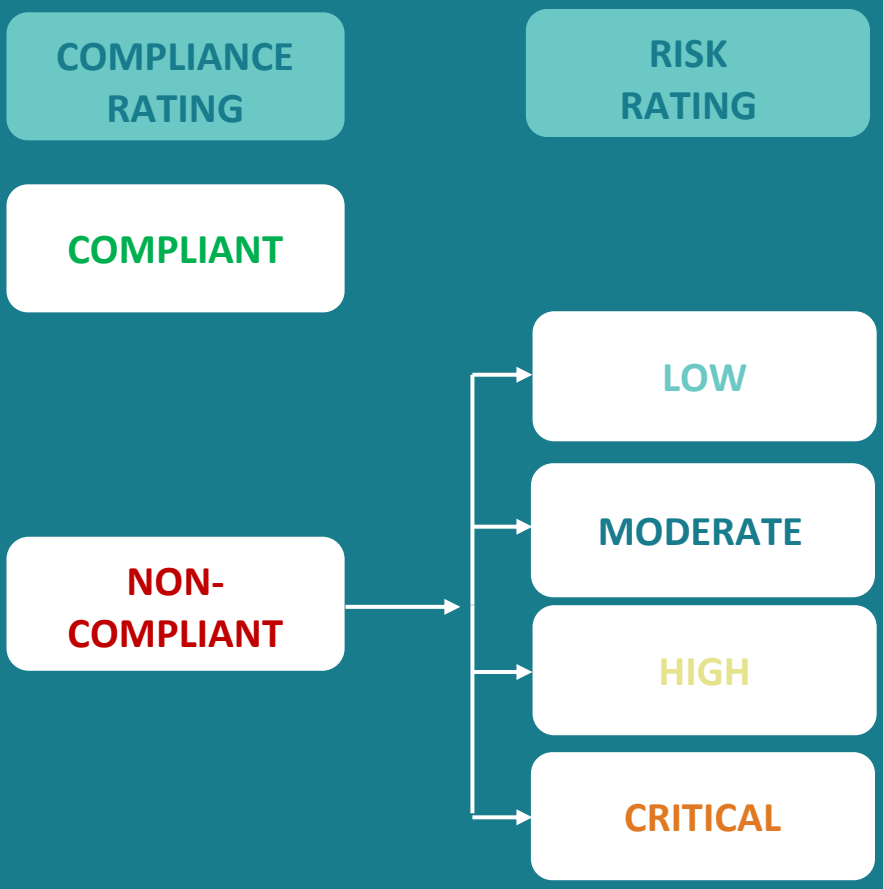
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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