National Eating Disorders Recovery Centre

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mental health commission

Annual Inspection Report 2024

Promoting Quality, Safety and Human Rights in Mental Health

NATIONAL EATING DISORDERS RECOVERY CENTRE

62 Merrion Road, Ballsbridge, Dublin 4

Date of Publication: 29th August 2024

ID Number: AC0310

2024 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:
Marianne Griffiths, Lead Inspector
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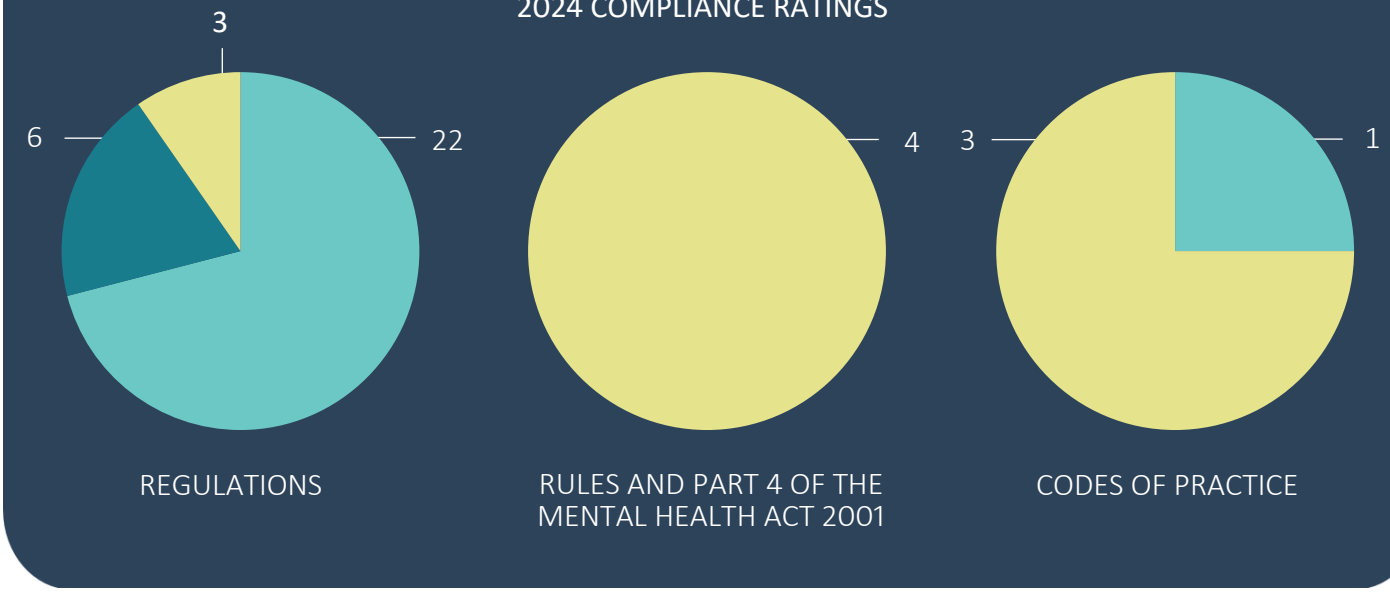
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
19 – 22 March 2024

Previous Inspection date:
18 – 21 April 2023

Inspection Type:
Unannounced Annual Inspection

2024 COMPLIANCE RATINGS

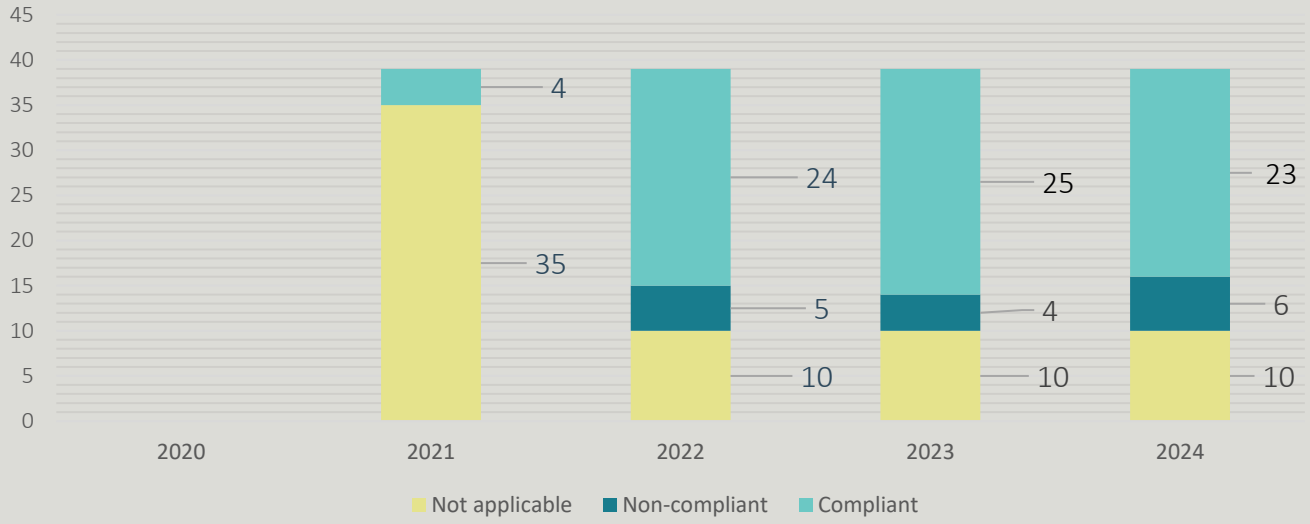


RATINGS SUMMARY 2020 – 2024

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

Please note: **The approved centre opened for the first time in 2021**

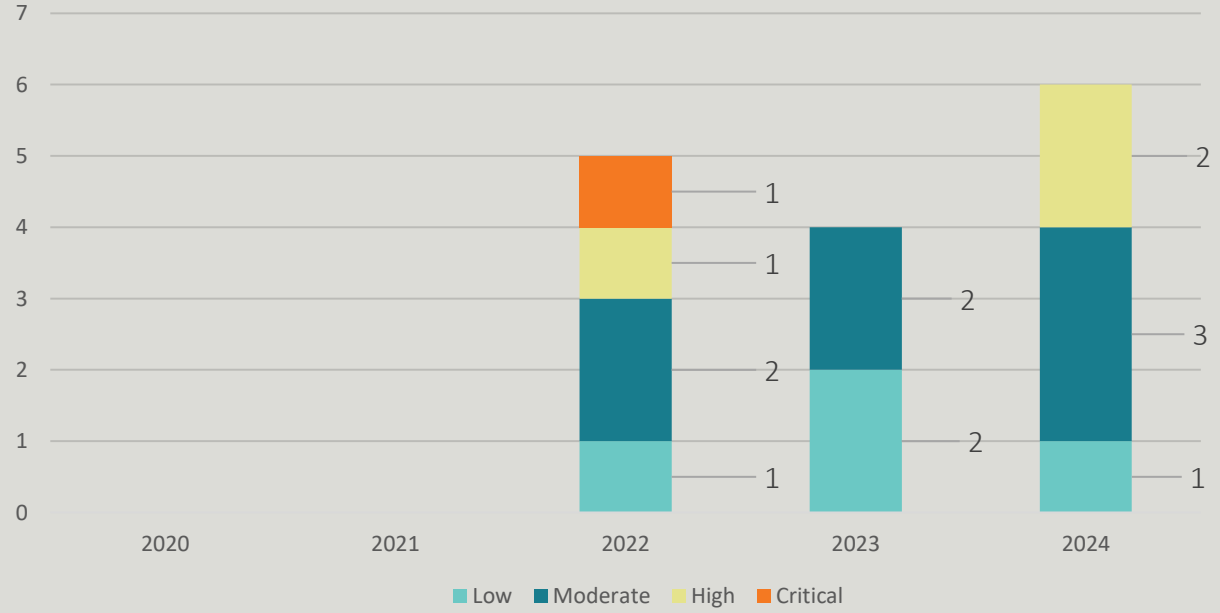
CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2020 – 2024



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.

Please note: **The approved centre opened for the first time in 2021**

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2021 – 2024



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services Professor James V Lucey

Inspector of Mental Health Services Summary

The National Eating Disorder Recovery Centre (NEDRC) is a six-bed eating disorder service, located in Ballsbridge. The inspection was unannounced and occurred over a four-day period, from 18 to 21 March, 2024. The inspection report reflects findings of the inspection over this period only. The approved centre limited its use of restrictive practices to the locking of bedrooms during the day on the basis of risk assessment. There had been no searches since the 2023 inspection. Involuntary residents were not admitted to NEDRC. The approved centre had a very defined criteria in terms of the admission of their residents, which included an analysis of a person's body-mass index and their motivation to partake in the programme. The approved centre was designed and decorated with the needs of the residents in mind. Some cleanliness issues were observed over the course of the inspection; there were plans to rectify these issues immediately.

The approved centre did not have an up-to-date ligature audit and was non-compliant with Regulation 15 (Individual Care Plan) due to the inadequacy of the resident goals. Both of these issues had been highlighted to the management of the approved centre on a previous Mental Health Commission visit. Staff and management in the approved centre showed great willingness to learn from the inspection findings in order to improve aspects of the approved centre service delivery.

Compliance summary

	2020	2021	2022	2023	2024
% Compliance	N/A	100%	83%	86%	79%

Conditions of 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.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- Regulation 21: Privacy: The approved centre promoted inclusion; resident feedback indicated residents had control over their own recovery journey.
- The approved centre had due regard for the human rights of residents by empowering residents to maintain autonomy throughout their recovery journey.
- The rear garden was redesigned into a tranquil outdoor space with a water fountain and covered seating area, offering residents a space to utilise and enjoy during free time. During the good weather the space was utilised for outdoor dining at the request of residents.
- The approved centre had set up a new tea/coffee/filtered water dock for residents with a wide selection of different herbal teas, offering another space for residents and visitors to sit and chat outside of the kitchen environment. Residents had autonomy in accessing this coffee dock and could access it as and when they wanted to.
- During the weekly community meeting residents had requested additional desks to use while doing individual work (journalling, homework from group sessions, routine planning). Two desks were added to residential areas for individual use.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

National Eating Disorder Recovery Centre is an independent therapeutic service specialising in the treatment of eating disorders. The National Eating Disorder Recovery Centre is located on Merrion Road, Ballsbridge, Dublin. It is a two-storey semi-detached house that has been renovated and refurbished for the purpose of providing both an inpatient and outpatient service. The inpatient treatment facility was registered with the Mental Health Commission for six beds for the care and treatment of adults with an eating disorder. The outpatient facility provided assessment and treatment for both adolescents and adults. Service users were assessed as they attended the outpatient programme and were offered inpatient treatment if it was clinically indicated. Use of the outpatient programme frequently made up part of the discharge process.

The approved centre is divided into distinct areas. The therapeutic area has group rooms, consulting rooms and facilities for inpatient and outpatient services. The kitchen and dining facilities for the residential service are also located in this area. Two large sitting rooms were used for relaxation and for group therapeutic and recreational activities. These rooms had been decorated with input from the residents. There is a comfortable relaxation room that also facilitated resident study or visitors if required. Lockers were available to residents to store their personal effects close to the therapeutic area during the day.

A separate building at the back of the approved centre contains a large multi-purpose room and an office area. A nursing office is centrally located that was for both the outpatient and inpatient service. Sleeping accommodation is located on the first floor of the approved centre. This comprised single bedrooms with rooms numbered two to eight. Room eight, which was larger in size, was identified as the isolation and infection control room if required. There are two separate shower and toilet facilities located on the first-floor landing. A further two bedrooms, a shower room and toilet facilities are located on the second floor. These were not commissioned for use at the time of the inspection. The approved centre offered a 24/7 staffed service.

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's senior management team comprised the Registered Proprietor (RP), the Clinical Director (CD) the Director of Services (DOS) and the Assistant Director of Services. A monthly governance meeting was attended by the senior management and reviewed the following agenda items: clinical effectiveness, audit, risk management, staff management and education and training. Due to the small nature of the approved centre and the senior management, issues escalated to the senior management could be addressed in a timely fashion as they arose.

A local management meeting took place weekly. Minutes of these meetings indicated that resident feedback was discussed and followed up on. This meeting provided an opportunity to review the therapeutic programme as well as discuss and plan new activities to be integrated into the programme. Resident bedroom doors were locked during the day; each person agreed to this as part of the contract of care and treatment in NEDRC. Aside from this practice the approved centre did not employ any restrictive practices.

Governance questionnaires were completed by the Clinical Director, Registered Proprietor, Director of Services and Senior Psychologist. Operational risks outlined in governance questionnaires acknowledged the challenge posed by the nationwide shortage of nursing staff and dietitians; however, at the time of the inspection the approved centre was fully staffed. The lack of availability of specialized eating disorder training in Ireland was also highlighted. Senior management strategic goals included: 'becoming more community based,' 'continuous improvement of the services' and 'improving the communication skills of residents who have autism spectrum disorder and adapting the programme to their specific needs.'

The Director of Services had overall responsibility for risk management and was known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The National Eating Disorder Recovery Centre retained a local risk register which identified current risks. This was monitored and reviewed appropriately. There was a process in place for consultation with an independent risk manager. There were systems in place to support continuous quality improvement. The approved centre had an established system of audit in place and utilised the 'Eating Disorder Evaluation Questionnaire' in order to review processes and procedures. Outcomes from audits and reviews were used as a mechanism for quality improvement.

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 were logged, reviewed and risk rated within this system. In general, 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. However, the approved centre ligature audit required updating at the time of the inspection. There was a multi-disciplinary team within the approved centre which met on a weekly basis to review resident care and treatment.

The National Eating Disorder Recovery Centre operated 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.

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 2024 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating							
	2021		2022		2023		2024	
Regulation 15: Individual Care Plan		N/A	✗	Moderate	✗	Low	✗	Moderate
Regulation 22: Premises		N/A	✓		✗	Moderate	✗	Moderate
Regulation 23: Ordering, Prescribing Storing and Administration of Medicines		N/A	✗	High	✗	Low	✗	Moderate
Regulation 27: Maintenance of Records		N/A	✓		✓		✗	High
Regulation 28: Register of Residents		N/A	✓		✓		✗	Low
Regulation 32: Risk Management Procedures		N/A	✓		✓		✗	High

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. 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 a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- A private room was available for inspectors to talk to residents.

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

The inspection team met with three residents of the National Eating Disorder Recovery Centre. Feedback from all three residents was positive indicating that the eating disorder programme was developed to maintain a good balance between therapeutic activities and free time. Nurses were described as 'supportive'. Residents felt that nurses had time to listen to them when they needed support. One resident stated, 'The inpatient programme has done amazing work for me – I am so happy with it'. Suggestions pertaining to the timetable were taken on board immediately by the director of services. All issues identified were resolved quickly. Residents met their therapeutic team regularly and were aware of the process of making a complaint.

No resident returned a completed questionnaire to the inspection 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:

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

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 had a process in place for the identification of residents with the same or similar names.

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. Nutritional and dietary needs were assessed, with the use of an evidence-based nutrition assessment tool and addressed in the resident's individual care plan. The needs of residents identified as having special nutritional requirements were regularly reviewed by a dietitian. Menus were a collaborative decision between residents and the dietitian, decided a week in advance based on food preferences and any special dietary requirements.

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.

Food and fridge temperatures were recorded in line with food safety recommendations. A log sheet was maintained and monitored with clearly identified actions if the temperature breaches cold chain parameters.

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. Each resident was supported to manage and maintain their own laundry through the provision of internal or external laundry services.

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 October 2022.

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. 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 access to and use of resident monies was overseen by either two members of staff or the resident and two staff members. There was a process to record, secure and manage the personal property and possessions of the resident, including money.

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: outings, games, television, books, arts and crafts.

The recreational facilities provided by the approved centre were appropriately resourced.

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 October 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 October 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. Where restrictions had been applied to a resident's means of communication, this was supported by an individual risk assessment.

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 October 2023 and included all requirements related to:

- The management and application of searches of a resident, their belongings and the environment in which they are 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.

As no resident of the approved centre had been searched since the previous inspection, this regulation was assessed on the basis of the 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 October 2023.

As no resident had passed away in the approved centre since the last inspection, this regulation was inspected on the basis of the policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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

Five individual care plans (ICPs) were reviewed on inspection of residents who had been in the approved centre since the last inspection. The individual care plan was a composite set of documents which addressed the resident's goals, mental health care and treatment needs based on a multi-disciplinary team assessment of the person and where practicable, in consultation with them. All ICPs were identifiable and uninterrupted. They were not amalgamated with progress notes.

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 examined did not identify appropriate goals for the resident. The ICPs detailed 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 non-compliant with this regulation because the individual care plans did not include appropriate goals for the resident, 15.

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.

The approved centre had an activities schedule which included therapeutic and recreational activities. The therapeutic activities provided by the approved centre included dialectical behaviour therapy, food and nutrition education and food planning.

The approved centre also provided individual therapies including dietetics, social work, nursing, medical 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 March 2023.

As no resident had been transferred out of the approved centre since the 2023 inspection, this regulation was inspected on the basis of the policy only.

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 and Medical Emergencies Policy which was last reviewed in December 2023.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

As no resident had been in the approved centre for over six months, no bi-annual general health assessments were not inspected.

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 operational policies and procedures on the provision of information to residents. The policy was last reviewed in March 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

Residents were called by their preferred name based on their self-identification. Staff displayed professional, engaging and compassionate attributes in their interactions with residents. Staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. The doors of treatment rooms and bedrooms did not have windows. Rooms were not overlooked by public areas. All residents wore clothes that respected their privacy and dignity.

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 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 but ligature anchor points were not consistently minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good 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 hygienic and free from offensive odours. Current national infection control guidelines were followed. Some issues around cleanliness were observed with regard to the premises:

- There was a film of grime noted on the outside of windows and skylights as well as some accumulated dust in the cavity between the window and the inner screen. This was due to works outside the building that had recently been carried out and were continuing during the inspection.
- There were cobwebs on the window panel over the door to the rear garden. In the entrance hall outside the nursing office the skylights needed cleaning.

- There were signs of water damage to the walls in the entrance foyer and the glass ceiling in the foyer was leaking.
- The carpet in the entrance foyer needed cleaning.
- The area above the door to the rear garden required cleaning,

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 non-compliant with this regulation for the following reasons:

a) **The windows and skylights needed cleaning externally, 22(1)(a).**
b) **The cavity between the windows and protective screening internally required cleaning, 22(1)(a).**
c) **The glass ceiling in the entrance foyer was leaking. There were signs of water damage to plasterwork in the entrance foyer and mould in one corner where the wall and ceiling met, 22(1)(a).**
d) **The carpet in the entrance foyer needed cleaning, 22(1)(a).**
e) **The area above the door to the rear garden required cleaning, 22(1)(a).**
f) **Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(3).**

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

NON-COMPLIANT

Risk Rating MODERATE

(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, prescribing, 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. Two 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 had none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

However, one medication record contained an administration omission. In one MPAR examined, the signature of a medical practitioner was omitted for one entry. In three of the five MPARs examined, the documented frequency for medication was illegible.

Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

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

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, one record of medication administered to a resident was omitted, 23(1).**
b) **In one of the five Medication Prescription and Administration Records (MPARs) examined, the signature of a medical practitioner was omitted for one entry, 23(1).**
c) **In three of the five Medication Prescription and Administration Records (MPARs) examined, the documented frequency for 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 a site-specific safety statement in place. The policy was last reviewed in October 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 written policy and procedures in place relating to staffing. The policy was last reviewed in December 2023, 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, three Dietitians, and a Social Worker. While not all staff worked in the approved centre on a full-time basis, the services that they provided met the assessed needs of residents. There was a pathway for external referrals should residents require speech and language therapy or 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.

Training Record

Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (7)	7	100%	7	100%	7	100%	7	100%	7	100%	7	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%

Psychologist (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Dietitian (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating HIGH

(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.

The approved centre had a series of written operational policies and procedures in relation to the maintenance of records. The policies were 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.

All residents' records were secure and up to date. However, three records were not in good order and were not maintained in accordance with national guidelines and legislative requirements.

All resident records were physically stored together, where possible; some records were stored in an online format. Resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and there were no loose pages. 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 non-compliant with this regulation because the registered proprietor did not ensure that all residents' records were in good order, as three medication prescription administration records (MPARs) were not maintained in accordance with national guidelines and legislative requirements, 27(1).

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating LOW

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record the residents' next of kin details.

The approved centre was non-compliant with this regulation because the register of residents did not include all the information specified in Schedule 1 of the Mental Health Act as it did not contain completed next of kin details, 28(2).

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 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 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

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in October 2023 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. The approved centre did not have a comprehensive, up to date ligature audit therefore ligature anchor points were reduced to the lowest practicable level. At the time of the inspection, the approved centre was in the process of working with their newly appointed Risk Manager in order to update the ligature audit.

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 non-compliant with this regulation because the approved centre did not have a comprehensive, up to date ligature audit. Therefore ligature points were not reduced to the lowest practicable level, 32(2)(a).

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 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. The certificate was displayed prominently at the entrance to 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 Section 69: The Use of Seclusion, Section 69: The Use of Mechanical Restraint and Section 59: The Use of ECT.

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 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 plan. 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: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10005436	**The individual care plans did not include appropriate goals for the resident, 15.**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Updates to the ICPs are being trialed to see efficacy. Evaluation of same will continue.	ICP audits increased until most efficient and effective ICP decided on.	Achievable and realistic.	12/07/2024	Clinical Nurse Manager, Director of Services.
Preventative Action	Updates to the ICPs are being trialed to see efficacy. Evaluation of same will continue.	ICP audits increased until most efficient and effective ICP decided on.	Achievable and realistic.	27/09/2024	Clinical Nurse Manager, Director of Services.

Regulation 22: Premises					
Reason ID : 10005437		**The windows and skylights needed cleaning externally, 22(1)(a). The cavity between the windows and protective screening internally required cleaning, 22(1)(a). The carpet in the entrance foyer needed cleaning, 22(1)(a). The area above the door to the rear garden required cleaning, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Areas that required cleaning post building work being carried out has now been completed.	Updated schedule of cleaning to include windows regularly on a timed scale. Audit of maintenance includes larger scale cleaning.	Achievable and realistic, already in place.	03/05/2024	Maintenance manager, Director of Services.
Preventative Action	Areas that required cleaning post building work being carried out has now been completed. Ongoing, updated schedule of cleaning to include windows regularly on a timed scale.	Audit of maintenance includes larger scale cleaning.	Achievable and realistic.	03/05/2024	Maintenance manager, Director of Services.
Reason ID : 10005439		**The glass ceiling in the entrance foyer was leaking. There were signs of water damage to plasterwork in the entrance foyer and mould in one corner where the wall and ceiling met, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Building work that was scheduled to rectify this, i.e. replace roof in entrance foyer has now been completed. As a result, plasterwork has also now been completed.	Maintenance schedule of works.	Achievable and realistic, same completed.	17/05/2024	Maintenance manager, Director of Services.
Preventative Action	Building work that was scheduled to rectify this, i.e. replace roof in entrance foyer has now been completed. As a result, plasterwork has also now been completed.	Maintenance schedule of works.	Achievable and realistic, same completed.	17/05/2024	Maintenance manager, Director of Services.

Reason ID : 10005442		Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Prior to unannounced inspection, NEDRC had sought services from new Risk Manager to consult with. Consultations had commenced and are ongoing.	Risk Register, Ligature Audit, Schedule of maintenance audit.	Achievable and realistic.	26/04/2024	Registered Proprietor, Director of Services, Assistant Director of Services, Clinical Director, Maintenance.
Preventative Action	Prior to unannounced inspection, NEDRC had sought services from new Risk Manager to consult with. Consultations had commenced and are ongoing with new Risk Manager in place.	Risk Register, Ligature Audit, Schedule of maintenance audit.	Achievable and realistic.	30/08/2024	Registered Proprietor, Director of Services, Assistant Director of Services, Clinical Director, Maintenance.

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10005443		**In one of the five Medication Prescription and Administration Records (MPARs) examined, one record of medication administered to a resident was omitted, 23(1). In one of the five Medication Prescription and Administration Records (MPARs) examined, the signature of a medical practitioner was omitted for one entry, 23(1). In three of the five Medication Prescription and Administration Records (MPARs) examined, the documented frequency for medication was illegible, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Clinical Nurse Manager/ Nurse in Charge to review all kardex on a daily basis to ensure all kardex are maintained correctly. Kardex checklist reviewed and checked weekly by nursing staff and discrepancies alerted to CNM to investigate and resolve. Clinical Director to ensure medical team are ensuring prescription and administration instructions are recorded and legible. CNM completing monthly MPAR audits. Nursing staff reviewing kardex of residents daily to ensure medication is recorded correctly. MPAR auditing tool in process of being re-evaluated to ensure maintenance in accordance with national and legislative guidelines.	Monthly kardex audit until further notice.	Achievable and realistic time frame set.	26/07/2024	Clinical Nurse Manager, Director of Services, Clinical Director.
Preventative Action	Nursing staff reviewing kardex of residents daily to ensure medication is recorded correctly. Kardex checklist checked weekly by nursing staff and discrepancies alerted to CNM to investigate and resolve. CNM reviewing kardex of each resident at the end of every working day to ensure	Monthly auditing.	Achievable and realistic.	25/10/2024	Clinical Nurse Manager, Director of Services, Clinical Director.

	compliance with requirements. MPAR audit tool in process of being re-evaluated to ensure corrective prescribing and administering processes are being fostered.				

Regulation 27: Maintenance of Records					
Reason ID : 10005446		**The registered proprietor did not ensure that all residents' records were in good order, as three medication prescription administration records (MPARs) were not maintained in accordance with national guidelines and legislative requirements, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Clinical Nurse Manager/ Nurse in Charge to review all kardex on a daily basis to ensure all kardex are maintained correctly. Kardex checklist reviewed and checked weekly by nursing staff and discrepancies alerted to CNM to investigate and resolve. Clinical Director to ensure medical team are ensuring prescription and administration instructions are recorded and legible. CNM completing monthly MPAR audits. Nursing staff reviewing kardex of residents daily to ensure medication is recorded correctly. MPAR auditing tool in process of being re-evaluated to ensure maintenance in accordance with national and legislative guideline.	Monthly kardex audit until further notice.	Achievable and realistic time frame set.	26/07/2024	Clinical Nurse Manager, Director of Services, Clinical Director.
Preventative Action	Nursing staff reviewing kardex of residents daily to ensure medication is recorded correctly. Kardex checklist checked weekly by nursing staff and discrepancies alerted to CNM to investigate and resolve. CNM reviewing kardex of each resident at the end of every working day to ensure compliance with requirements. MPAR audit tool in process of being re-evaluated to ensure corrective prescribing and	Monthly auditing.	Achievable and realistic.	25/10/2024	Clinical Nurse Manager, Director of Services, Clinical Director.

	administering processes are being fostered.				

Regulation 28: Register of Residents					
Reason ID : 10005447		**The register of residents did not include all the information specified in Schedule 1 of the Mental Health Act as it did not contain completed next of kin details, 28(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A new format on NEDRC online system has been competed to address this.	Completed within one week of the most recent inspection. Template completed and in use since.	Already achieved.	29/04/2024	Assistant Director of Nursing.
Preventative Action	A new format on NEDRC online system has been competed to address this.	Completed within one week of the most recent inspection. Template completed and in use since.	Already achieved.	29/04/2024	Assistant Director of Nursing.

Regulation 32: Risk Management Procedures					
Reason ID : 10005448	**The approved centre was non-compliant with this regulation because the approved centre did not have a comprehensive, up to date ligature audit. Therefore ligature points were not reduced to the lowest practicable level, 32(2)(a).**				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Prior to unannounced inspection, NEDRC had sought services from new Risk Manager to consult with. Consultations had commenced and are ongoing.	Risk Register, Ligature Audit, Schedule of maintenance audit.	Achievable and realistic.	26/04/2024	Registered Proprietor, Director of Services, Assistant Director of Services, Clinical Director, Maintenance.
Preventative Action	Prior to unannounced inspection, NEDRC had sought services from new Risk Manager to consult with. Consultations had commenced and are ongoing.	Risk Register, Ligature Audit, Schedule of maintenance audit.	Achievable and realistic.	30/08/2024	Registered Proprietor, Director of Services, Assistant Director of Services, Clinical Director, Maintenance.

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.

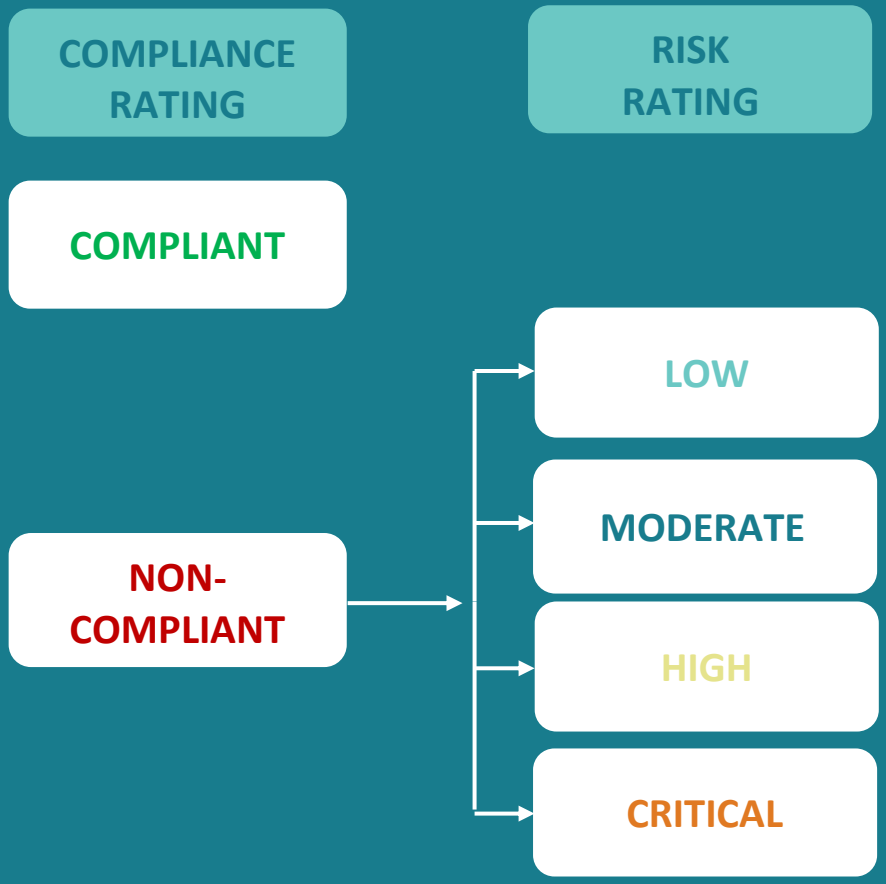
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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