Carraig Mór Centre

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

CARRAIG MÓR CENTRE

Shanakiel, Cork.

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2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Other

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Hugh Scully, General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
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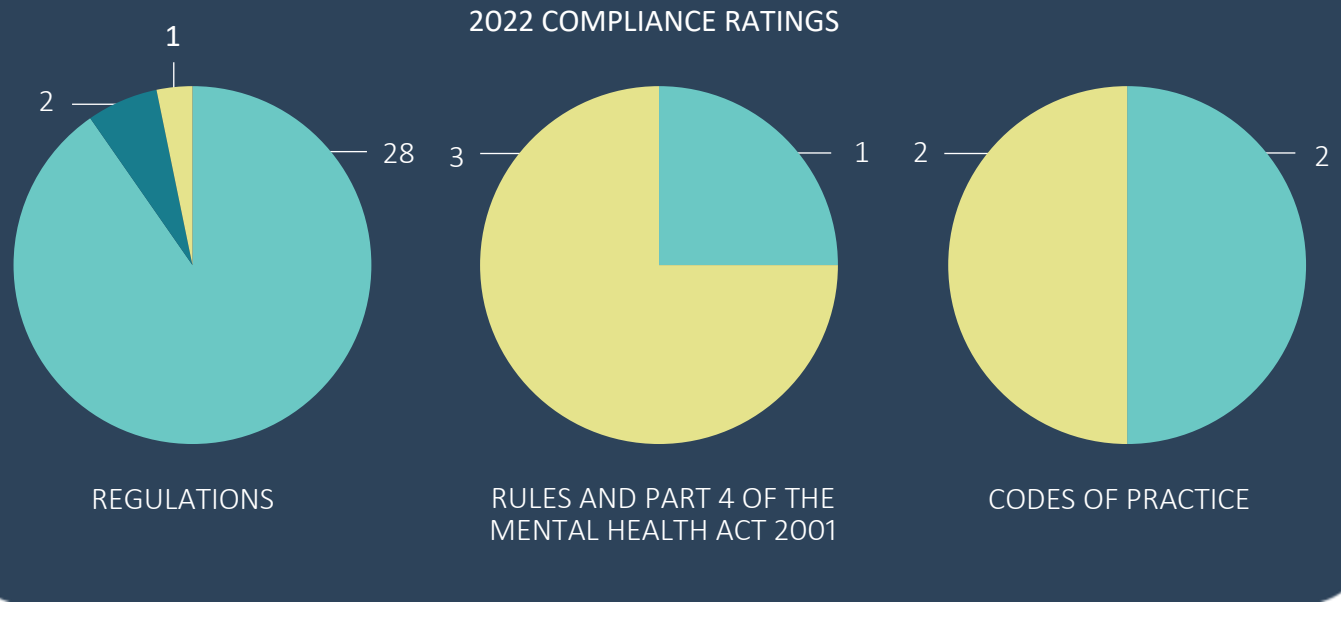
Inspection Date:
30 August – 2 September 2022

Previous Inspection date:
27 – 30 July 2021

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

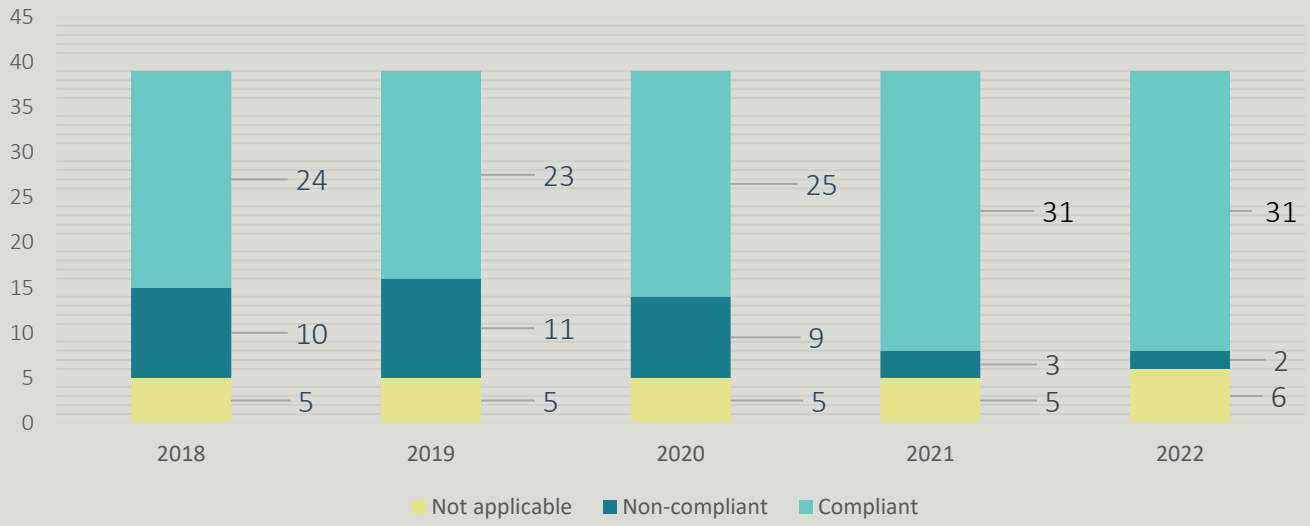
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2018 – 2022

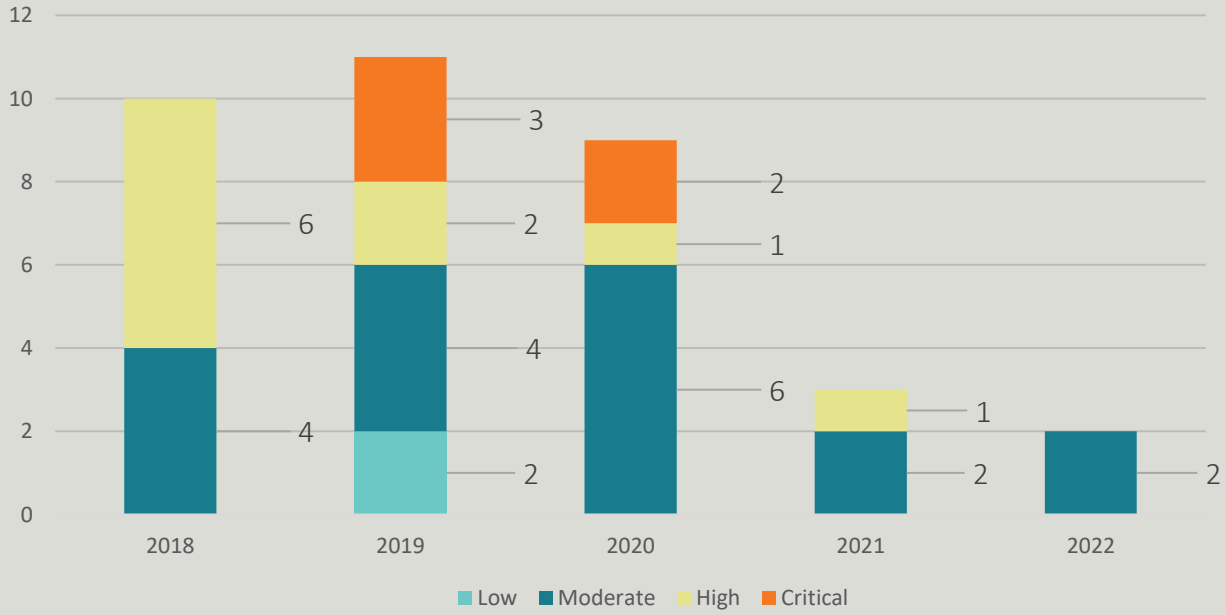
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2018 – 2022



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

In brief

Carraig Mór was an 18-bed locked Psychiatric Intensive Care Unit (PICU) in Cork. Since May 2021 the facility had an operational capacity of 10 beds by agreement with the Mental Health Commission.

The approved centre operated on a 24-hour basis for Cork city and county. Referrals to this service predominantly came from other acute mental health services in Cork. Admissions were also from the Flexible Assertive Community Treatment (FACT) team. There was one multi-disciplinary team (MDT) for the approved centre.

There have been extensive refurbishments in the approved centre on a phased basis. Phase 1 work was scheduled for new extensions, modernising the unit with new anti-ligature furniture and plans to build more single rooms.

The approved centre had maintained a high compliance rate since 2021.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	71%	68%	74%	91%	94%

Conditions to registration

There were five conditions attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1:	The approved centre was not in breach of Condition 1 and the approved centre was

To ensure adherence to, the approved centre shall implement the costed, funded and time-bound plan to reconfigure the approved centre received in accordance with plans submitted on 17 February 2021, 7 May 2021 and 10 May 2021. All works must be completed by 30 November 2022. The approved centre shall provide regular updates on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.	compliant with Regulation 22: Premises at the time of inspection.
Condition 2: *To ensure adherence to Regulation 22: Premises and Regulation 32: Risk Management, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs of residents. This plan shall address all issues of concern and take all necessary actions identified in the: Fire Safety Risk Assessment (submitted 28 April 2021), Ligature Audit Review & Action Plan (submitted 28 April 2021), Health and Safety Report (submitted 7 May 2021). The approved centre shall provide regular updates to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.*	The approved centre was not in breach of Condition 2 and the approved centre was compliant with Regulation 22: Premises with at the time of inspection.
Condition 3: *To ensure adherence to Regulation 26(4) and 26(5): Staffing, the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*	The approved centre was not in breach of Condition 3 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.
Condition 4: *To ensure adherence to Regulation 27: Maintenance of Records, the approved centre shall audit their records and reports on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.*	The approved centre was not in breach of Condition 4 and the approved centre was compliant with Regulation 27: Maintenance of Records at the time of inspection
Condition 5: *The approved centre shall, as of Friday 14 May 2021, reduce its occupancy from 18 to 10 residents. On commencement of Phase 1 of construction works, as referenced in the plans submitted by the HSE on 17 February 2021, 7 May 2021 and 10 May 2021, the approved centre shall reduce its occupancy to 8 residents. On commencement of Phase 2 of construction works as referenced in the plans*	The approved centre was not in breach of Condition 5.

submitted by the HSE on 17 February 2021, 7 May 2021 and 10 May 2021, the approved centre shall reduce its occupancy to 6 residents. The approved centre shall not increase its occupancy from 6 residents until such time as the construction works outlined above have been completed in compliance with Regulation 21: Privacy, Regulation 22: Premises and Regulation 32: Risk Management.	

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety in the approved centre

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

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Medication was ordered, stored and administered in a secure and safe manner.
- Ongoing refurbishment work was evident especially in the female ward where anti ligature furniture and curtains were installed and alarms were installed on bathroom door to detect prolonged weight.

However, not all staff were trained in Basic Life Support and Fire Safety.

Appropriate care and treatment of residents

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

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The approved centre's social worker worked on a one-to-one basis with the residents. Groups co-facilitated between the occupational therapist, dietitian, and nurse therapy included horticulture, pet therapy, exercise groups, community access and integration outings, healthy food made easy, cooking support, and creative artwork. The psychologist co-facilitated groups with nurse therapy including Connecting with Calmness and Compassion, Planning for the Future, Managing Distress Using the My Five Senses, Mindful Music, Figuring Things Out, and Self Care groups.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.
- The approved centre introduced a High Dose antipsychotic treatment policy to ensure optimum care and monitoring of service users receiving high dose antipsychotics.

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

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 an excellent range of appropriate recreational activities during the weekdays and at the weekend. Activities included a gardening group, community integration visits to local services, shops, cafes and restaurants, a pottery group, relaxation groups, bingo, and board games. There was a quiet room with seating and TV, a well-equipped gym, and an activities room with arts and crafts and cooking.

- On admission, residents' personal wishes and interests regarding outings and activities were recorded, and these suggestions were used in the planning of the approved centre's weekly activities schedule.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance, Leadership and Accountability

There was evidence of good governance structures and processes in place.

- Carraig Mór Psychiatric Intensive Care Unit (PICU) was part of the Cork North Mental Health Services and the wider Cork Kerry Mental Health Community Healthcare Services (CHO 4).
- Carraig Mór was governed by the Carraig Mór Senior Management Team (SMT) which reported to the Head of Service. Numerous sub-committees and working groups fed into the Carraig Mór SMT.
- There was also a bi-monthly Clinical Nurse Manager meeting which dealt with the management of nursing resources, training and audit activities.
- There was a bimonthly Governance and Steering Committee meeting that provided a two-way communication link to the Senior Management Team, which was an additional oversight measure.
- There was an established culture of implementing quality improvement audit tools to monitor and evaluate standards of care. There was an audit cycle in place and audit results were monitored by the Audit Committee.
- The approved centre had maintained a high compliance rate with rules, regulations and codes of practice since 2021 which was a significant improvement from previous years.
- The approved centre's risk register fed into the wider risk register maintained by the Cork Area Management Team. Incidents and trends were discussed at the monthly Incident Review Group. Escalated incidences were discussed at multi-disciplinary team meetings at the North Lee the Quality and Patient Safety (QPS) Department.
- Input from service users was sought by the SMT through a number of channels, such as the HSE's 'Comment, Compliment or Complaint' process and resident community meetings.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre introduced a digital screen assessing programme to meet the needs of the HSE audit programmes and the approved centre had trained onsite digital assessors to conduct the audits internally.

2. Some members of the multi-disciplinary team completed Reinforce Appropriate, Implode Disruptive behaviour (RAID) training. The training was a three-day comprehensive approach to working with extreme behaviour when it occurred but also preventing it by tackling it at source.

3. The approved centre had developed a new recovery focused collaborative Individual Care Plan (ICP) document in line with the Judgement support framework. The approved centre also developed a service user information poster.

4. The approved centre reviewed and updated its existing seclusion management booklet based on audits results to ensure the rules was achieved.

5. The approved centre introduced a high dose antipsychotic treatment policy to ensure optimum care and monitoring of service users receiving high dose antipsychotics.

6. A new patient diagnosis information sheet written in a patient friendly language which incorporated best practice and updated information was available to residents.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Carraig Mór was an 18-bed Psychiatric Intensive Care Unit (PICU) in Shanakiel, Co. Cork, which opened in 2002. Since May 2021 the facility had an operational capacity of 10 beds by agreement with the Mental Health Commission.

The approved centre operated on a 24 –hour basis for Cork city and county. Referrals to this service predominantly came from the following services: St. Michael's Adult Mental Health Unit, Mercy University Hospital, South Lee Adult Mental Health Unit, Cork University Hospital, St. Stephen's Hospital, Glanmire Centre for Mental Health Care and Recovery, Bantry General Hospital, Central Mental Hospital and Dublin/Cork Prison Services. Admissions were also from the Flexible Assertive Community Treatment (FACT) team. There was one multi-disciplinary team (MDT) for the approved centre.

The centre comprised of two floors with resident accommodation on the ground floor and facilities for activities and therapies on the first floor. Two isolation suites were opened on the first floor to accommodate new admissions awaiting COVID-19 swabs and results. The entrance door was locked at all times. A locked door from the main reception area led to a visitor's room, a multi-disciplinary team (MDT) meeting room, offices, and subsequently onto the female and male wards. There was a modern seclusion suite between the two wards. There were two large gardens catering for both male and female residents.

There have been extensive refurbishments of late in the approved centre. The approved centre had proposed buildings work to commence imminently on a phased basis. Phase one work was schedule for new extensions, modernising the unit with new anti-ligature furniture and plans to build more single rooms. It was evident that upon completion of all phases of work the approved centre will be a modern PICU conducive to a more suitable environment for treatment.

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

Resident Profile	
Number of registered beds	***10***
Total number of residents	**2**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Carraig Mór Psychiatric Intensive Care Unit (PICU) was part of the Cork North Mental Health Services and the wider Cork Kerry Mental Health Community Healthcare Services (Area 4). Carraig Mór was governed by the Carraig Mór Senior Management Team (SMT) which reported to the Head of Service. The Senior Management Team met monthly. Numerous sub-committees and working groups fed into the Carraig Mór Senior Management Team, some of which included the Audit Committee, Policy Committee, Risk Register and Incidents Committee and Consultant Group and a Health and Safety Committee. There was also a bi-monthly Clinical Nurse Manager meeting which dealt with the management of nursing resources, training and audit activities. The bi-monthly Governance and Steering Committee meeting ensured a two-way communication to the link to Senior Management Team which was regarded as an additional oversight measure.

There was an established culture of implementing quality improvement audit tools to monitor and evaluate standards of care. A multi-disciplinary approach was fostered within governance structures and clinical care. The various committees' purposes, structures, responsibilities and reporting relationships were well defined. The Policies Procedures, Protocols and Guidelines (PPPGs) group provided a multi-disciplinary approach to policy development, review, approval, and dissemination. There was an audit cycle in place and audit results were monitored by the Audit Committee.

The approved centre's registered proprietor had overall responsibility for the risk management process, however the Assistant Director of Nursing had the local risk management responsibilities. The approved centre's risk register fed into the wider risk register maintained by the Cork Area Management Team. Incidents and trends were discussed at the monthly Incident Review Group. Escalated incidences were discussed at multi-disciplinary team meetings at the North Lee the Quality and Patient Safety (QPS) Department.

The approved centre had been refurbished since the last inspection following discussions and enforcements by the Mental Health Commission (MHC). Plans to reconfigure the approved centre had been submitted to the MHC. The work was evident especially in the female ward where anti ligature furniture and curtains were installed. Bathroom were refurbished, walls painted, and alarms were installed on bathroom door to detect prolong weight. The approved centre had plans for a phased work schedule to be completed within an eighteen-month period. It was also confirmed that whilst refurbishment was taking place, bed capacity will further reduce in line with the phased works.

The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE's 'Comment, Compliment or Complaint' process and resident community meetings.

The approved centre had a COVID-19 contingency plan in place and a COVID-19 Outbreak Control Team met every six weeks to discuss procedures and risks to the unit. Two isolation rooms were prepared upstairs to ensure all new admissions were isolated on admission.

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 26: Staffing	✗	Moderate	✗	Moderate	✓		✓		✗	Moderate
Regulation 28: Register of Residents	✓		✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
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.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The inspection team spoke to one resident. The feedback was very positive. It was reported that the food was delicious and there were choices. Staff were reported to be nice, professional and resident was treated with respect at all times. It was also reported that there were plenty of activities during the weekdays and weekends. Furthermore, the resident stated that on admission, rights were explained, received an information booklet and also got information about medications. It was also reported that the resident attended her ICP and received a copy after each ICP.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Head of Services
- Registered Proprietor
- Area Director of Nursing
- Principal Psychologist
- Occupational Therapy Manager
- Principal Social Worker
- Area Administrator
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2

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. The approved centre used stickers to identify residents. The stickers included the resident's name, address, date of birth, and medical record number (MRN).

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals, special diets were facilitated when required, and resident requests were facilitated by the kitchen. 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 March 2022. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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 on weekdays and during the weekend which were appropriate to the resident group profile. On admission, residents' personal wishes and interests regarding outings and activities were recorded, and these suggestions were used in the planning of the approved centre's weekly activities schedule. The centre had two vehicles available for resident outings. Activities were risk-assessed and included full day outings in Cork and to other counties, a gardening group, community integration visits to local services, shops, cafes and restaurants, a pottery group, relaxation groups, bingo, and board games.

The centre had access to large gardens outside the unit, including a pitch and putt course for the residents. Residents also used the gardens to spend time outside and for walks. On the week of the inspection, the centre had animal assisted therapy dog visits, Managing Anxiety and Worry and Connecting with Calmness and Compassion groups, and a full day outing for the residents. Both wards in the approved centre had one main living room and a garden area. The two main living rooms had newspapers, books, and TV for resident use. The approved centre also provided a quiet room with seating and TV, a well-equipped gym, and an activities room with arts and crafts and cooking.

The approved centre was compliant with the 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

COMPLAINT

(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 2021.

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

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in July 2021.

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. 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 had restricted communication 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 August 2021, and included all requirements related to:

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

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

The resident was 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 search, and due regard was shown to the resident’s dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in March 2022.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's 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). As there were two residents in the approved centre at the time of inspection, two ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

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

ICPs identified appropriate goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident, weekly in an acute setting, and at least every six months for residents in a continuing care facility. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre's social worker worked on a one-to-one basis with the residents, focusing on family therapy, assistance with income support, accommodation, and advocacy. When numbers in the approved centre were higher, the social worker co-facilitated groups with the occupational therapist (OT). Groups co-facilitated between the OT, dietitian, and nurse therapy included horticulture, pet therapy, exercise groups, community access and integration outings, healthy food made easy, cooking support, and creative artwork. The OT also conducted one-to-one sessions with residents based on their needs.

The psychologist co-facilitated groups with nurse therapy including Connecting with Calmness and Compassion, Planning for the Future, Managing Distress Using the My Five Senses, Mindful Music, Figuring Things Out, and Self Care groups.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in September 2021. As no resident had been transferred to or from the approved centre since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in April 2022. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were assessed and monitored on admission. No residents had been in the approved centre for longer than six months since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in September 2021.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs.

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were fitted with privacy screens. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. 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: each ward had access to a large garden area. Residents also had access, subject to risk assessment, to the grounds surrounding the approved centre. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in good a state of repair externally and internally. 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. All resident bedrooms

were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

The approved centre was compliant with this regulation.

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

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 June 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, two of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including a record of the following: a record of any (or no) allergies or sensitivities to medications, a record of medications administered to the resident and the administration route for all medications, clear records of the date of discontinuation for each medication, and the Nursing and Midwifery Board of Ireland (NMBI) registration number or PIN of every nurse prescriber prescribing medication to the resident.

All entries in the MPARs were legible. 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. This was evident in the clinical file. No withholding of medication, or directions to crush medication, were recorded in the MPARs examined.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified.

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 November 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 May 2021.

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 MODERATE

(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 April 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 was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. Not all nursing staff were trained in Basic Life Support and Fire Safety. All but one nursing staff were trained the Management of Violence and Aggression. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The following table gives a breakdown of the numbers and percentages of staff trained in each of the separate areas:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (43)	36	84%	40	93%	42	98%	43	100%
Consultant Psychiatrist (3)	3	100%	3	100%	3	100%	3	100%
Medical (1)	1	100%	1	100%	1	100%	1	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%

Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%

The approved centre was non-compliant with this regulation because 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 nursing staff and social worker were not all trained in Basic Life Support and Fire Safety, 26(4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

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

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

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence and kept in good order with no loose pages.

Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorized access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating MODERATE

(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 did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006, as the register did not record a date for resident discharges, or a code for the resident's diagnosis on discharge.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the register included all the information specified in Schedule 1 to the Regulations, as the register did not contain a discharge date or diagnosis code on discharge, 28(2).

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 a large separate meeting room and staffing support to facilitate the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary. The approved centre provided resources and facilities to access the Mental Health Tribunals remotely if required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed March 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.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaint's procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaint's procedure, including how to contact the nominated person, was publicly displayed in the approved centre. Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made.

There had been no complaints in the approved centre since the last inspection. Any inquiries were discussed with the residents in resident meetings in the approved centre.

The approved centre was compliant with the regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in May 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 and the risk management procedures actively reduced identified risks to the lowest practicable level of risk.

Individual risk assessments were completed in conjunction with medication requirements or administration, 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 compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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 March 2022, and 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.

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 taking Rule 5.1 (direct observation) into account. Residents in seclusion had access to a full en suite bathroom with shower. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

Two clinical files, covering three separate episodes of seclusion, were 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 resident's unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner (RMP) or a registered nurse. 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 the residents were informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless it was detrimental to the resident. One of the seclusion orders was extended by the RMP following examination for a further period not exceeding eight hours. Where seclusion wasn't extended, the residents were informed of the ending of the episode of seclusion. Residents' rights to dignity, bodily integrity, and privacy were respected. Cultural awareness and gender sensitivity were demonstrated.

A registered nurse undertook direct observation for the first hour following the initiation of a 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 resident. 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 files. The episodes were reviewed by members of the multi-disciplinary team and documented in clinical file 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 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.

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.

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

Evidence of Implementation: The clinical file of one resident that had been physically restrained was examined on inspection. Physical restraint had been used in rare, exceptional circumstances and the best interest of the resident. 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 resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint.

The order for physical restraint lasted for a maximum of 30 minutes. The clinical practice form had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after the episode and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

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. Where practicable, same sex staff members were present during the physical restraint episodes. The completed clinical practise form had been placed in the resident's clinical file.

The resident was afforded an opportunity to discuss the episode with members of the MDT involved in their care as soon as was practicable. The episode of physical restraint was 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 compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

Discharge: The discharge policy, which was last reviewed in March 2022, 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, and all other relevant information. A key worker system was in place, full physical examination carried out, 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 Residents.

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse/risks, and documented communications with the relevant 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; and comprehensive risk assessment and risk management plan. 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 or advocates were involved in the discharge process, where appropriate.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 26: Staffing					
Reason ID : 10003574		**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 nursing staff were not all trained in Basic Life Support and Fire Safety, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Mandatory training is being followed up with all staff.	Quarterly audit. Discuss at each months Carraig Mor Management meeting to discuss progress	Achievable On-going as training can expire and new staff join. As it is on-going, timebound is set to 31/12/2023	31/12/2023	All Heads of Discipline
Preventative Action	Training audit conducted and sent to MHC on a quarterly basis Training plan in place for all staff. Additional BLS spaces have been sourced. All HOD have agreed that training is requested 3 months prior to expiry	Quarterly training audit. Agenda item on each months Carraig Mor Management Team Meeting	Achievable. As it is an ongoing audit, timebound is set to 31/12/2023	31/12/2023	All Heads of Discipline

Regulation 28: Register of Residents					
Reason ID : 10003573		**The registered proprietor did not ensure that the register included all the information specified in Schedule 1 to the Regulations, as the register did not contain a discharge date or diagnosis code on discharge, 28(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Register of Residents has been updated to include all the information specified in Schedule 1 of the Register	Six monthly audits	Achieved. Audit on 15/10/2022 gave 100% results. Will be audited on a six monthly basis – next audit scheduled for March 2023	31/03/2023	CD, A/DON, CNM3
Preventative Action	This occurred due to an unexpected staff leave. Area Administrator now has a plan in place to ensure any absences are covered.	Audits on a six monthly basis	Achieved Audit on 15/10/2022 gave 100% results. Will be audited on a six monthly basis – next audit scheduled for March 2023,.	31/03/2023	Area Administrator Auditor allocated from audit committee.

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.

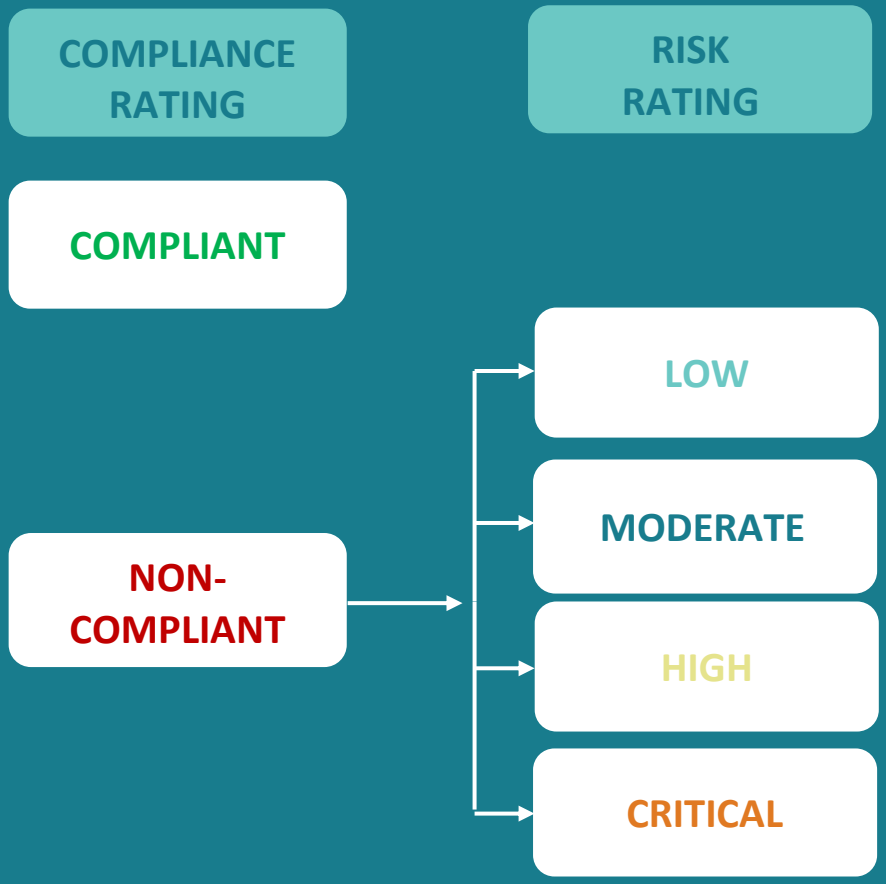
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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