National Eating Disorders Recovery Centre

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mental health commission

Focused Inspection
Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

National Eating Disorders Recovery Centre

62 Merrion Road, Ballsbridge, Dublin 4.

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2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Other

Conditions Attached:
None

Most Recent Registration Date:
18 June 2021

Registered Proprietor:
Linmore Health Limited

Registered Proprietor Nominee:
Ms Carla Johnson, Director of Services

Inspection Team:
Aoife Gallaher, Lead Inspector
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The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
1 – 4 November 2022

Previous Inspection date:
19 – 22 July 2022

Inspection Type:
Unannounced Annual Inspection

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1.0 Background

1.1 Reason for focused inspection

At the time of the annual inspection the numbers and skill mix of staff was not sufficient to meet resident's needs. A registered psychiatric nurse (RPN) was not always on duty. A registered general nurse (RGN) was on duty on occasions.The approved centre had experienced a period of instability in relation to changing members of the multi-disciplinary team which had an impact on the provision of therapeutic services.

1.2 Background

During the annual inspection on 19th to 22nd July 2022, it was found that Regulation 15: Individual Care Plan, Regulation 23: Ordering, Prescribing, Storing, and Administration of Medicines, Regulation 31: Complaints Procedures, and the Code of Practice on Admission, Transfer and Discharge were non-compliant. Regulation 26: Staffing was non-compliant, rated critical risk. The approved centre was required to take immediate steps to address non-compliance with Regulation 26: Staffing.

2.0 Overview of the Approved Centre

2.1 Description of the Approved Centre

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

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

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

2.2 Governance

The approved centre was owned by Linmore Health Limited. The approved centre management team composed of the Registered Proprietor (RP), the Clinical Director (CD), and the Director of Services (DOS). The Director of Services was the Registered Proprietor Nominee.

A local management meeting took place weekly to discuss issues relating to the approved centre that included residents' care and treatment, admission and discharge, any risk or incidents identified the previous week, COVID-19, health and safety, and any other relevant clinical and operational matters. Weekly multi-disciplinary meetings occurred to discuss the residents care and treatment and any relevant clinical information. The approved centre had monthly staff meetings chaired by the Director of Services.

Management Team Governance Meetings were held quarterly and were attended by the Registered Proprietor Nominee/Director of Services, Clinical Director, Clinical Nurse Manager and Consultant Psychiatrist. These meetings had standing agenda items which included clinical effectiveness, risk management, patient and public involvement, audit, staff management, and education and training. There was a formal system for staff supervision in place in the approved centre, that was carried out every six to eight weeks.

The Director of Services had the overall responsibility for risk management and was known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The National Eating Disorder Recovery Centre retained a local risk register which identified current risks. This was monitored and reviewed appropriately. The approved centre demonstrated adequate and appropriate processes to identify, assess, treat, and monitor risk, and incidents were reviewed to identify any trends or patterns occurring in the service. There was a process in place for consultation with an independent Risk Manager.

At the time of Inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. All nurses were registered psychiatric nurses and there was a registered psychiatric nurse (RPN) on duty, day and night. Staffing in the approved centre consisted of one RPN and one Health Care Assistant (HCA) on day duty and on night duty. Night duty staffing consisted of one RPN nurse and one HCA. At weekends the HCA was sleeping but on call. It was confirmed that a Clinical Nurse Manger 3 was to commence in post on 21st November 2022.

The multi-disciplinary team (MDT) had experienced a number of staff changes since the annual inspection. The MDT within the approved centre consisted of a consultant psychiatrist, a clinical psychologist, counselling psychologist, horticulture therapist, social worker, and dietitian. A non-consultant hospital doctor was to commence in post on 14th November 2022 three days a week. A second dietitian was to commence on 14th November 2022. Three therapists were new to the service having commenced since the previous inspection in July 2022. Therapists worked across the inpatient and outpatient programme with designated group time and residents for one-to-one therapy.

Residents in the approved centre were supported to provide service feedback through different pathways including suggestion box, the complaints process, and weekly community meetings which were documented. The complaints, compliments and feedback arrangements were publicly displayed. Minor complaints had been dealt with and documented. Advocacy services were available if a resident required them.

3.0 Methodology

The Inspection Team spoke with five residents and all members of the Senior Management Team.

The Inspection Team examined the following regulations:

Regulation 15: Individual Care Plan
Regulation 16 Therapeutic services and programmes
Regulation 19: General Health
Regulation 21: Privacy
Regulation 26: Staffing
Regulation 31: Complaints Procedures
Regulation 32: Risk Management Procedures

4.0 Inspection Findings

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

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 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). All five ICPs inspected were a composite set of documentation, with allocated space and sections for goals, treatment, care, resources required, and reviews. ICPs were stored within the clinical file. The clinical file was mainly comprised of the 'EpicCare' online system. The ICP was in document form. The ICP was presented in a book format and formed part of the clinical file. The ICP document was stored in a clear sleeve, one for each resident. ICPs were identifiable and were not interrupted. ICPs were not amalgamated with progress notes.

All ICPs for resident admissions were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. All ICPs identified appropriate goals for the resident. All ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICP's identified the resources required to provide the care and treatment. A multi-disciplinary team reviewed and updated the ICPs, as indicated by the residents' changing needs, condition, circumstances, and goals, this was documented.

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

The approved centre had a horticulture therapist and a counselling psychologist. Therapy programmes included a one-to-one psychotherapy session weekly for each resident, one-to-one dietetics weekly, group work at least once a day (either morning or afternoon) for 2.5 hours with a 30 minute break. Daily meal support and post meal support were provided. Six sessions of Family Therapy were offered to all residents during their stay in the approved centre; not all residents availed of this therapy.

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 policy for responding to medical emergencies. The policy was last reviewed in March 2022.

The approved centre had access to an Automated External Defibrillator (AED) and a small amount of emergency supplies. The approved centre's practice for emergency situations was to contact the emergency services number by phone. Residents received appropriate general health care interventions in line with individual care plans. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

The clinical files of two residents who were resident in the approved centre for over six months at the time of inspection were examined in relation to the provision of general health services. These two residents' general health needs were reviewed in the general hospital. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

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 and the manner in which staff interacted with residents was respectful. Residents were called by their preferred names, staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information. Residents had their own mobile phones and were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in December 2020 and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs.

Staffing in the approved centre consisted of one Registered Psychiatric Nurse (RPN) and one Health Care Assistant (HCA) on day duty and on night duty. Night duty staffing consisted of one RPN and one HCA. At weekends the HCA was sleeping but on call. It was confirmed that a Clinical Nurse Manger 3 was to commence in post on 21st November 2022.

The MDT within the approved centre consisted of a consultant psychiatrist, a clinical psychologist, counselling psychologist, horticulture therapist, social worker and dietitian. A non-consultant hospital doctor was to commence in post on 14th November 2022 three days a week. A second dietitian was to commence on 14th November 2022. Three therapists were new to the service having commenced since the previous inspection in July 2022. Therapists worked across the inpatient and outpatient programme with designated group time and residents for one-to-one therapy.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the management of complaints. The policy was last reviewed in October 2020. The policy covered the process for the management of complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan. Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them, and this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There were a series of written policies, and procedures in relation to risk management and health and safety management processes. The risk management policy was reviewed in December 2020. The person with responsibility for risk, was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation.

Multi-disciplinary teams (MDT) were involved in the development, implementation, and review of individual risk management processes. Individual risk assessments were completed at resident admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed prior to resident transfer and resident discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

The risk management policy was implemented in full throughout the approved centre. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

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

and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

5.0 Summary

In summary, residents who engaged with the Inspection Team reported a positive experience in relation to care and treatment and were complimentary towards all staff within the National Eating Disorders Recovery Centre, (NEDRC).

The approved centre had experienced a period of instability in relation to changing members of the multi-disciplinary team (MDT). However, the Senior Management Team described the recruitment of two counselling psychologists and a horticultural therapist as having a stabilising effect.

A second dietitian and a Clinical Nurse Manager 3 were due to commence in the approved centre the week following the inspection. A non-consultant hospital doctor was also due to commence two weeks following the focused inspection.

The inspection team concluded that the new staff and increased personnel that had been recruited would benefit the therapeutic programme.

All regulations inspected were deemed compliant.

Appendix 1

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.

On a focused inspection, the Inspector does not assess all regulations, rules, code of practice, and Part 4 of the 2001 Act. The focus of the inspection will be on specific legislative requirements, or parts of legislative requirements where it is determined that there may be a risk to the safety, health and well-being of residents and/or staff members.

Following the focused 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.

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.