Drogheda Department of Psychiatry

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

DROGHEDA DEPARTMENT OF PSYCHIATRY

Crossland, Drogheda, Co. Louth

Date of Publication: 26th May 2023

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2022 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
1 September 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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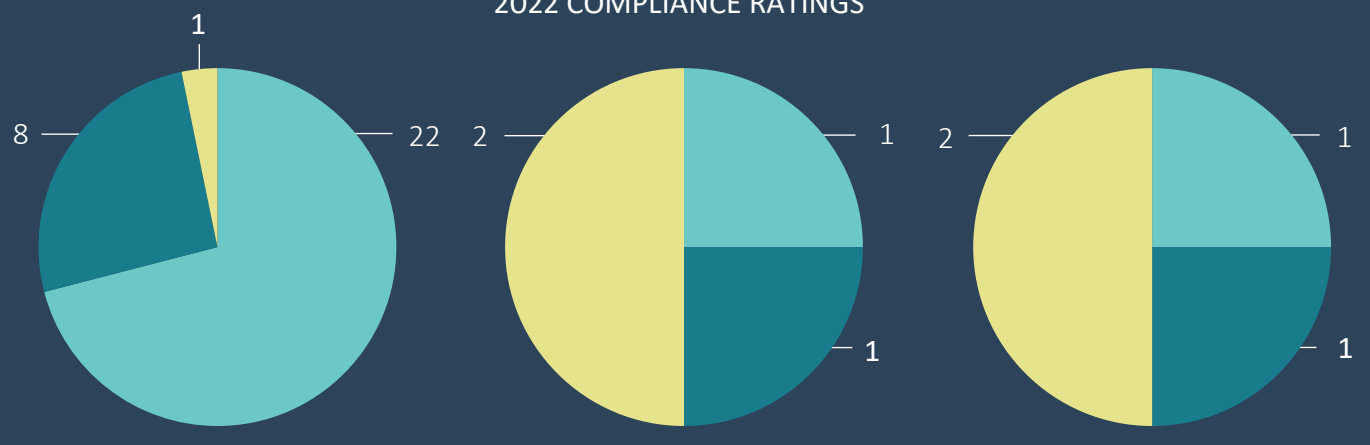
Inspection Date:
15 – 18 November 2022

Previous Inspection date:
12 – 15 October 2021

Inspection Type:
Announced Annual Inspection

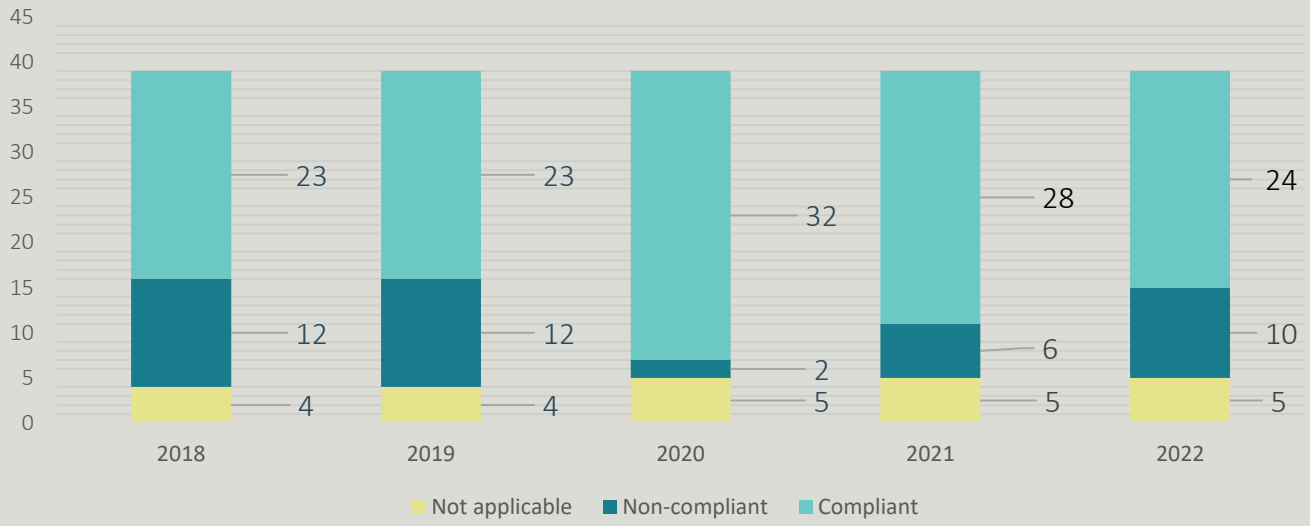
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

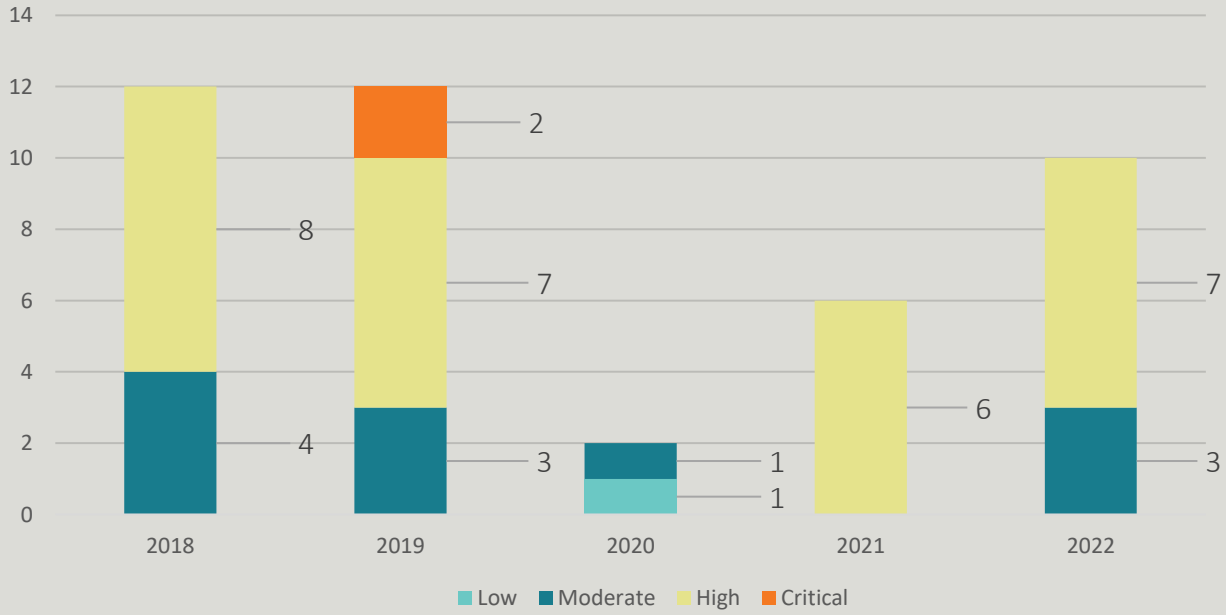
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2018 – 2022



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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 Department of Psychiatry, Drogheda was located at the back of the carpark for Our Lady of Lourdes General Hospital and was a purpose-built standalone structure. The approved centre served the counties of Louth and Meath. The approved centre had 46 beds single en suite bedrooms subdivided into three areas.: Psychiatry of Old Age (POA) ward with 8 beds, a General Adult ward with 34 beds and a High Observation area with 4 beds.

The approved centre was subdivided into two general adult treating teams: Louth and Meath teams and three in-reach Psychiatry of Old Age. At the time of inspection nine residents had resided in the approved centre for a year or longer.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	66%	66%	94%	82%	71%

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *The registered proprietor must implement the safeguarding actions which are described and referred to in the e-mail correspondence and associated attachments, submitted to the Mental*	The approved centre was not in breach of Condition 1.

Health Commission on 22 July 2022. The safeguarding actions must be implemented in accordance with the timeframes submitted to the Mental Health Commission. The registered proprietor shall submit updates in a form and frequency specified by the Mental Health Commission.	

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Regulatory compliance meeting	*07/02/2022*	*Serious Reportable Event was escalated to a regulatory compliance meeting as a result of unsatisfactory plans to mitigate against safeguarding risks in the approved center.*	*Acceptable plans were received at the regulatory compliance meeting and the Mental Health Commission continues to monitor progress of the plan submitted.*

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.
- There was an appropriately qualified staff member on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, stored and administered in a secure and safe manner.

However :

- Mandatory training completion across the clinical disciplines for the Mental Health Act, Basic Life Support, Fire Safety and Prevention and Management of Violence and Aggression (PMVA) was poor.
- In the approved centre, one fire door was missing and a newly replaced fire door was not flush with opposite fire door and therefore was not sealing.

Appropriate care and treatment of residents

We found that staff provided therapeutic service in the following area:

- Therapeutic activities delivered included art therapy group facilitated once a week by a qualified art therapist, a sleep hygiene group facilitated by a social worker and an in-reach occupational therapist (OT), a recovery education group facilitated by an in-reach social worker and peer educators and a horticulture group facilitated by an in-reach OT and horticulturalist for residents of the Psychiatry of Old Age ward only.

However:

- Individual care plans were not of a good standard:
    - Individual care plans for two residents were not in their active clinical file but located in previous volumes of their clinical file.
    - Appropriate goals were not identified in the individual care plans of two residents.
    - The individual care plans for seven residents were not reviewed weekly as required in an acute setting and no reason for less frequent review was documented.
    - The individual care plan was not regularly updated for three residents, as the individual care plan reviews for these residents did not correspond with the goals identified in their care plans.
- There was no therapeutic programme timetable at the time of inspection. There were some individual therapeutic activities at the approved centre but no defined programme that was directed at restoring and maintaining residents' optimal levels of physical and psychosocial functioning.
- There was no dedicated occupational therapist based at the approved centre at the time of inspection. However, residents had access to an OT on an in reach basis from community teams on a one-to-one basis for urgent functional assessments only.
- The monitoring of residents who were more than six months in the approved centre was inadequate.

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:

- All bedrooms were single rooms with en suite bathroom and toilet.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was 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 and residents privacy was respected in the approved centre.

However, a number of walls and floors throughout the approved centre were peeling and damaged by water; four nurse call bells in the High Observation area were damaged; one bedroom door in the High Observation area was damaged; a mirror in an en suite bathroom of the same room was damaged with scratches; as were two windows and one door in the Psychiatry of Old Age unit.

Responsiveness to residents' needs

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

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. There was access to televisions, books, art materials, board games, and a supervised pool table and table tennis table. All wards had access to a garden and outdoor exercise equipment. Recreational activities included word search, relaxation and walks in the garden.
- The information booklet was clearly and simply written. It was recently updated to reflect changes to the services provided at the approved centre.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance, Leadership and Accountability

- The approved centre was part of the Community Healthcare Organization 8 (CHO 8) area, and was governed by the Louth/Meath Mental Health Services (LMMHS). There was a Multi-disciplinary Executive Management Team and a Clinical Governance Committee for LMMHS with responsibility for the approved centre and the wider mental health services in the counties of Louth and Meath. These committees reported to the CHO 8 leadership team which was chaired by the Head of Mental Health Services.
- The approved centre had a Quality and Patient Safety (QPS) committee that met monthly.
  The approved centre inputted all incidents into the National Incident Management System (NIMs). All clinical incidents were reviewed and discussed.
- There was a delayed discharge committee that met monthly. Sixteen residents were in the approved centre for over six months and nine for over a year. This impacted on clinical activity in the approved centre and staff reported difficulties in accessing beds and admission to the approved centre.
- The peer advocacy service facilitated a weekly one-to-one session with residents.
- There were regular resident community meetings and suggestion boxes which encouraged resident input into the service.

However:

- While there was a risk register for the approved centre, it did not document identified risks relating to fire safety and did not identify faulty fire doors as risks and hence did not provide methods of mitigating the risk.
- The risk register did not identify that not all staff had completed Fire Safety training and no fire evacuation drills were completed by the approved centre since the last inspection.
- Information about the local complaints officer and procedure were not provided to residents and their representatives at admission. The phone number and email address provided on the poster for the nominated complaints person were incorrect. Although contact information for the Your Service Your Say was provided in the resident information booklet, it did not detail the local complaints procedure.
- There were ten nursing vacancies, two vacant social worker posts, two vacant occupational therapist posts, and one vacant psychologist post at the approved centre. There was access to the health and social care professionals through the catchment area teams on an in-reach basis.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The introduction of a horticultural group in the psychiatry of old age ward and the provision of raised flower beds for the purpose of this group.
2. Improvement to the resident environments that included the installation of wall mural graphics in resident sitting rooms and activity areas, purchase of new indoor and outdoor furniture, installation of a sky light feature ceiling in the psychiatry of old age ward and the installation of a phone charging station for residents use.
3. Continuing professional development training for staff included sexual health and awareness, venepuncture and ECG training and staff were trained in Sonas therapy which is a therapeutic activity programme for people with dementia that have significant communication difficulties.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry, Drogheda was located at the back of the carpark for Our Lady of Lourdes General Hospital. The approved centre served the counties of Louth and Meath. The Mental Health Service provided a liaison psychiatry service to Our Lady of Lourdes General Hospital on a Monday to Friday, eight hours a day basis. Separately, the approved centre had an assessment unit whereby service users or individuals who were referred were seen.

The approved centre was a purpose-built standalone structure. Accommodation comprised of 46 single en suite bedrooms subdivided into three areas. There was a Psychiatry of Old Age (POA) ward with 8 beds, a General Adult ward with 34 beds and a High Observation area with 4 beds. The High Observation area also had a seclusion suite and a designated chill out room. There was a large external garden surrounding the building and a smaller internal garden, both for resident use with exercise equipment, gardening planters and seating with accessible pathways. There was an occupational therapy kitchen, television lounge, visiting rooms, a quiet room, a games room, a computer hub, a Snoezelen room and dedicated rooms for both team meetings and Mental Health Act Tribunals.

Serving a population in excess of circa 325,000, the service was subdivided by the two counties. There was two general adult treating teams at the approved centre, one associated with county Meath and one associated with county Louth. Additionally, there was three in reach Psychiatry of Old Age team that managed the inpatient care of older adults admitted to the approved centre. At the time of inspection nine residents had resided in the approved centre for a year or longer.

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

Resident Profile	
Number of registered beds	***46***
Total number of residents	**44**
Number of detained patients	9
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	16
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of the Community Healthcare Organization 8 (CHO 8) area, and was governed by the Louth/Meath Mental Health Services (LMMHS). There was a Multi-disciplinary Executive Management Team (MEMT) and a Clinical Governance Committee for the Louth Meath Mental Health Service (LMMHS) with responsibility for the approved centre and the wider mental health services in the counties of Louth and Meath. These committees reported to the CHO 8 leadership team which was chaired by the Head of Mental Health Services. There was an organizational chart outlining the management and reporting structure within the approved centre and the wider service.

The approved centre had a Quality and Patient Safety (QPS) committee that met monthly. Agenda items included Safeguarding, COVID-19, Health and Safety, Incident Reporting, Audits and Best Practice, Risk Management and the Risk Register, Service User Experience and Compliance and Site Safety Management. The approved centre inputs all incidents into the National Incident Management System (NIMs). All clinical incidents were reviewed and discussed.

However, the risk register for the approved centre reviewed by the inspection team did not document identified risks relating to fire safety and the risk register did not identify faulty fire doors as risks and hence did not provide methods of mitigating the risk of faulty fire doors or a process of rectifying the risk.
The risk register did not identify that not all staff had completed Fire Safety training and no fire evacuation drills were completed by the approved centre since the last inspection.

Mandatory training across the clinical disciplines for the Mental Health Act, Basic Life Support, Fire Safety and Prevention and Management of Violence and Aggression (PMVA) was not up to date.

Inpatient care provided in the approved centre was under the management of two inpatient adult consultant led psychiatry teams and three in reach consultant led psychiatry of old age teams. Clinical staff at the approved centre included two (agency) social workers, two pharmacists and a pharmacy technician, two full-time consultant psychiatrists, three NCHD and seventy-nine nursing staff. There was always a Non-Consultant Hospital Doctor (NCHD) on duty. Part of the NCHD role was to see and assess people who presented to or were referred to the approved centre.

However, the numbers and skill mix of staff was not sufficient to meet residents' needs in that there were ten nursing vacancies, two vacant social worker posts, two vacant occupational therapist posts, and one vacant psychologist post at the approved centre. On an individual needs assessed basis there was access to the health and social care professionals through the catchment area teams on an in-reach basis.

There was no therapeutic programme timetable at the time of inspection. There were some individual therapeutic activities at the approved centre but no defined programme that was directed at restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

There was a delayed discharge committee that met monthly. Sixteen residents were in the approved centre for over six months, nine over a year. The service was looking for more suitable accommodation for many of these residents and for some the transition was interrupted by lack of suitable services and the impact of

COVID-19. Nonetheless this impacted on clinical activity in the approved centre and staff reported difficulties in accessing beds and admission to the approved centre.

The peer advocacy service facilitated a weekly one-to-one session with residents. At the time of the inspection these meetings were held both virtually using an audio-visual link with an electronic tablet and face to face on a scheduled basis.

At a local level, there was regular resident community meetings and suggestion boxes which encouraged resident input into the service. The community meeting held once a week which discussed local issues that included feedback from service users, introduction of new initiatives, activities information giving and comfort issues for residents. The resident information booklet was recently updated to reflect changes to the services provided at the approved centre.

Information about the local complaints officer and procedure were not provided to residents and their representatives at admission or soon thereafter. A poster in the approved centre identified a nominated person with responsibility for dealing with all complaints. However, the phone number and email address provided on the poster for the nominated person were incorrect. Contact information for the Your Service Your Say was provided in the resident information booklet.

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 15: Individual Care Plan	✓		✗	Moderate	✓		✗	High	✗	High
Regulation 16: Therapeutic Services and Programmes	✓		✗	High	✓		✗	High	✗	High
Regulation 19: General Health	✗	Moderate	✗	High	✗	Low	✗	High	✗	High
Regulation 22: Premises	✓		✓		✓		✗	High	✗	High
Regulation 26: Staffing	✗	High	✗	Critical	✗	Moderate	✗	High	✗	High
Regulation 27: Maintenance of Records	✗	High	✗	High	✓		✓		✗	Moderate
Regulation 31: Compliant Procedures	✓		✓		✓		✓		✗	Moderate
Regulation 32: Risk Management Procedures	✓		✗	High	✓		✓		✗	High
Part 4 of the Mental Health Act: Consent to Treatment	✓		✓		✓			N/A	✗	High
Code of Practice: Physical Restraint	✗	High	✗	High	✓		✓		✗	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 no child with educational needs had been admitted to 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 Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted since the last inspection, this code of practice was not applicable.

Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. As such, service users' experiences were gathered in the following ways:

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team on any matter relating to their care whilst in the approved centre.
- 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.
Nine completed service user experience questionnaires were returned to the inspectors.
Nine residents spoke to the inspection team.

Of the nine completed questionnaires, eight respondents indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood, one respondent indicated no to this question. Six respondents indicated they had received information on their diagnosis, two indicated sometimes and one indicated never to this question. Eight respondents indicated that they understood what their care plan was, one indicated that they did not understand their care plan. Of the eight respondents who knew what their care plan was, six indicated that they were always involved in setting goals for their individual care plans and two indicated that they were involved sometimes. One respondent indicated that they were never involved in their care planning. Seven of the respondents indicated that they knew their multi-disciplinary team members, two did not. Eight respondents knew their keyworkers, and one respondent did not know their keyworker. Six respondents indicated that they were always able to discuss worries or concerns with a member of staff, with three respondents indicating sometimes to this question. Seven respondents felt there was enough activities in the approved centre, one did not, and one respondent did not answer this question. Eight respondents were happy with how staff spoke with them, and one was not happy how staff spoke with them. All nine respondents felt they had space for privacy and eight respondents felt their privacy and dignity were respected during their stay, one respondent did not. Eight respondents said they could communicate freely with family, friends and the advocate, one expressed they could not communicate freely. Seven said that they always felt safe with one saying sometimes and one saying never to this question. Six respondents indicated that they were always able to give feedback to staff, and to make a complaint when they were not satisfied with any part of their stay. The remaining three respondents indicated sometimes for this question.

On a scale of 1-10, with 1 being poor and 10 being excellent, three residents rated 5 out of 10 for their overall experience of care and treatment, one resident rated 6 out of 10, two residents rated 8 out of 10, three residents rated 10 out of 10.

Comments made by residents on the questionnaires were that they wanted to speak with their team to talk about their medication, that everything was “okay so far" and that the care was excellent and key nurses are pivotal to their treatment and recovery and that facilities, services and food are of a high standard.

The inspection team spoke with nine residents during the inspection. Their feedback indicated that the approved centre environment was very clean, and bedrooms were of a good standard and that services in the approved centre such as food were very good with choices for meals. Residents reported to feeling safe but that on occasion there was a lot of shouting on the wards. Residents reported having access to visits when they wanted. Residents said that there needed to be a greater level of recovery focussed activities on the ward and that they wanted to get better while in the approved centre. Residents were aware of their care plans and who their key worker were. Residents said that they could easily speak with a nurse but that it was harder to speak to their doctors. Residents indicated that they could speak to their keyworker daily and their treating team weekly. Residents described staff as lovely. Other residents stated that they would like information on the rights of a voluntary patient.

5.2 Advocacy

The approved centre had an advocacy service. In line with national restrictions and infection control measures, the Peer Advocacy representative had engaged with the residents once weekly using an electronic tablet during COVID-19 restrictions or in person when possible. The peer advocate details were displayed on the notice board in the approved centre.

The inspectors received a report from the regional Peer Advocate in Mental Health and in that report feedback from residents described that staff were very good, that they found that the food was very good, and the bedrooms were very comfortable. Concerns raised by the residents to the advocate stated that residents were not being listened to by the staff and some residents were unsure of who their key nurses were.

6.0 Feedback Meeting

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

- Clinical Director
- Executive Clinical Director
- Registered Proprietor
- Area Director of Nursing
- Assistant Director of Nursing x 2
- Consultant Psychiatrist x 3
- Mental Health Act Administrator
- Complaints Officer
- Risk Advisor
- Principal Psychology Manager
- Principle Social Worker
- Occupational Therapy Manager
- Pharmacist

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in December 2019. Resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. There was access to televisions, books, art materials, board games, and a supervised pool table and table tennis table. All wards had access to a garden and outdoor exercise equipment. Recreational activities included word search, relaxation and walks in the garden. The approved centre provided access to recreational activities on weekdays and during the weekend. Nursing staff facilitated access to recreational activities at the weekend.

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.

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 July 2022.

Visiting times were appropriate and reasonable, and the justifications for any visiting restrictions were documented in the clinical file. Appropriate steps were taken to ensure the safety of residents and visitors during visits. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in February 2022.

Residents in the approved centre had access to mail, e-mail, Internet, telephone, or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Pay as you use computers for resident's use were available in the information area and residents had access to their own mobile phones.

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. No resident's communication was restricted at the time of inspection.

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 November 2022, and included all requirements related to:

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

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

staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

As there were no deaths in the approved centre since the past inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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. Not all ICPs inspected were a composite set of documentation. Three resident ICPs were unavailable to review in their active clinical files; two were subsequently located in previous files while the third was not located. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs were identifiable and uninterrupted and were not amalgamated with progress notes.

Not all the inspected ICPs identified appropriate goals for the resident: two of the ten ICPs contained mental health needs assessments and goals only. The care and treatment required to meet the goals was identified, including the frequency and responsibility required for implementing the care and treatment. Not all the inspected ICPs were subject to review by the MDT in consultation with the resident, weekly in an acute setting, and at least every six months for residents in a continuing care facility: seven of the ten ICPs had not been reviewed on a weekly basis, and no reason for this was documented. One of the ICPs which was reviewed had not been dated and had a next review date of December 2021.Not all the inspected ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals: the ICP reviews in three clinical files did not correspond with the goals identified in the ICP.

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

a) **Not all individual care plans were one composite set of documentation, as the individual care plans for two residents were not in their active clinical file but located in previous volumes of their clinical file.**
b) **Appropriate goals were not identified in the individual care plans of two residents.**
c) **The individual care plans for seven residents were not reviewed weekly in an acute setting and no reason for less frequent review was documented.**

d) **The individual care plan was not regularly updated for three residents, as the individual care plan reviews for these residents did not correspond with the goals identified in their care plans.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

(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 provided by the approved centre were not appropriate and did not meet the assessed needs of the residents, as detailed in their individual care plans (ICPs). There was no therapeutic programme timetabled in the approved centre at the time of inspection. There were some individual therapeutic activities at the approved centre but no defined programme that was directed at restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

Individual groups being facilitated were an art therapy group facilitated once a week by a qualified art therapist, a sleep hygiene group facilitated by a social worker and an in-reach occupational therapist (OT), a recovery education group facilitated by a an in-reach social worker and peer educators and a horticulture group facilitated by an in reach OT and horticulturalist for residents of the Psychiatry of Old Age ward only.

There was no dedicated occupational therapist based at the approved centre at the time of inspection. However, residents had access to an OT on an in reach basis from community teams on a one-to-one basis for urgent functional assessments only.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre did not arrange for the service to be provided by an approved, qualified health professional in an appropriate location. One resident who had received a high falls risk assessment was not referred to physiotherapy or reviewed by a physiotherapist.

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

a) **Residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their individual care plans, 16(1).**
b) **Programmes and services were therefore not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, 16(2).**

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 August 2020. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(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 which was last reviewed in September 2021. 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. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Five clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessments documented a physical examination, family or personal history, dental health, medication review, and nutritional status. Two of the five six-monthly general health assessments reviewed did not document body mass-index, weight, and waist circumference; one did not document blood pressure; and one did not document smoking status. For residents on anti-psychotic medication, there was an annual assessment of their prolactin and electrocardiogram (ECG) heart function. However, the clinical file of one resident prescribed anti-psychotic medication did not have a fasting glucose level documented, and the clinical file of one resident prescribed anti-psychotic medication did not have a blood lipid level documented.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

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

a) **Two six-monthly general health assessments did not document body mass-index, weight, and waist circumference, 19(1)(b).**
b) **One six-monthly general health assessment did not document blood pressure, 19(1)(b).**

c) **One six-monthly general health assessment did not document smoking status, 19(1)(b).**
d) **The clinical file of one resident prescribed anti-psychotic medication did not have a fasting glucose level documented, 19(1)(b).**
e) **The clinical file of one resident prescribed anti-psychotic medication did not have a blood lipid level documented, 19(1)(b).**

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 June 2022.

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 Your service Your Say formal 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. Staff sought the resident's permission before entering their room, as appropriate.

All bedroom doors had locks on inside of the door. All en suite bathroom doors in the High Observation area had been removed. En suite bathrooms in the General Adult and Psychiatry of Old Age wards had curtains as privacy barriers at the entrance of the en suites. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(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. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Health and safety hazards were not all minimized in the approved centre: the floor area in the cleaner's storeroom was uneven and damaged. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in a good state of repair externally and internally. One fire door was missing. A newly replaced fire door was not flush with the opposite fire door and therefore was not sealing. The opposite door only functioned in closed position. Lower walls throughout the approved centre were peeling and damaged. Walls in the garden of the High Observation area were dirty and stained. Four nurse call bells in the High Observation area were damaged. One bedroom door and a mirror in the en suite bathroom of a room in the High Observation area were damaged. Two windows and one door in the Psychiatry of Old Age unit were damaged with scratches.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

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

a) **The premises were not maintained in good structural condition, as a number of walls and floors throughout the approved centre were peeling and damaged by water; four nurse call bells in the High Observation area were damaged; one bedroom door in the High Observation area was damaged; a mirror in an en suite bathroom of the same room was damaged with scratches; and two windows and one door in the Psychiatry of Old Age unit were damaged with scratches, 22(1)(a).**
b) **The premises were not maintained in good structural condition as one fire door was missing. A newly replaced fire door was not flush with opposite fire door and therefore was not sealing, 22(1)(a).**
c) **The registered proprietor did not ensure that the condition of the physical structure was developed and maintained with due regard to the safety and wellbeing of residents, as the floor in the cleaner's storeroom was uneven and damaged, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in November 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; the frequency of administration (including the minimum dose interval for PRN 'as required' medications); a record of all medications administered to the resident; a clear record of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

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

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Scheduled 2 and 3 controlled drugs were secured separately from other medications 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 September 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in March 2022.

The inspection found that there were clear signs in prominent positions where CCTV cameras or other monitoring devices were utilized throughout the approved centre. The approved centre's use of CCTV and any other monitoring system was disclosed to residents, residents' representatives, and the Mental Health Commission. Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed solely by the health professional with responsibility for the resident. CCTV was not used to monitor a resident in the event of their dignity being compromised, and all monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc, or hard drive.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

(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 June 2021, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre were not sufficient to meet resident needs. There was no dedicated occupational therapist (OT) in the approved centre at the time of inspection. There was two vacant OT posts at the approved centre. There were ten nursing department vacancies and a review of the nursing rosters evidenced that over the previous forty day shifts, only fifteen day shifts had the designated compliment of nursing staff. Two vacant social work posts were being covered by agency staff and there was a vacant psychologist post.

An appropriately qualified staff member was on duty at all times. 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. Not all healthcare staff were trained in Fire Safety, Basic Life Support, the Management of Violence and Aggression, and the Mental Health Act 2001. The following table breaks down the numbers and percentages of staff trained in each of the mandatory subjects:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (79)	59	75%	37	47%	70	89%	74	94%

Medical (34)	13	38%	6	18%	13	38%	9	26%
Occupational Therapist (2 vacant posts)	0	0%	0	0%	0	0%	0	0%
Social Worker (agency) (2)	0	0%	2	100%	2	100%	1	50%
Psychologist (in reach) (22)	6	27%	8	36%	11	50%	13	59%
Pharmacy (3)	1	33%	3	100%	2	67%	2	67%

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

a) **The numbers of and skill mix of staff were not appropriate to the assessed needs of residents and the size and layout of the approved centre, 26(2).**
b) **The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all staff had completed the required training in Fire Safety, Basic Life Support, and the Management of Violence and Aggression, 26(4).**
c) **The registered proprietor did not ensure that all staff members were made aware of the provisions of the Mental Health Act and all regulations and rules made thereunder, as not all staff had completed the required Mental Health Act training, 26(5).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating MODERATE

(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 2021, and included the following:

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

Resident records were not reflective of the resident's current status and the care and treatment being provided. On inspection, three clinical files did not have an individual care plan (ICP) attached. Two were located from previous files but the third could not be located for review. One of the ICPs which was located had not been dated and had a next review date of December 2021.

Not all resident records were developed and maintained in a logical sequence, as the laboratory results for one resident were filed in the correspondence section of the clinical file. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements.

Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

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

a) **The registered proprietor did not ensure that records were developed and maintained in a logical sequence, as laboratory results for one resident were filed in the correspondence section of the clinical file, 27(1).**
b) **The registered proprietor did not ensure all records were easily retrieved, as the individual care plan for one resident could not be located, 27(1).**

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 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. Staff attended Mental Health Tribunals and assisted the patient where necessary. The tribunal room had facilities to allow for remote tribunals and teleconferencing where necessary.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in November 2022, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

The Your Service Your Say designated person information was provided in the resident information booklet. However, correct Information about the local complaint procedure was not provided to residents and their representatives at admission or soon thereafter. A poster in the approved centre identified a nominated person with responsibility for dealing with local complaints. However, the phone number and email address provided on the poster for the nominated person were incorrect. The information booklet while referencing the local complaints process did not comprehensively outline the local complaints process.

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

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

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

a) **The registered proprietor did not ensure that each resident was made aware of the complaints procedure as soon as practicable after admission, 31(2).**
b) **The registered proprietor did not ensure that the correct complaints procedure information was displayed in a prominent position in the approved centre, 31(3).**
c) **The registered proprietor did not ensure that a nominated person was available in the approved centre to deal with complaints, 31(4).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

(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 policy and procedures in relation to risk management. The policy was last reviewed in October 2022, and included the following:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Health and safety risks were not identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. The risk register did not document fire risks associated with one missing and one broken fire door, incomplete mandatory staff training in Fire Safety, and the lack of fire evacuation drills carried out in the approved centre since the last inspection.

Clinical 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.

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

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

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

a) **The registered proprietor did not ensure that the approved centre had a comprehensive written risk management policy in place and that it was implemented throughout the approved centre, in that the local risk register did not identify faulty fire doors as risks and hence did not provide methods of mitigating the risk of faulty fire doors or a process of rectifying the risk, 32(1).**
b) **The registered proprietor did not ensure that the approved centre risk management policy was implemented throughout the approved centre, in that not all staff had completed Fire Safety training, and no fire evacuation drills had been completed by the approved centre since the last inspection, 32(1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with one condition to registration attached. The certificate was displayed prominently in the main entrance area 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)

Section 69: The Use of Seclusion

COMPLIANT

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It was last reviewed in August 2021.

The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy. The training record was available to the inspector. A record of attendance at training in the use of seclusion was maintained.

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Seclusion facilities were furnished and maintained to ensure respect for resident dignity and privacy, as far as practicable. Residents in seclusion had access to adequate toilet and washing facilities. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

Three episode of seclusion was reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage the residents' unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner and/or a registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion. The seclusion orders did not last longer than eight hours and residents were informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless it was detrimental to the residents. The residents were informed of the ending of each episode of seclusion. Residents' rights to dignity, bodily integrity, and privacy were respected. Cultural awareness and gender sensitivity was demonstrated.

The residents' next of kin or representative were informed of the use of seclusion, and this was recorded in the clinical file. Where the next of kin or representative were not informed, a reason for this was recorded in the clinical file.

A registered nurse undertook direct observation for the first hour following the initiation of each seclusion episode, with continuous observation thereafter. A written record of the residents' well-being was made by a nurse every 15 minutes, including the level of distress and behaviour displayed by the residents. Following a risk assessment, a nursing review took place every two hours. During this review, at least two staff entered the seclusion room. A medical review of the residents was undertaken no later than four hours after the commencement of each episode of seclusion and reviewed every four hours.

The seclusion episodes were recorded in the clinical files and seclusion register by the person who initiated seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of each episode. A copy of the seclusion register was placed in the clinical file. The episodes were reviewed by members of the multi-disciplinary team and documented in the clinical files within two working days.

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

NON-COMPLIANT

Risk Rating HIGH

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 file of a patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment and that the patient was unable to consent.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient. It documented:

- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the patient in relation to the discussion and their decision-making.

- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

However, the names of the specific medications prescribed to the patient were not listed in the relevant section (6) of the Form 17.

The approved centre was non-compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment because the names of the medications prescribed to the patient were not listed in Section 6 of the Form 17.

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

NON-COMPLIANT

Risk Rating MODERATE

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: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was last reviewed in August 2022. It addressed the following:

- 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 to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

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 that had been physically restrained were examined on inspection. Physical restraint had been used in rare, exceptional circumstances and the best interest of the residents. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered medical practitioner (RMP), registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the residents. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical flies. Where applicable, a physical examination of the resident was completed no later than three hours after the start of the episodes of restraint.

The orders for physical restraint lasted for a maximum of 30 minutes. In one episode of physical restraint inspected, the clinical practice form was not completed by the person who ordered and initiated the use of physical restraint. The date and time that the episode ended were not recorded. In each episode, the clinical practice form was signed by the consultant psychiatrist within 24 hours. In two separate episodes of physical restraint, the residents were not informed of the reasons for, likely duration of, or the circumstances leading to the discontinuation of physical restraint. No reason was documented as to why the residents were not provided with this information.

As soon as practicable and with the resident's consent, the resident's next of kin or representative was informed of the use of physical restraint, and this was recorded in the clinical file. There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episodes. The clinical practise forms had been placed in the residents' clinical files.

Where applicable, the residents were afforded an opportunity to discuss the episode with members of the multi-disciplinary team involved in their care as soon as was practicable. Where applicable, the episodes of physical restraint were reviewed by members of the multi-disciplinary team and documented in the clinical files no later than two working days after the episode.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **In one episode of physical restraint the clinical practice form for physical restraint was not completed by the person who ordered and initiated the use of physical restraint. The date and time the episode ended were not recorded, 5.7(b).**
b) **In two separate episodes of physical restraint involving two different residents, the resident was not informed of the reasons for, likely duration of, or the circumstances leading to the discontinuation of physical restraint, and no reason was recorded as to why the residents were not provided with this information, 5.8.**

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 April 2022, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in August 2020, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in August 2020, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, risk assessment, and all other relevant information. A key worker system was in place and a family member or carer was involved in the admission process with the resident's consent.

Transfer: The approved centre complied with Regulation 18: Transfer of Resident

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and other risks, and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10003813		**Not all individual care plans were one composite set of documentation. Care plans for two residents were not in their active clinical file but were located in previous volumes of their clinical file**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Care Plan template being reviewed to ensure one full composite set of documentation	Fortnightly Audit schedule	Achievable	04/08/2023	Sub Group of DDOP QPS
Preventative Action	Schedule of 2 weekly audits programe in care planning	Audits reports to be discussed at individual team meetings. Audit results to be reviewed at DDOP QPS group	Achievable	28/04/2023	Clinical Nurse Manager
Reason ID : 10003814		**The individual care plans for two residents did not identify appropriate goals for those residents**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	External Provider identified to roll out specific training in relation to care planning and documentation requirements	Training records to be maintained	Achievable	04/08/2023	Executive Clinical Director
Preventative Action	Schedule of 2 weekly audits programme in care planning	Audits reports to be discussed at individual team meetings. Audit results to be	Achievable	08/04/2023	Clinical Nurse Manager

		reviewed at DDOP QPS group			
Reason ID : 10003815		**The individual care plans for seven residents were not reviewed weekly in the acute setting and no reason for less frequent reviews was documented in the resident's individual care plan**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	External Provider identified to roll out specific training in relation to care planning and documentation requirements	Training records to be maintained	Achievable	04/08/2023	Executive Clinical Director
Preventative Action	Schedule of 2 weekly audits programme in care planning	Audits reports to be discussed at individual team meetings. Audit results to be reviewed at DDOP QPS group	Achievable	28/04/2023	Clinical Nurse Manager
Reason ID : 10003816		**The individual care plan reviews for three residents did not correspond with the goals identified in the care plan, therefore the individual care plan was not regularly updated**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	External Provider identified to roll out specific training in relation to care planning and documentation requirements	Training records to be maintained	Achievable	04/08/2023	Executive Clinical Director
Preventative Action	Schedule of 2 weekly audits programme in care planning	Audits reports to be discussed at individual team meetings. Audit results to be	Achievable	28/04/2023	Clinical Nurse Manager

		reviewed at DDOP QPS group			

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10003817		**Residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their individual care plans, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Therapeutic timetable to be developed with input from the following: In patient Psychologist to commence end of May, 2nd 2023 post offered out to NRS Panel. Staff nurse campaign commenced in March 2023 with recent intake of graduates in November/December. Monthly WTE reports provide with nursing and trends related to roster shifts completed. One Social Work permanent post to be filled on 8th of August There are 2 SSW posts in the DDOP and one of those will continue to be filled (using Agency staff) until 8th August when there will be 2 social workers (1	Monthly reports	Achievable	31/05/2023	Heads of Discipline

	Agency) in place Occupational Therapist part time agency to commence end of Month, recruitment campaign to commence for permanent panel, end of April 2023.				
Preventative Action	1.Development of MDT sub group to create weekly therapeutic timetabled programme 2.Increase availability of therapeutic programme through the roll out of Open Dialogue involving collaboration resident's/families 3.Development of fortnightly medication information group 4.Roll Out of Making Every Contact Count with associated brief intervention programmes from findings of individual assessment	1.Minutes of meeting will be available 2.Log maintained of open dialogue interventions 3.Log maintained of group 4.Record maintained in individual file Training records of staff who completed MECC	All Achievable	31/05/2023	1. Occupational Therapist Manager 2. Consultant Psychiatrist 3.Pharmacist 4.Heads of Discipline
Reason ID : 10003818		**Programmes and services were therefore not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Therapeutic timetable to be developed with relevant staffing to provide therapeutic input, see below: Inpatient Psychologist to commence end of May, 2nd post offered out to NRS Panel. Staff nurse campaign commenced in March 2023 with recent intake of graduates in November/December. Monthly WTE reports provide with nursing and trends related to roster shifts completed. One Social Work permanent post to be filled on 8th of August, There are 2 SSW posts in the DDOP and one of those will continue to be filled (using Agency staff) until 8th August when there will be 2 social workers (1 Agency) in place Occupational Therapist part time agency to commence	Monthly reports	Achievable	31/05/2023	Heads of Discipline

	end of Month, recruitment campaign to commence for permanent panel, end of April				
Preventative Action	1.Development of MDT sub group to create weekly therapeutic timetabled programme 2.Increase availability of therapeutic programme through the roll out of Open Dialogue involving collaboration resident's/families 3.Development of fortnightly medication information group 4.Roll Out of Making Every Contact Count with associated brief intervention programmes from findings of individual assessment 5. Seek approval for Health Eating programme facilitated by dietician on a weekly basis	1.Minutes of meeting will be available 2.Log maintained of open dialogue interventions 3.Log maintained of group 4.Record maintained in individual file Training records of staff who completed MECC 5.Monthly DDOP QPS Governance Group	All Achievable	31/05/2023	1. Occupational Therapist Manager 2. Consultant Psychiatrist 3. Pharmacist 4. Heads of Discipline 5. Executive Clinical Director

Regulation 19 General Health					
Reason ID : 10003833		**Two six-monthly general health assessments did not document BMI, weight and waist circumference, 19(1)(b). One six-monthly general health assessment did not document a blood pressure, 19(1)(b). One six-monthly general health assessment did not document a smoking status, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	National Template for recording physical health has been introduced –both for admission assessment and for 6 monthly	Monthly audit to be completed on an going basis to ensure compliance	Achievable	28/04/2023	Clinical Nurse Manager and Medical Staff
Preventative Action	Monthly audit to monitor compliance Ongoing awareness at NCHD teaching sessions regarding the importance of completing full documentation Checklist completed on a weekly basis to identify physicals due	Results to be reviewed at QPS Group and notified to each individual team Attendance records at teaching sessions Checklist documentation	Achievable	11/04/2023	Clinical Nurse Manager and Medical Staff Clinical Director Clinical Nurse Manager
Reason ID : 10003836		**The clinical file of one resident prescribed anti-psychotic medication did not have a fasting glucose level documented, 19(1)(b). The clinical file of one resident prescribed anti-psychotic medication did not have a blood lipid level documented, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	National Template for recording physical health has been introduced –both for admission assessment and for 6 monthly	Monthly audit to be completed on an going basis to ensure compliance	Achievable	28/04/2023	Clinical Nurse Manager and Medical Staff

Preventative Action	Monthly audit to monitor compliance Ongoing awareness at NCHD teaching sessions regarding the importance of completing full documentation Checklist completed on a weekly basis to identify physicals due	Results to be reviewed at QPS Group and notified to each individual team Attendance records at teaching sessions	Achievable	11/04/2023	Clinical Nurse Manager and Medical Staff Clinical Director Clinical Nurse Manager

Regulation 22: Premises					
Reason ID : 10003819		**The premises was not maintained in good structural condition as; a number of walls and floors throughout the centre were peeling and damaged, from water damage , four nurse call bells in the High Observation area were damaged; one bedroom door in High Obervation was damaged; a mirror in en suite bathroom of same room was damaged with scratches; two windows and one door in POA were damaged with scratches.22(1)(a)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1.2 windows and one door in POA were replaced 2.Bedroom Doors in High Obs-Approval obtained to replace doors and quotations being received. Bedroom mirror in hi obs replaced since inspection. 3.4 nurse calls bells repaired	Visual Inspection of Works	Achievable	05/04/2023	Maintenance Manager
Preventative Action	Ongoing monitoring of environment Walls/Floor-Site Survey carried out and a number of leaks discovered, costings for planned works currently being progressed	Visual Inspection of Works	Achievable	30/05/2023	Maintenance Manager / Facilities Manager
Reason ID : 10003820		**The premises was not maintained in good structural condition as one fire door was missing. A newly replaced fire door was not flush with opposite fire door, therefore, not sealing, 22(1)(a)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire door ordered and awaiting supply, site	Ongoing monitoring of environment	Achievable	31/05/2023	Maintenance Manager

	visit carried out by Fire Officer and agreed plan of works put in place approved fire officer				
Preventative Action	Ongoing monitoring of environment	Visual inspection of premises	Achievable	11/04/2023	Maintenance Manager/ Facilities Manager
Reason ID : 10003821		**The registered proprietor did not ensure that the condition of the physical structure was developed and maintained with due regard to the safety and wellbeing of residents, as the floor in the cleaners room was uneven and damaged 22(3)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Site Survey carried out and a number of leaks discovered, costings for planned works currently being progressed	Visual Inspection of works	Achievable	14/04/2023	Facilities Manager/Maintenance Manager
Preventative Action	Ongoing monitoring of environment	Visual Inspection of premises	Achievable	11/04/2023	Maintenance Manager/Facilities Manager

Regulation 26: Staffing					
Reason ID : 10003829		**The numbers of staff and skill mix of staff are not appropriate to the assessed needs of residents, the size and layout of the approved centre. 26(2)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In patient Psychologist to commence end of May, 2nd post offered out to NRS Panel. Staff nurse campaign commenced in March 2023 with recent intake of graduates in November/December. Monthly WTE reports provide with nursing and trends related to roster shifts completed. One Social Work permanent post to be filled on 8th of August, Occupational Therapist part time agency to commence end of Month, recruitment campaign to commence for permanent panel, end of April	Discipline report at DDOP Governance Group	Realistic	31/05/2023	Heads of Discipline
Preventative Action	Monthly Discipline reports at Area Management Team	Monthly reports	Achievable	28/04/2023	Heads of Discipline
Reason ID : 10003830		**The registered proprietor did not ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice. 26(4)**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Full Mandatory Training scheduled for January to June 2023. 8 fire training sessions carried out since Jan to March, PMAV training monthly,	Training record reports provided to each Heads of discipline and reviewed at DDOP QPS	Achievable	28/04/2023	Heads of Discipline
Preventative Action	Full Mandatory Training scheduled for January to June 2023. 8 fire training sessions carried out since Jan to March, PMAV training monthly.	Training record reports provided to each Heads of discipline and reviewed at DDOP QPS	Achievable	28/04/2023	Heads of Discipline
Reason ID : 10003831		**Not all staff had completed the required Mental Health Act training, 26(5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Staff complete the required Mental Health act Training 26(5), current levels averaged across all disciplines 90%	Quarterly Training reports sent to all Heads of Discipline	Achievable	31/05/2023	Heads of Discipline
Preventative Action	Training database and quarterly training reports are in place	Discipline Specific line manager reports received on	Achievable	31/05/2023	Heads of Discipline

		quarterly basis with line manger to review compliance and current levels			

Regulation 27:Maintenance of Records					
Reason ID : 10003822		**The registered proprietor did not ensure that records were kept in good order. Laboratory results for one resident were filed in the correspondence section of the clinical file, 27(1).**			
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.					
Reason ID : 10003823		**The registered proprietor did not ensure all records were easily retrieved. The care plan for one resident could not be located, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Care Plan Completed and stored in Clinical File	2 weekly audit carried out	Achievable	28/04/2023	Clinical Nurse Manager
Preventative Action	Schedule of 2 weekly audits programme in care planning DDOP Maintenance of Records Policy to be updated Quarterly Audit to be completed in relation to record keeping	Audits reports to be discussed at individual team meetings Audit results to be reviewed at DDOP QPS group Record of staff maintained for reading policy Audit report available on viclarity software and reports reviewed at DDOP QPS Group	All Achievable	28/04/2023	Clinical Nurse Manager DDOP QPS Group Clinical Nurse Manager

Regulation 31: Complaints Procedures					
Reason ID : 10003824		**The registered proprietor did not ensure that each resident was made aware of the complaints procedure as soon as practicable after admission, 31(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Specific notice following inspection displayed throughout the unit on complaints process Sub group working on updating information booklet to outline localised process for complaints	Visual check Copy available throughout unit and handed out/discussed through admission	Achievable	30/11/2022	Mental Health Administrator DDOP QPS Group
Preventative Action	Ongoing visual checks of notices carried out	Visual check carried out	Achievable	11/04/2023	Facilities Manager
Reason ID : 10003825		**The registered proprietor did not ensure that the correct complaints procedure information was displayed in a prominent position in the approved centre, 31(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Specific notice following inspection displayed throughout the unit on complaints process Sub group working on updating information booklet to outline localised process for complaints	Visual check Copy available throughout unit and handed out/discussed through admission	Achievable	31/05/2023	Clinical Nurse Manager 2 DDOP QPS Group
Preventative Action	Ongoing visual checks of notices carried out	Visual check carried out	Achievable	11/04/2023	Facilities Manager
Reason ID : 10003826		**The registered proprietor did not ensure that a nominated person was available in the approved centre to deal with complaints, 31(4).**			

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 32: Risk Management Procedures					
Reason ID : 10003827		**The registered proprietor did not ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre in that the local risk register did not identify faulty fire doors as risks and hence did not provide methods of mitigating the risk of faulty fire doors or a process of rectifying the risk. 32 (1)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Specific risk assessment completed in relation to fire doors. This risk is now placed on the approved centre's risk register with set actions and identified person's for implementation.	Review of risk register DDOP QPS Meeting on a quarterly basis	Achievable	30/03/2023	QPS Advisor
Preventative Action	Programme of risk assessment training put in place for all staff in approved centre. Risk Register standing agenda on DDOP QPS	1.Reports of training attendance on a quarterly basis at DDOP QPS 2.Minutes of DDOP QPS	1. Realistic 2. Achievable	28/04/2023	QPS Advisor
Reason ID : 10003828		**The registered proprietor did not ensure that an approved centre risk management policy was implemented throughout the approved centre in that not all staff had completed Fire Safety training and no fire evacuation drills were completed by the approved centre since the last inspection, 32(1). Amended following IQR DL**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1.Training schedule developed for Fire Safety, 8 training sessions provided on in DDOP from January	Quarterly reports provided to each Head of Discipline on current attendance	Realistic	28/04/2023	1.Nurse Practice Development Co-Ordinator 2.Executive Clinical Director, Area

	to March 2.Meeting scheduled with Estates and Senior Manager's in relation to organising fire evacuation programme for DDOP	level Minutes of Meeting			Director of Nursing, Business Manager
Preventative Action	1.Additional training sessions to be planned for remaining of the year from June to December. 2.Memo issued in relation to requirement to attend fire training	1.Training records 2.Copy of Memo	1. Realistic 2.Achievable	30/06/2023	1.Nurse Practice Development Co-ordinator 2.Heads of Discipline

Part 4 of the Mental Health Act 2001: Consent to Treatment					
Reason ID : 10003832		**The names of the medication(s) prescribed were not listed in Section 6 of Form 17**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New template in relation to Section 60 outlining specific requirements of medication developed	Audit	Achievable	09/12/2022	Mental Health Administrator
Preventative Action	Audit to be conducted on a quarterly basis in relation to requirements set out in section 6 of From 17	Audit report to be brought to QPS Group	Achievable	28/04/2023	Clinical Nurse Manager/Mental Health Administrator

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10003811		**In two separate episodes of physical restraint involving two different residents, the resident was not informed of the reasons for, likely duration of or the circumstances leading to the discontinuation of physical restraint and no reason for the resident not being provided with that information was recorded, 5.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Developed Physical Restraint Care Pathway incorporating the clear communication requirements	Checklist available and completed after every episode of physical restraint	Achievable	06/04/2023	Clinical Nurse Manager
Preventative Action	1.Monthly audits carried out on electronic software Viclarity and reported to monitoring and oversight restrictive practice group 2.Roll out of powerpoint presentations with regards to the codes of Practice in Physical Restraint with emphasis on communication requirements 3.Development of Monitoring and oversight committee	1.Audit Reports Minutes available each meeting 2.Training sessions available 3.Minutes available	1.Achievable 2.Achievable 3.Achievable	28/04/2023	Clinical Nurse Manager 3 (1&2) Area Director of Nursing (3)
Reason ID : 10003812		**In one episode of physical restraint the clinical practice form for physical restraint was not completed by the person who ordered and initiated the use of physical restraint. The date and time the episode ended was not recorded, 5.7(b).**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Developed Physical Restraint Care Pathway incorporating the clear communication requirements	Checklist available and completed after every episode of physical restraint	Achievable	06/04/2023	Clinical Nurse Manager
Preventative Action	Monthly audits carried out on electronic software Viclarityand reported to Monitoring and oversight restrictive practice group Roll out of powerpoint presentations with regards to the Codes of Practice in Physical Restraint with emphasis on communication requirements Development of Monitoring and Oversight Committee in relation to restrictive practice	Audit Reports Minutes available of each meeting Training sessions available Minutes available	Achievable	28/04/2023	Clinical Nurse Manager 3 & Area Director of Nursing

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.

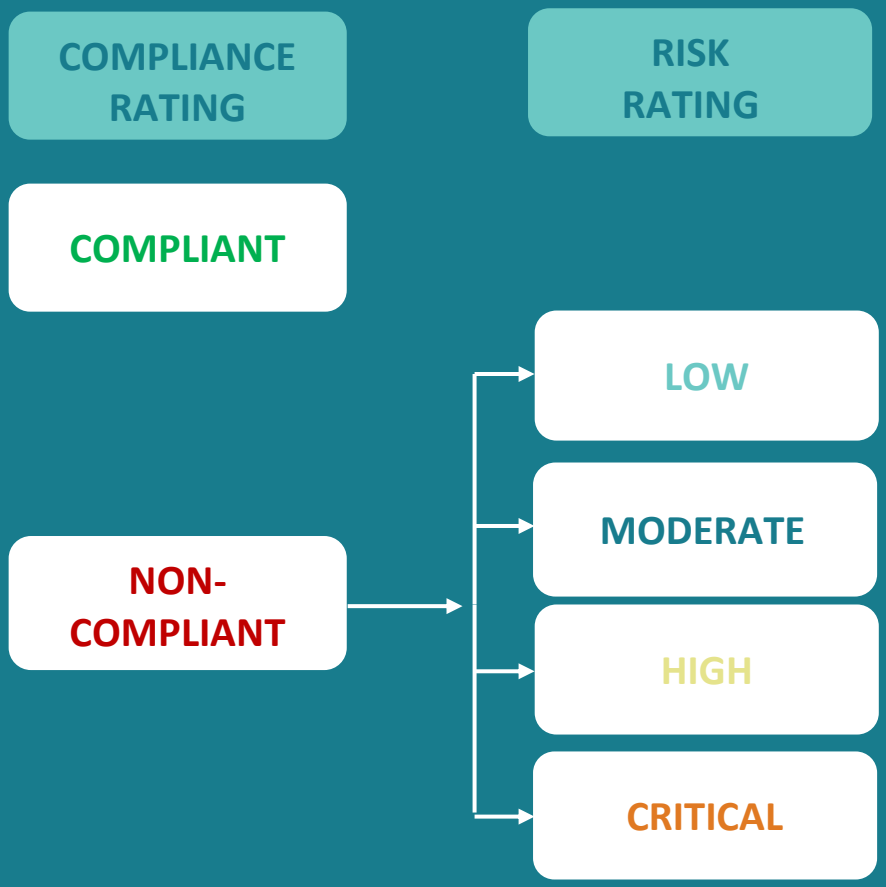
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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