St Patrick's Hospital, Lucan

Annual Inspection Report 2023

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Promoting Quality, Safety and Human Rights in Mental Health

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mental health commission

ST PATRICK'S HOSPITAL, LUCAN

Lucan, Co Dublin, K78 NW63

Date of Publication:
02.April 2024

ID Number: AC0127

2023 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
None

Most Recent Registration Date:
25 May 2022

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr. Paul Gilligan, Chief Executive Officer

Inspection Team:
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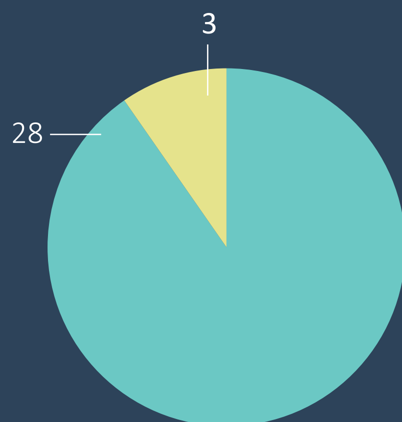
Professor James V Lucey MCRN000646

Inspection Date:
7 – 10 November 2023

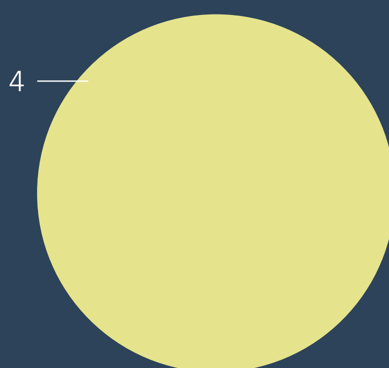
Previous Inspection date:
4 – 7 September 2022

Inspection Type:
Announced Annual Inspection

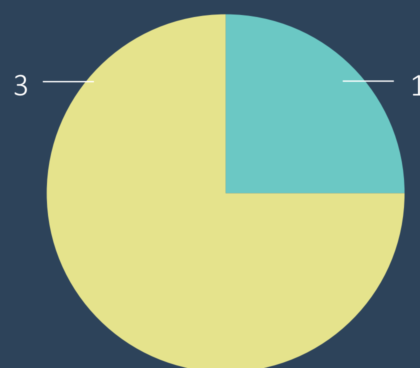
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



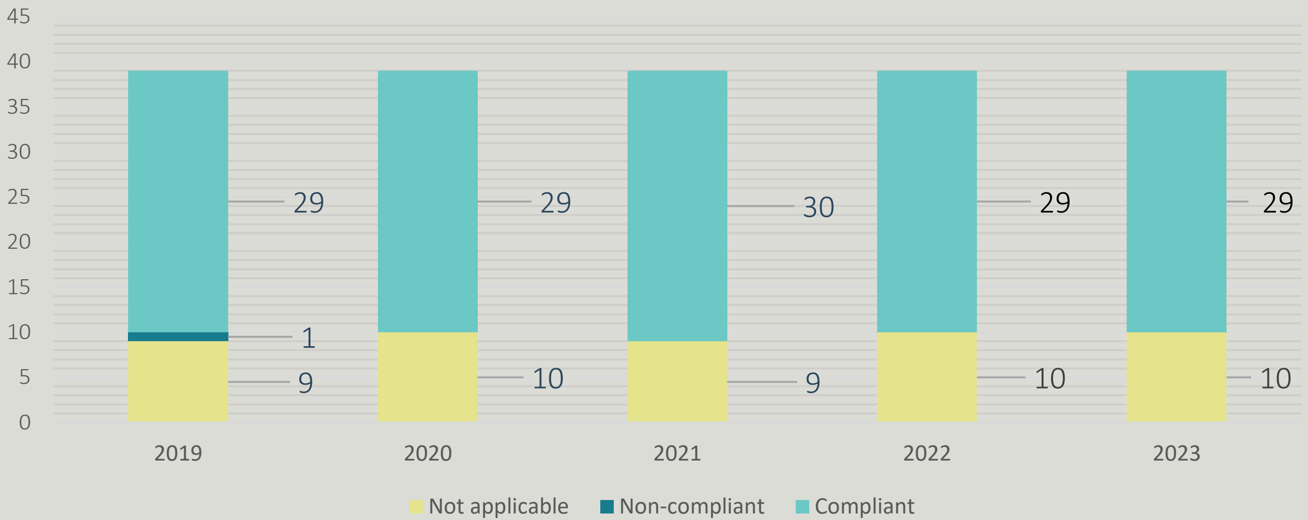
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2019 – 2023

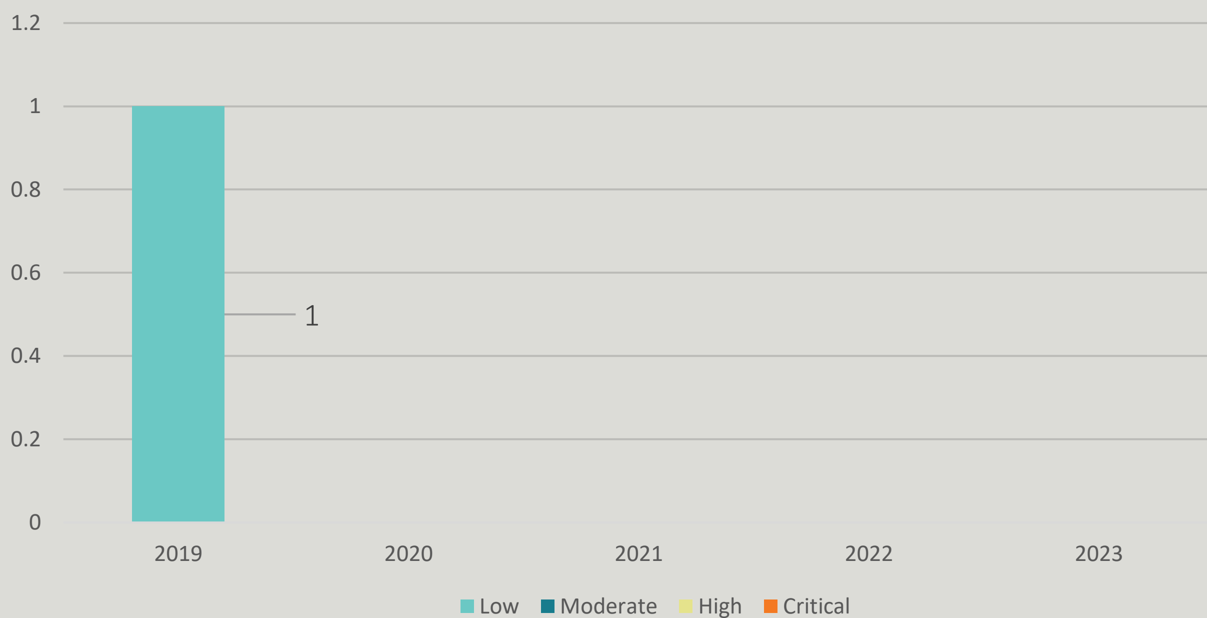
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Professor James V Lucey

In brief

St. Patrick's Lucan was part of the larger St. Patrick's Hospital and shared management structures with this larger service. The approved centre provided treatment for voluntary residents only. It was located at the edge of Lucan village and was set within extensive grounds and had a capacity of 52 beds. At the time of the inspection, two multi-disciplinary teams worked out of the approved centre.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	97%	100%	100%	100%	100%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety 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 with fire safety in the approved centre.

- ***Number of registered nurses in the approved centre***: There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***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 person. 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 and had a comprehensive COVID-19 management plan.

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 St. Patrick's Hospital, Lucan was of high standard and met the needs of the resident group. The approved centre was well maintained and bright and spacious. There was a dining room, art room, therapy room, sitting room and occupational therapy kitchen. There was a large group room located upstairs within the approved centre.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** The therapeutic activities provided by the approved centre included mindfulness, guided meditation, sound meditation, anti-tension groups, art therapy, music therapy, creative writing, yoga, indoor and outdoor exercise groups, and gardening groups. The approved centre also ran an 'Older Adult' group for residents.
- ***Access to other medical services:*** Specialist therapeutic interventions, including physiotherapy, dietetics, speech and language therapy and chiropody, were provided from external sources if required.

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:*** Sleeping accommodation consisted of single and double bedrooms.
- ***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:*** All bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents’ names, and it was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre had not used any restrictive practices since the previous inspection. The approved centre had a reduction of restrictive practices strategy.
- ***Person-centred Care:*** There was evidence of person-centred care in the care plans, the individual therapeutic programmes, the feed-back and involvement of residents in their care and in service planning.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices as far as was possible, dependent on their assessed capacity. There was access to advocacy and relationships with families and friends were encouraged. Consent for personal care and therapeutic and physical interventions 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 communal areas and in bedrooms. Rooms were ventilated and there was no 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.
- ***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. The extensive gardens and multipurpose areas were available to residents for socialising.
- ***Cultural and spiritual support.*** There was an oratory on the ground floor of the approved centre. Mass was streamed online every day. Catholic priests visited regularly. Multi-faith religions were accommodated.
- ***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. A “What's my Drug” online link was added to the SPMHS website that provided brief information about all medications and the link was added to the Service User Portal. There was an information centre in the hospital that people could visit.

- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities*** Recreational activities included the following: These included books, crafts, bingo, pottery Tai Chi, yoga, gardening groups, playing cards, jigsaws, movies and botanical plaster casting. There was also a 'Knit and Natter' group, a card making group and a walking group.
- ***Residents' feedback:*** Residents were satisfied with the care delivered to them by St. Patricks Hospital Lucan. They had previously provided feedback emphasising their preference in terms of in-person therapeutic services as opposed to online services. This feedback had been acknowledged by the management of the approved centre and a new timetable of in person services had been implemented. Residents who completed the questionnaire rated the service at 7 out of 10 and 10 out of 10.

Governance, Leadership and Accountability

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

- ***Structure in place:*** St. Patrick's University Hospital Lucan was part of St. Patrick's Mental Health Services (SPMHS). The approved centre was governed by a charter which outlined the governance of the approved centre through a Board of Governors. The Senior Management Team (SMT) were responsible to the Board of Governors for the operation of the approved centre. The Clinical Governance Group and the Senior Management Team (SMT) focused on specific aspects of approved centre governance along with numerous other committees. A detailed clinical and corporate governance structure was in place. This outlined the areas of responsibility and lines of reporting within the approved centre.
- ***Clinical Governance:*** A clinical governance committee meeting which was held weekly. The agenda of the clinical governance committee included clinical audits, quality improvements, incidents/near misses, and policies.
- ***Leadership:*** The organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. The SMT had overall responsibility for the monitoring and management of risks. All heads of discipline were able to identify strategic aims for their teams and how they were going to achieve these.
- ***Restrictive Practices Reduction:*** The Use of Physical Restraint Policy had been updated and the required Reduction of Physical Restraint Policy was implemented and displayed on SPMHS website. The project manager of the Clinical Governance Office of the approved centre was the named senior manager responsible for the approved centre's reduction in physical restraint.
- ***Risk:*** Incidents were reported, and risk assessed. There was a risk and safety committee meeting which completed a monthly overview of the serious incidents in the approved centre. Persons with responsibility for risk working directly in the approved centre were known by staff. The approved centre had a local risk register and applicable risks had been escalated to the Quality and patient safety committee and the area risk register. Senior management formally reviewed and updated the content of the risk registers and control measures every quarter.
- ***Policies:*** All policies were in place, up to date and implemented.
- ***Quality improvement:*** Key performance indicators assisted the approved centre to measure the achievement of set goals. Clear systems were in place to support and monitor quality improvement.

A programme manager worked together with the approved centre management, and oversaw a programme aimed at enhancing quality and regulatory compliance. A scheduled programme of audit, involving all disciplines, was implemented in the approved centre.

- ***Staff training:*** Annual staff training plans were completed to identify and address training needs.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement:*** Residents had input into future development in SPMHS and this was facilitated through various methods and further supported by the project advisory service user forum. There was service user representation on interview panels for new appointments. Community meetings, evaluation forms, surveys, suggestion boxes, a complaints process, and an independent advocacy service also provided feedback to staff and management about the resident experience of service provision. There were clear processes in place to follow up on any issues identified by service users and residents.
- ***Advocacy Services:*** A peer advocacy representative met with residents on a weekly basis. Contact details for this service were displayed.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last five years of 99%. There are no conditions attached to its registration. 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. A ‘Medicines Information Access for Service Users’ initiative was developed this enabled patient information to be accessed online through the St. Patrick’s website or by way of a QR code. This was also linked to the Choice and Medication website, which provided brief information about various medications, not limited to mental health medications. This information was linked to the patient portal.

2. The nursing and pharmacy departments developed a Medicines Management Care Plan. Residents were given a care plan which highlighted physical health monitoring required by a certain medication or identified interactions that may affect a resident’s response to medications. The Medicines Management Care Plan used service-appropriate language to make medication management more efficient, improve the consistency of recording and empower residents to better understand their medication.

3. A Family Members, Carers and Supported Advisory Network was developed to broaden the engagement structures within St. Patrick’s Lucan. It provided opportunities for consultation and engagement with a broad group of stakeholders. Network members were involved in developing services by joining projects and steering groups and by taking part in group discussion, focus groups and consultative forums.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Patrick's Lucan was part of the larger St. Patrick's Hospital and shared management structures with this larger service. The approved centre provided treatment for voluntary residents only and had a service agreement that residents requiring higher levels of observation or different clinical treatments to those offered in St. Patrick's Lucan would be transferred to St. Patrick's University Hospital.

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

All clinical files were stored in an electronic format and residents could access their Individual Care Plans and other relevant documentation using their individualised Patient Portal. A Service User Information technology group was available to assist residents who required guidance in terms of using the system.

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

Resident Profile	
Number of registered beds	***52***
Total number of residents	**22**
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

St. Patrick’s Hospital Lucan was part of St. Patrick’s Mental Health Services. The approved centre was formed in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a board of governors. The senior management team were accountable to the board for the direct operation of the approved centre. A detailed clinical and corporate governance structure was in place. This outlined the areas of responsibility and lines of reporting within the approved centre.

The senior management team met fortnightly. These meetings were attended by representatives of various disciplines within the approved centre. The minutes from these meetings were provided to the inspection team and outlined an active governance process involving senior management. Issues such as service development, quality and human resources were discussed. The results of the St. Patrick’s Service User Experience survey were also discussed. The Clinical Governance Committee met each week in order to discuss issues of clinical significance. The Quality and Risk Committee and Senior Council Group each met fortnightly. Other committees were the Drugs and Therapeutics Committee, the Health and Safety Committee and the Service User Committee. The approved centre meeting minutes evidenced a robust governance process with outcomes and actions documented.

Key personnel with responsibility for risk management worked in the approved centre. The approved centre had a risk manager. The person with overall responsibility for risk was identified and known by staff. The approved centre had a local risk register. The risk register contained health and safety risks, clinical risks and corporate risks. All incidents had been appropriately reported and were reviewed for patterns and trends by the risk manager. An organisational chart defined key positions and lines of responsibility. The approved centre was adequately staffed; core staff included nurses, psychologists, social workers, occupational therapists, a pharmacist, and medical staff. Goals specified by the heads of discipline included the implementation of a strategic plan for the service that would provide quality, evidence-based care in compliance with Mental Health Commission requirements and would ensure a full quota of suitable, qualified, and trained staff to deliver care of the highest quality standard.

Some risks outlined included: difficulties in recruiting and retaining qualified staff, completing all mandatory training in a timely manner, ensuring that staff were CORU registered and remote-working challenges for staff. Operational risks were managed and escalated to the risk register as required. Clinical supervision was provided for medical staff and health and social care professionals. All the disciplines were involved in the approved centre clinical audit programme.

The process for making a complaint was publicly displayed and available to residents and family members. The details of the complaints officer were displayed in communal spaces throughout the approved centre, in an information booklet in each resident's bedroom and on the approved centre’s website. Complaint and suggestion boxes were available in communal areas throughout the approved centre and these could be used by residents, families, representatives and advocates. Minor complaints were documented with clear actions and outcomes detailed. A representative from Peer Advocacy in Mental Health was available to the residents of the approved centre. Governance processes provided for the involvement of service users and their representatives where appropriate.

At the time of the inspection, St. Patrick's Lucan had recently reopened to the physical admission of residents to the approved centre, having been closed over the course of the COVID-19 pandemic period. Residents had been provided with home care packages and online therapies up until its reopening in July 2023. A full programme of therapeutic activities had been developed for delivery to residents; these were a combination of in-person and online activities. Two fully staffed multi-disciplinary teams worked out of the approved centre.

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

No areas were non-compliant on this inspection.

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 no involuntary patient had received ECT since the last inspection, 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 no resident had been mechanically restrained since the last inspection, 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 no resident in the approved centre had been physically restrained since the last inspection, 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. To that end, the inspection team engage with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete, 'Your Views'; a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- 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. Some issues arose that were specific to individual residents; these were fed back to the treating team for resolution. Residents were complimentary toward the approachability and kindness of nursing staff. Residents stated that they enjoyed the food provided by the approved centre. Feedback from the residents indicated that they had not been entirely satisfied with the therapeutic timetable and felt that many of the activities had been recreational in their nature. This feedback had been given to the St. Patrick's Lucan management team by the residents prior to the annual inspection and as a result a new comprehensive therapeutic schedule had been introduced that week. Various residents disliked the fact that some of the therapeutic activities, one-to-one meetings with clinicians and individual care plan reviews continued to be held over Zoom; they would have preferred in-person contact rather than teleconference consultations in these cases. Residents also stated that, given the long walk to the local shop, they would prefer if the vending machine accepted card payments. This matter had already been acknowledged by the St. Patrick's Lucan management team and the vending-machine payment mechanism was due to be updated in the coming weeks.

Two residents returned the 'Your Views' service user questionnaire. Both respondents understood their care plan and were familiar with the members of their multi-disciplinary team. Both were happy with how staff spoke to them and felt that their privacy and dignity were respected. One respondent responded 'no' to the questions 'There are enough activities for me to do during the day', while the other responded 'yes' to this question. One respondent knew who their key worker was but the other did not. In rating the overall experience of care and treatment out of ten (with one being poor and ten being excellent), the residents who completed the questionnaire ranked the approved centre as '7' and '10' respectively. Comments included in the questionnaire indicated the desire for quicker access to GP services within the approved centre, and that the respondent was receiving the best of care with full support of their team.

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:

- Clinical Director
- Director of Nursing St. Patrick's Hospital
- Director of Nursing St. Patrick's Lucan
- Registered Proprietor
- Medical Director
- Director of Services
- Programme Manager Clinical Governance,
- MHA Administrator
- Head of Occupational Therapy
- Acting Head of Social Work
- Director of Psychology

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. The identifiers were checked before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

Night clothes were not worn by residents during the day unless specified in their individual care plan.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to residents' personal property and possessions which was last reviewed in January 2023.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary. Each resident had a secure locker located in the property room to store their valuable items. The approved centre also provided a safe to store resident 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 on weekdays and weekends appropriate to the resident group profile.

The approved centre had a variety of recreational activities. These included books, crafts, bingo, pottery Tai Chi, yoga, gardening groups, playing cards, jigsaws, movies and botanical plaster casting. There was also a 'Knit and Natter' group, a card making group and a walking group. Televisions were located in the recreational room and in each of the bedrooms.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2023. Visiting times were appropriate and reasonable.

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

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy on service user access to communication facilities was last reviewed in January 2023.

Residents had access to postal mail, telephone and Wi-fi enabled internet, unless otherwise risk-assessed with due regard to the residents' well-being, safety and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in January 2023. It included all the policy regulation requirements including:

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

No searches had taken place since the last inspection; therefore, this regulation was assessed for compliance on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

No resident had passed away in the approved centre since the last inspection; therefore, the approved centre was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

Residents were provided with an electronic tablet and had virtual access to therapeutic programs and to individual meetings with their multi-disciplinary team (MDT).

The approved centre had an activities schedule which included therapeutic and recreational activities. The therapeutic activities provided by the approved centre included mindfulness, guided meditation, sound meditation, anti-tension groups, art therapy, music therapy, creative writing, yoga, indoor and outdoor exercise groups, and gardening groups. The approved centre also ran an 'Older Adult' group for residents.

The approved centre also provided individual therapies including cognitive behavioural therapy, social work, occupational therapy, psychotherapy and psychology. Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in July 2023.

The clinical file of one resident who had been emergency transferred from the approved centre was examined. Communications between the approved centre and the receiving facility were documented and followed up with a written referral. Full, complete, and relevant written information about the resident was transferred to the receiving hospital when they moved there. The transfer documentation included a letter of referral, which contained a list of current medication and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in October 2023. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator. Residents received appropriate general health care interventions in line with individual care plans.

No resident had been in the approved centre for over six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Access was provided to a dietitian, chiropodist and physiotherapist as required.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had two written operational policies and procedures on the provision of information to residents. Each policy was last reviewed in January 2023.

Residents and their representatives received all required information at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. It contained details of housekeeping arrangements including arrangements for personal property, mealtimes, the complaints procedure, visiting times and arrangements, relevant advocacy and voluntary agencies and residents' rights.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space and communal rooms. 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.

Residents had sufficient spaces to move about, including outdoor spaces. The outdoor space had been landscaped and had garden furniture, raised planter-style beds, a sensory garden, and a water feature.

Hazards 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 good a state of repair externally and internally. A programme of general and decorative maintenance, cleaning, decontamination and repair of assistive equipment was in place. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

There were sufficient toilets and showers for residents, as well as a designated cleaning room and sluice room. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administering medicine. The policy was last reviewed in July 2022 and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including a record of any allergies or sensitivities to medications, a record of medications administered to the resident and the administration route for all medications, clear records of the date of discontinuation for each medication and the Medical Council Registration Number of every medical practitioner prescribing medication to the resident. All entries in the MPARs were legible.

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and a site-specific safety statement in place. The policy was last reviewed in March 2023.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in place in relation to recruitment, selection and Garda vetting requirements. The policy was last reviewed in July 2022.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. All staff were trained in basic life support and fire safety, the management of violence and aggression and the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Two multi-disciplinary teams admitted residents to the approved centre. Both teams were fully staffed and members included; medical, nursing, social work, occupational therapy and psychology staff.

The following table shows the number and percentages of staff trained in the different aspects of mandatory training:

Staff Training Table								
Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (19)	19	100%	19	100%	19	100%	19	100%
Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%

Medical (2)	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	100%
Pharmacy (1)	1	100%	1	100%	1	100%	1	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a series of written operational policies and procedures in relation to the maintenance of records. The policies were last reviewed over the time period of May to July 2022.

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

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures 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 January 2023 and included the process for raising, handling and investigating complaints from any person, regarding any aspect of the services, care or treatment provided in or on behalf of the approved centre.

A nominated person in the approved centre was responsible for dealing with all complaints. Information about the complaint's procedure was provided to residents and their representatives in the resident information booklet. Information about the complaint's procedure, including how to contact the nominated person, was publicly displayed in the approved centre.

Residents, their representatives, family, and next of kin were informed of 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: 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

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in March 2022 and included the following:

- The process for identifying, assessing, treating, reporting and monitoring 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 to all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk.

Individual risk assessments were completed in conjunction with medication requirements and prior to and during resident discharge. Individual risk assessments were also completed at admission to identify individual risk factors, including general health risks, risk of absconding and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management

processes. The requirements for the protection of vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and of 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 anonymously at the resident level.

An emergency plan 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, which was displayed prominently in the entrance hall of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer and discharge. The admission policy was last reviewed in December 2022, the transfer policy was last reviewed in July 2023 and the discharge policy was last reviewed in July 2023. All policies combined included all the policy related criteria of the code of practice.

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

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

Evidence of Implementation:

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

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

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

There was appropriate MDT input in the discharge planning. A preliminary discharge summary was sent to relevant healthcare professionals within three days. A comprehensive discharge summary letter was issued within 14 days of discharge. The discharge summary letter included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health and social issues, follow-up arrangements and

names and contact details of key people for follow-up. The discharge summary included risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1 Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

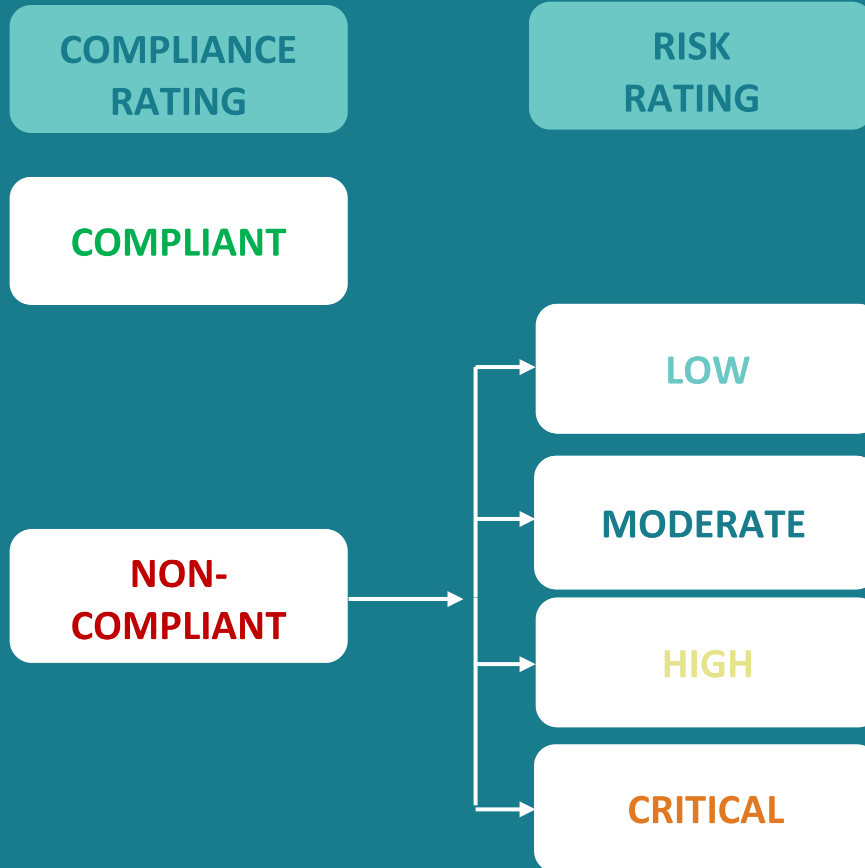
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.