# National Eating Disorders Recovery Centre

Annual Inspection Report 2023

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

# NATIONAL EATING DISORDERS RECOVERY CENTRE

62 Merrion Road, Ballsbridge, Dublin 4

**Date of Publication:**
13 December 2023

ID Number: AC0310

## 2023 Approved Centre Inspection Report (Mental Health Act 2001)

**Approved Centre Type:**
Other: Eating Disorders Treatment

**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:**
Noeleen Byrne, Lead Inspector
Susan O'Neill
Karen McCrohan

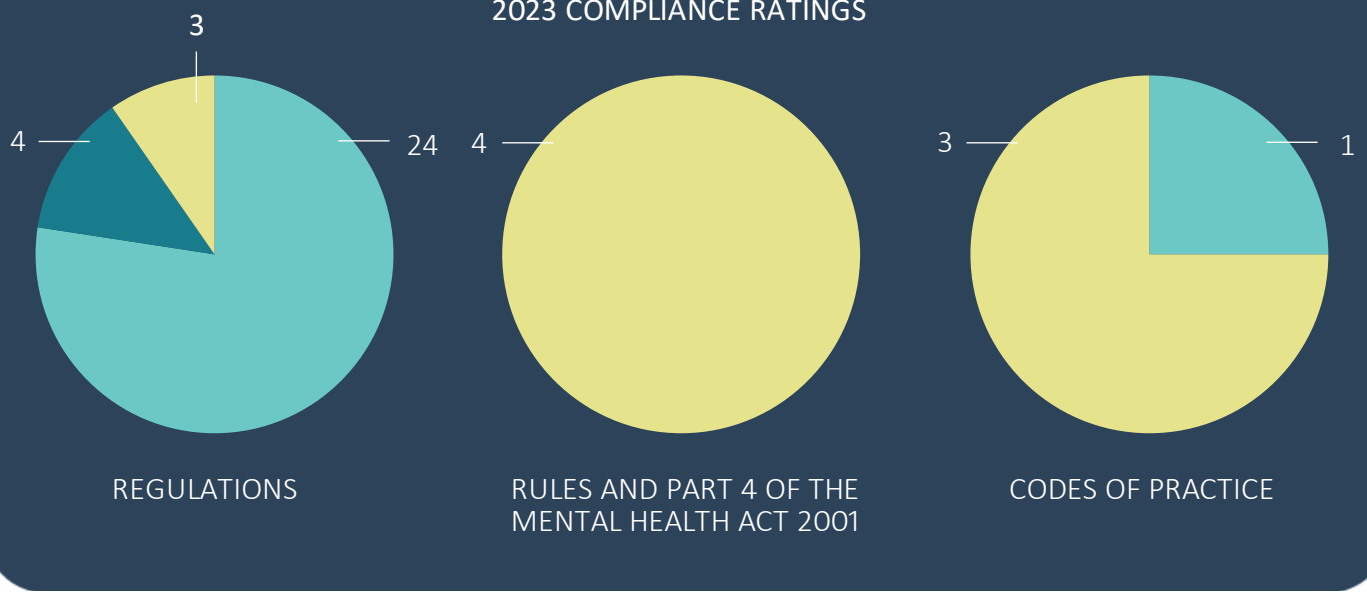
**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Inspection Date:**
18 – 21 April 2023

**Previous Inspection date:**
19 – 22 July 2022

**Inspection Type:**
Announced Annual Inspection

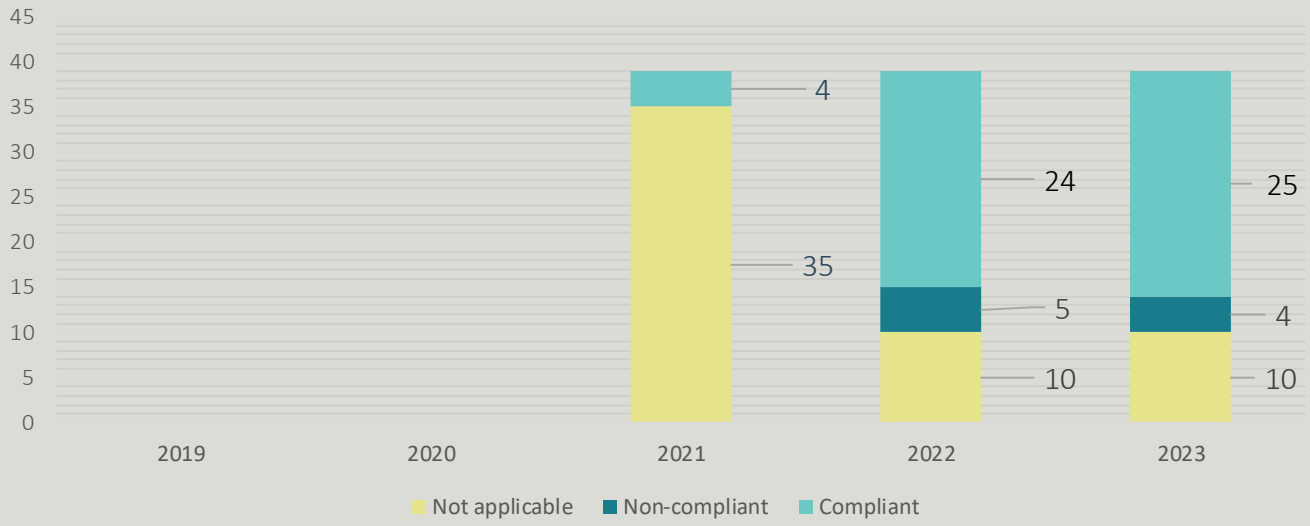
2023 COMPLIANCE RATINGS



## RATINGS SUMMARY 2019 – 2023

Compliance ratings across all 39 areas of inspection are summarised in the chart below.
The approved centre opened in 2021.

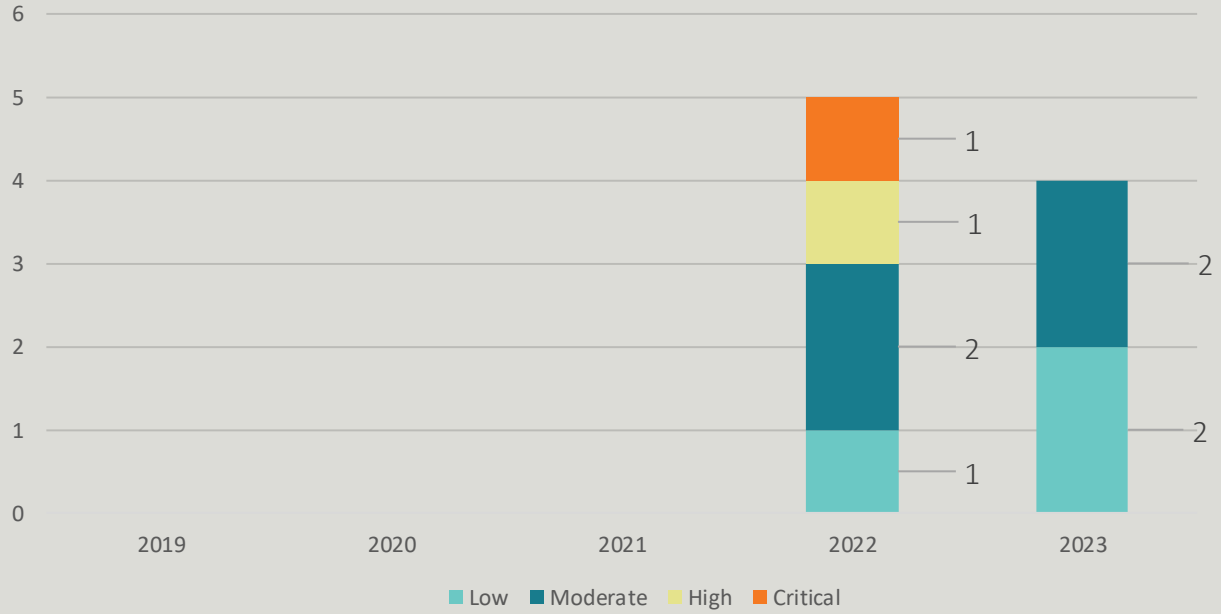
### CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023




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 2019 – 2023

The approved centre opened in 2021.



# Contents

# 1.0 Inspector of Mental Health Services – Review of Findings

## Inspector of Mental Health Services — Dr Susan Finnerty

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

## In brief

The National Eating Disorder Recovery Centre was a for-profit independent therapeutic service specialising in the treatment of eating disorder in Dublin. It provided both an inpatient and outpatient facility. The inpatient treatment facility was registered for six beds and was registered for the care and treatment of adults with an eating disorder. The outpatient facility was providing assessment and treatment for both adolescents and adults at the time of inspection.

| Compliance Summary | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| % Compliance | N/A | N/A | 100% | 83% | 86% |

## Conditions to registration

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

## Ongoing escalation and enforcement actions at time of inspection

None.

## Escalation and enforcement actions commenced following this inspection

None.

## Safety of people in the approved centre

**The approved centre demonstrated that they provided safe care in the following areas:**

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns on inspection with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained mental health nurses to provide safe care and treatment.
- ***Mandatory training:*** All staff were trained in fire safety, safeguarding, basic life support, management of violence and aggression, and the Mental Health Act.
- ***Ligature points:*** Ligature points were minimised to the lowest level, based on individual risk assessment.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Safeguarding:*** Staff were aware of safeguarding procedures.
- ***Access to essential information*****:** The clinical files were in order and it was easy to find essential information about the resident. The Health and Safety Statement was available to staff.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Alarms*****:** Staff were provided with alarms that were in working order.
- ***Infection control*****:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:
***Medication safety:*** One of the medication records examined did not document a clear record of the date of discontinuation for one medication. In another medication record examined, the documented frequency for one medication was illegible which resulted in a medication incident. This incident was identified by the service prior to the inspection and was appropriately reported and investigated.

## Appropriate care and treatment of residents

**The approved centre demonstrated that they provided appropriate care and treatment in the following areas:**

- **Appropriateness of environment:** The layout and the decoration of the approved centre was of high standard and met the needs of the residents.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. Residents had access to a local General Practitioner (GP) and local hospital for assessment and any treatment required.
- ***Individual care plans:*** There was evidence of significant engagement with residents in respect of their individual care plans. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, a senior registrar, director of services, assistant director of nursing, a clinical

nurse manager, three psychologists, two psychotherapists, two dietitians, and a social worker. While not all working a full week these positions covered throughout the week. There was a pathway for external referrals should residents require speech and language therapy and occupational therapy. There were regular MDT meetings to discuss residents' care plans which were attended by the resident.

- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan. There was a 12-week programme, in which all residents had one-to-one therapy with psychology and dietetics. Groups included a dietetic and nutrition group, a counselling and psychology-led group, a clinical psychology-led group, a dietetic cooking group, a psychotherapy group, decider skills, Wellness Recovery Action Plan (WRAP) groups, and therapeutic group outings. An eating disorder peer support worker had been introduced to the service.
- ***Access to other medical services:*** There was access to other medical services when required.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:
***Individual care plans:*** Three of the five ICPs inspected did not include appropriate goals for the resident.

## Respect for residents' privacy, dignity and autonomy

**The approved centre demonstrated that they respected people's privacy, dignity and autonomy in the following areas:**

- ***Sleeping accommodation:*** This consisted of single bedrooms, with two separate shower and toilet facilities nearby.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected. All bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. It was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialisation. Clinical files were securely stored.
- ***Use of restrictive practices:*** Restrictive practises were not used in the approved centre.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

## Responsiveness to residents' needs

**The approved centre demonstrated that they were responsive to people's needs in the following areas:**

- ***Environment:*** 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.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Activities included TV, books, board games, arts and crafts, and social outings.
- ***Residents' feedback:*** The residents were very complimentary about the environment and the care they received. They said that they received information on their treating teams and their individual care plans, were aware of their key workers and were able to give feedback about their care to staff. They said they had private spaces, their dignity was respected and that plenty of activities were provided during the day. All feedback was complimentary toward the staff and service provided. They specifically noted the excellent care, and the kind and helpful staff.

## Governance, Leadership and Accountability

**The approved centre had the following governance structures and processes in place:**

- ***Structure in place:*** The approved centre was owned by a private company. The senior management team comprised of the registered proprietor, the clinical director, the director of services and the assistant director of services. A local management meeting took place weekly and was attended by the director of services, the clinical director, the assistant director of nursing, the clinical nurse manager, psychologists, and dietitians.
- ***Leadership:*** There was evidence that good leadership in place. The registered proprietor attended the approved centre weekly to meet with the the Clinical Director, the Director of Services, and staff informally.
- ***Clinical governance:*** The approved centre had an online EpicCare system for the recording of information such as resident information, assessments, and individual care plans. This facilitated clinical audits.
- ***Risk:*** 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. There was a risk register which identified

current risks. This was monitored and reviewed appropriately. There was a process in place for consultation with an independent Risk Manager.

- ***Quality improvement:*** There was a dietetics audit of service user's vitamin D levels and supplementation of same where required.
- ***Policies:*** All policies were in date.
- ***Staff training:*** All staff had received mandatory training. Clinical supervision was provided for medical staff and the health and social care professional groups. There were nursing, dietetics, and psychology student placements. Staff training in Dialectic Behaviour Therapy (DBT) and Schema Therapy specific to eating disorders had been introduced.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** Residents were involved in their own care which included attendance at the MDT meetings.
- ***Advocacy services:*** A peer advocacy was available. Contact details for this service were displayed.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last three years of 90%. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

# 2.0 Quality Initiatives

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

1. Introduction of eating disorder peer support worker into service.

2. Introduction of weekly dietetic education and skills group for families.

3. Staff training in Dialectic behaviour therapy (DBT) and Schema therapy specific to eating disorders. DBT is a therapeutic intervention to help people manage intense emotions. Schema therapy is an integrated approach that brings together elements from cognitive behavioural therapy and object relations theories.

4. Introduction of nursing, dietetics, and psychology university students to use NEDRC services as a learning site.

5. Dietetics audit of service user's vitamin D levels and supplementation of same where required.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

National Eating Disorder Recovery Centre 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 two-storey semi-detached house that had been renovated and refurbished for the purpose of providing both an inpatient and outpatient facility. The inpatient treatment facility was registered for six beds and was registered for the care and treatment of adults with an eating disorder. The outpatient facility was providing assessment and treatment for both adolescents and adults at the time of inspection.

The approved centre was subdivided into two distinct areas. One had group rooms, consulting rooms, and facilities for inpatient and outpatient services. The kitchen and dining facilities for the residential service were also located in this area. There was a nursing office centrally located that was for both the outpatient and inpatient service. The residential area was well proportioned, which encompassed both living and recreational space on the ground floor, with two large sitting rooms that had been tastefully decorated. There was a quiet room that was also designated as a family visiting room. Located on the first floor of the approved centre was the sleeping accommodation which comprised of single bedrooms with rooms numbered two to eight. Room eight, which was larger in size, was identified as the isolation/infection control room if required. There were two separate shower and toilet facilities located on the first-floor landing. A further two bedrooms, a shower room and toilet facilities were located on the second floor but were not commissioned for use at the time of the inspection.

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 |

## 3.2 Governance

The approved centre was owned by a private company. The approved centre senior management team comprised of the Registered Proprietor (RP), the Clinical Director (CD) the Director of Services (DOS) and the

Assistant Director of Services. This team attended Governance meetings quarterly and standing items on the agenda included clinical effectiveness, risk management, patient and public involvement, audit, staff management, education and training.

A local management meeting that took place weekly was attended by the Director of Services, the Clinical Director, the Assistant Director of Nursing, the Clinical Nurse Manager, Psychologists and Dietitians. These meetings discussed issues relating to the approved centre that included residents care and treatment, admission and discharge, any risk or incidents identified the previous week, health and safety, and any other relevant clinical and operational matters. The Registered Proprietor attended the approved centre weekly to meet with the DOS, CD and staff informally. There was a formal system for staff supervision in place in the approved centre, that was carried out every six to eight weeks.

Governance questionnaires were provided to the Clinical Director, Registered Proprietor, Director of Services, Psychologists, Dietitian and Social Worker. Operational risks outlined in governance questionnaires included nursing staff shortage, however at the time of the inspection the approved centre was fully staffed.

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. National Eating Disorder Recovery Centre retained a local risk register which identified current risks. This was monitored and reviewed appropriately. There was a process in place for consultation with an independent Risk Manager.

The approved centre had an online system, known as the EpicCare system for the recording of information such as resident information, assessments, and individual care plans. Incidents was one part of the system which included the risk rating of incidents, accidents and near miss situations. 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 multi-disciplinary team within the approved centre which consisted of a Consultant Psychiatrist, a senior psychiatry registrar, three Psychologists, a Social Worker and two Dietitians. There was a pathway for external referrals should residents require services that were not available in the approved centre such as speech and language therapy and Occupational Therapy.

The National Eating Disorder Recovery Centre operates a 12 week programme. Residents and their families were encouraged to be involved in the development and review of their individual care plans. Residents in the approved centre were supported to provide service feedback through different pathways including a suggestion box, the complaints process and weekly community meetings which were documented. The complaints, compliments and feedback arrangements were publicly displayed.

Activities to support quality improvement in the approved centre included in-house training, staff supervision and team meeting reviews. New therapy programmes had been added to include weekly dietetic education and skills group for families. The approved centre had recently completed an audit of service user's vitamin D levels.

## 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 2021 and 2023 and the relevant risk rating when the service was non-compliant:

| Regulation/Rule/Act/Code | Compliance/Risk Rating | | | | | |
|---|---|---|---|---|---|---|
| | 2021 | | 2022 | | 2023 | |
| Regulation 13: Searches | N/A | ✓ | | ✗ | Moderate | |
| Regulation 15: Individual Care Plan | N/A | ✗ | Moderate | ✗ | Low | |
| Regulation 22: Premises | N/A | ✓ | | ✗ | Moderate | |
| Regulation 23: : Ordering, Prescribing, Storing and Administration of Medicines | N/A | ✗ | High | ✗ | Low | |

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

## 4.2 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice | Details |
|---|---|
| Regulation 17: Children's Education | As the approved centre did not admit children, this regulation was not applicable. |
| Regulation 25: Use of Closed Circuit Television | As CCTV was not in use in the approved centre, this regulation was not applicable. |
| Regulation 30: Mental Health Tribunals | As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable. |
| Rules Governing the Use of Electro-Convulsive Therapy | As the approved centre did not provide an ECT service, this rule was not applicable. |
| Rules Governing the Use of Seclusion | As the approved centre did not use seclusion, this rule was not applicable. |
| Rules Governing the Use of Mechanical Means of Bodily Restraint | As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable. |
| Part 4 of the Mental Health Act 2001: Consent to Treatment | As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, |

| | |
|---|---|
| | Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable. |
| Code of Practice on the Use of Physical Restraint in Approved Centres | As the approved centre did not use physical restraint, this code of practice 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. As such, service users' experiences were gathered in the following ways:

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team in person 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.

No residents filled out the questionnaire and three choose to meet the inspection team in person. All were very complimentary of the staff, describing them as compassionate, supportive, kind and very approachable. Residents described the environment as homely with staff sometimes joining for meals and it being like a family. The structure of the programme was praised with many group therapies and one to one sessions with staff. All residents were invited to the multi-Disciplinary Meetings (MDT) and invited to partake in planning their care and treatment.

## 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:

- Registered Proprietor
- Director of Services
- Assistant Director of Nursing
- Senior Dietitian

Apologies received from the Clinical Director.

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

**COMPLANT**

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

### INSPECTION FINDINGS

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

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

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

## Regulation 5: Food and Nutrition

**COMPLIANT**

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

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

### INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents were offered a sufficient range of options for their meals, following consultation with the dietitian regarding menu choices and food preferences. 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

All residents brought an adequate supply of clothing with them for the approved centre's 12-week programme of care. Petty cash was available where extra clothing was required in an emergency. All residents changed out of nightclothes during daytime hours.

**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 October 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Residents were encouraged not to bring large sums of money or valuables to the approved centre. Bedrooms were locked during daytime hours as a risk measure, and residents removed what they needed for the day. Lockers with coded padlocks were provided to residents, and a separate lockable unit was available for residents who wanted to store monies.

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

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

## Regulation 9: Recreational Activities

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Activities included TV, books, board games, arts and crafts, and social outings.

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

## Regulation 10: Religion

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

## Regulation 11: Visits

**COMPLIANT**

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in October 2020.

There were no strict visiting hours in the approved centre, and residents could receive visitors at their convenience outside of mealtimes and when group therapy was in progress. There were no restrictions on any resident's visits at the time of inspection. Appropriate steps were taken to ensure the safety of residents and visitors during visits. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting area was suitable for child visitors.

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

## Regulation 12: Communication

**COMPLIANT**

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

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and out going 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 d evice for the purposes of sending or receiving messages or goods.

### INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing communications. The policy was last reviewed in October 2020. Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents had access to postal mail, their own mobile phones where applicable, a shared landline and mobile phone, and the use of a laptop and electronic tablet where required.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others.

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

## Regulation 13: Searches

**NON-COMPLIANT**

**Risk Rating** **MODERATE**

(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 October 2020, and included all requirements related to:

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

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

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were not in attendance at all times during the searches, as only one staff member was recorded as having been in attendance for the search of one resident. Due regard was shown to the residents' dignity, privacy, and gender. At least one of the staff members conducting the searches 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 (excepting the aforementioned search where only one staff member was recorded as present), and details of who was in attendance for the search.

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that there was a minimum of two clinical staff in attendance at all times when searches were being conducted, 13 (6).**

## 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 October 2020.

As there had been no death 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

**NON-COMPLIANT**

**Risk Rating** LOW

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). Five 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.

Three of the five ICPs inspected did not include appropriate goals for the resident. The care and treatment required to meet goals was identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to weekly review by the MDT in consultation with the resident. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

**The approved centre was non-compliant with this regulation because three of the five individual care plans inspected did not include appropriate goals for the resident.**

## 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 operated a set 12-week programme, in which all residents had one-to-one therapy with psychology and dietetics. Groups included a dietetic and nutrition group, a counselling and psychology-led group, a clinical psychology-led group, a dietetic cooking group, a psychotherapy group, decider skills/Wellness Recovery Action Plan (WRAP) groups, and therapeutic group outings.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

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

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

## Regulation 18: Transfer of Residents

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in March 2023. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

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

## Regulation 19: General Health

**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 October 2020. Staff in the approved centre had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents had access to "GP 24", a private general practitioner (GP) service. The GP saw residents to undertake admission assessments and as required thereafter. Access to speech and language therapy, occupational therapy, and physiotherapy was provided via private services. There were two full-time dietitians working onsite.

Residents could access national screening programmes that were available according to age and gender, including the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

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

## Regulation 20: Provision of Information to Residents

**COMPLIANT**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

### INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in March 2023.

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

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

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

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

## Regulation 21: Privacy

**COMPLIANT**

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

### INSPECTION FINDINGS

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

All 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 blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

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

## Regulation 22: Premises

**NON-COMPLIANT**

**Risk Rating** **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. 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: the back yard area was small, but residents were free to walk about outdoors. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good 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. However, there was no access to an assisted toilet in the approved centre. Although the approved centre did not admit residents with mobility needs, assisted toilet facilities were still required for visitors. There was one toilet

for the ground floor which was spacious but did not contain any grab rails or other features to assist those with a physical disability. This toilet was accessed by descending a flight of three steps, making it unsuitable for visitors who may have physical disabilities or require a wheelchair. All resident bedrooms were appropriately sized to address the resident needs, and furnished to support resident independence and comfort.

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the condition of the physical structure of the approved centre was developed with due regard to the well-being of all visitors, as there was no access to an assisted toilet on site, 22 (3).**

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

**NON-COMPLIANT**

**Risk Rating** LOW

(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 January 2023, 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, five of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident. One of the MPARs examined did not document a clear record of the date of discontinuation for one medication.

The signature of the medical practitioner or nurse prescriber was included for each entry. In one of the MPARs examined, the documented frequency for one medication was illegible which resulted in a medication incident. This incident was identified by the service prior to the inspection and was appropriately reported and investigated. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

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

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

a) **In one of the five Medication Prescription and Administration Records (MPARs) examined, a clear record of the date of discontinuation was not documented for one medication, 23 (1).**
b) **In one of the five Medication Prescription and Administration Records (MPARs) examined, the documented frequency for one medication was illegible, 23 (1).**

## 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 October 2020.

**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 October 2020, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

There was one multi-disciplinary team consisting of a Consultant Psychiatrist, a senior registrar, Director of Services, Assistant Director of Nursing, a Clinical Nurse Manager, three Psychologists, two Psychotherapists, two Dietitians, and a Social Worker. While not all working a full week these positions covered throughout the week. There was a pathway for external referrals should residents require speech and language therapy and Occupational Therapy.

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

**Staff Training Table**

| Profession | Basic Life Support | | Fire Safety | | Management Of Violence and Aggression | | Mental Health Act 2001 | |
|---|---|---|---|---|---|---|---|---|
| Nursing (8) | 8 | 100% | 8 | 100% | 8 | 100% | 8 | 100% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Consultant Psychiatrist (1) | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| Medical (1) | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| Dietitian (2) | 2 | 100% | 2 | 100% | 2 | 100% | 2 | 100% |
| Social Worker (1) | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| Psychologist (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |

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

## Regulation 27: Maintenance of Records

**COMPLIANT**

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in January 2023, 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.

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

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

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

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

## Regulation 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 in October 2020, 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 complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints 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. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented. There had been no formal complaints since the last inspection.

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

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

## Regulation 32: Risk Management Procedures

**COMPLIANT**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in October 2020, 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. 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.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during

resident transfer and resident transfer. 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.

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 displayed prominently in the hall.

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

# 8.0 Inspection Findings – Rules

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

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

# 9.0 Inspection Findings – Mental Health Act 2001

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

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

# 10.0 Inspection Findings – Codes of Practice

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

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

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

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

## Admission, Transfer and Discharge

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**Admission:** The admission policy, which was last reviewed in January 2023, included all of the policy-related criteria for this code of practice.

**Transfer:** The transfer policy, which was last reviewed in March 2023, included all of the policy-related criteria for this code of practice.

**Discharge:** The discharge policy, which was last reviewed in January 2023, 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 state, risk assessment, 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 risks and early warning signs of relapse, and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

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

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

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

## Appendix 1: Corrective and Preventative Action Plan

| Regulation 13: Searches | | | | | |
|---|---|---|---|---|---|
| Reason ID : 10004089 | | The registered proprietor did not ensure that there was a minimum of two staff in attendance at time when searches were being conducted, 13(6). | | | |
| | Specific | Measurable | Achievable/Realistic | Time-bound | Post-Holder(s) |
| **Corrective Action** | All searches must be carried out by a minimum of two staff. | Audit of searches. | Achievable and realistic | 18/10/2023 | Director of Services. |
| **Preventative Action** | Staff awareness that all searches take place with a minimum two staff. | Audit of searches. | Achievable and realistic | 18/10/2023 | Director of Services |

| Regulation 15: Individual Care Plan | | | | | |
|---|---|---|---|---|---|
| Reason ID : 10004090 | | Three of the five individual care plans inspected did not include appropriate goals for the resident. | | | |
| | Specific | Measurable | Achievable/Realistic | Time-bound | Post-Holder(s) |
| **Corrective Action** | Individual Care Plans are currently in review to make larger space for goals set by residents | Review at MDT, Governance meeting and ICP audits. | Achievable and realistic | 17/11/2023 | Director of Services |
| **Preventative Action** | Individual Care Plans are currently in review to make larger space for goals set by residents | Review at MDT, Governance meeting and ICP audits. | Achievable and realistic | 17/11/2023 | Director of Services |

| Regulation 22: Premises | | | | | |
|---|---|---|---|---|---|
| Reason ID : 10004091 | | The registered proprietor did not ensure that the condition of the physical structure of the approved centre was developed with due regard to the well-being of all visitors, as there was no access to an assisted toilet on site, 22(3). | | | |
| | Specific | Measurable | Achievable/Realistic | Time-bound | Post-Holder(s) |
| **Corrective Action** | The assisted toilet that is currently already onsite now has a handrail in situ and ramp down the three steps in the hall for any visitors that may require in the future. | Immediate works carried out and completed. | Achieved and realistic | 18/10/2023 | Proprietor |
| **Preventative Action** | The assisted toilet that is currently already onsite now has a handrail in situ and ramp down the three steps in the hall for any visitors that may require in the future. | Immediate works carried out and completed. | Achieved and realistic | 18/10/2023 | Proprietor |

| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10004092** | | **In one of the five Medication Prescription and Administration Records (MPARs) examined, a clear record of the date of discontinuation was not documented for one medication, 23 (1). In one of the five Medication Prescription and Administration Records (MPARs) examined, the documented frequency for one medication was illegible, 23 (1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Medical staff aware of importance of legibility on kardex. | Kardex audits. Kardex audit carried out prior to inspection had noted the above already. | Achievable and realistic | 01/11/2023 | Director of Services |
| **Preventative Action** | Medical staff aware of importance of legibility on kardex. | Kardex audits. Kardex audit carried out prior to inspection had noted the above already. | Achievable and realistic | 01/11/2023 | Director of Services |

## 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.

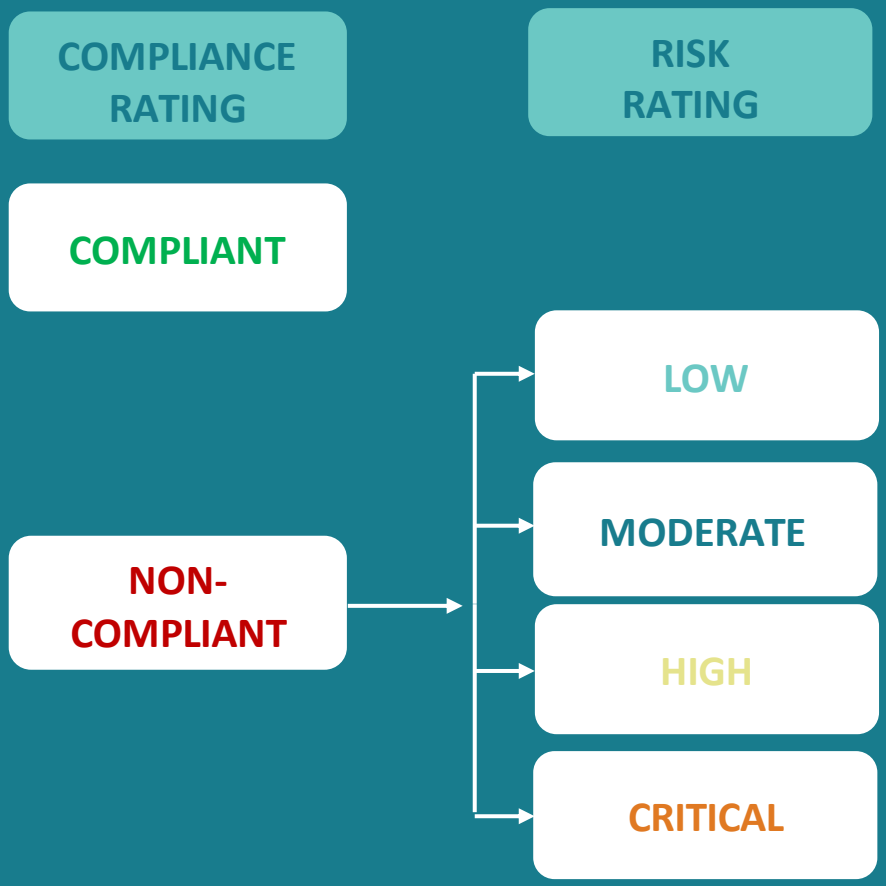
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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