Cois Dalua

mhc
coimisiún meabhair - shláinte
mental health commission

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

COIS DALUA

Meelin, Knockduff Upper, Newmarket, Co. Cork

Date of Publication:
Friday 04 February 2022

ID Number: AC0128

2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay
Mental health rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
1 June 2021

Registered Proprietor:
Nua Healthcare Services

Registered Proprietor Nominee:
Mr Noel Dunne, Chief Executive

Inspection Team:
Sarah Jones, Lead Inspector
Susan O'Neill
Rajeev Ramasawmy

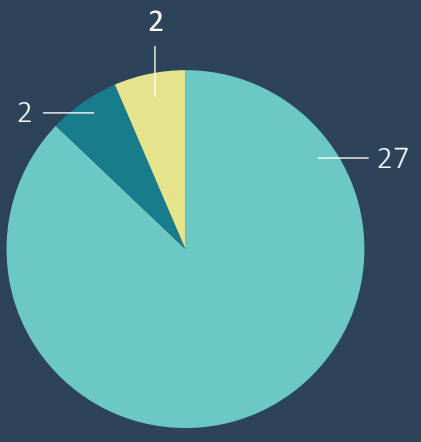
Inspection Date:
7 – 9 September 2021

Previous Inspection date:
6 – 9 October 2020

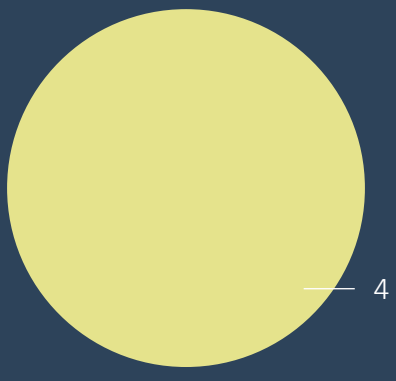
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

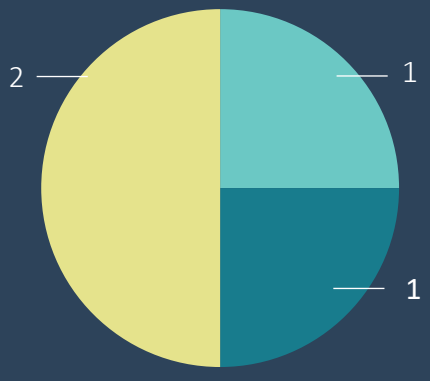
2021 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



CODES OF PRACTICE

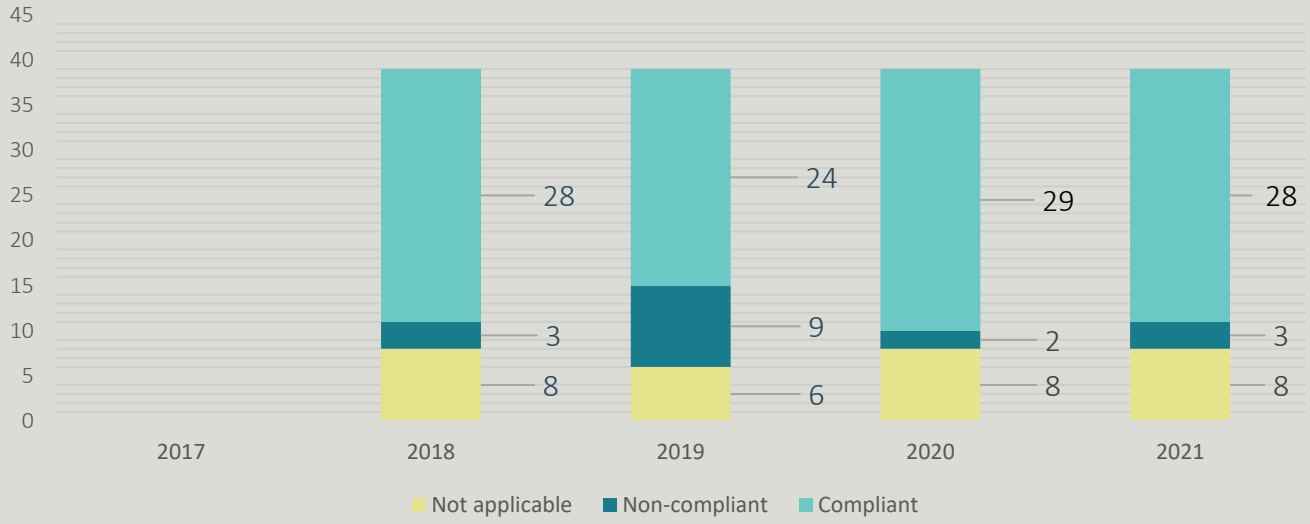
Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2017 – 2021

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

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021

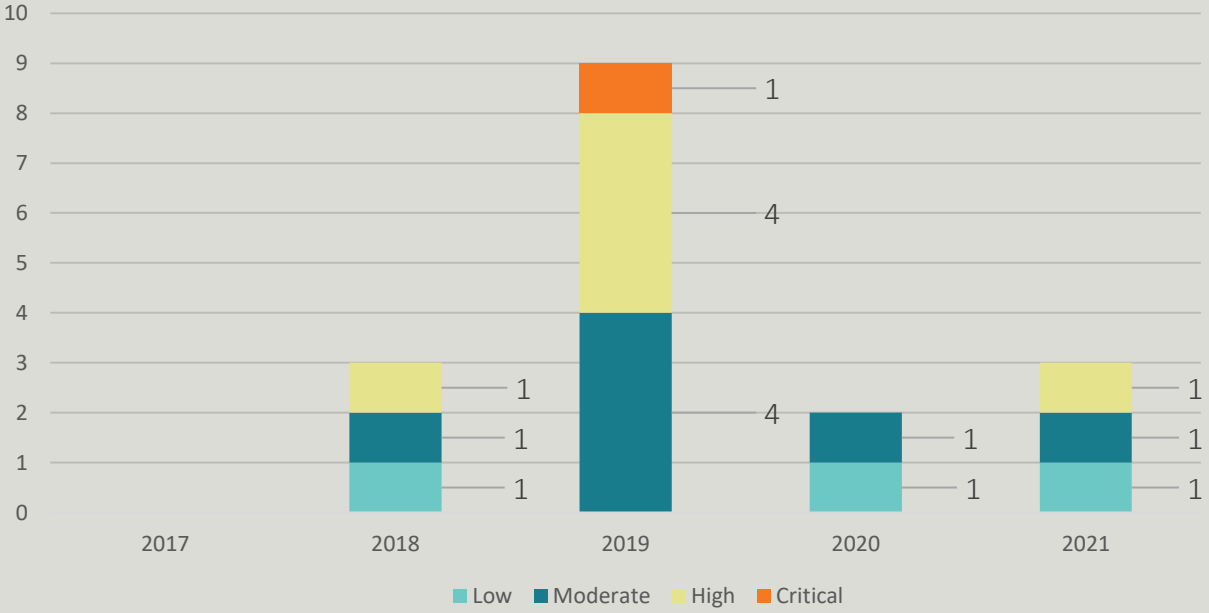
Please note the approved centre opened in June 2018.



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 2017 – 2021

Please note the approved centre opened in June 2018.



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with Regulations, Rules and Codes of Practice.

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

In brief

Cois Dalua was a 16-bed privately operated approved centre run by Nua Healthcare. It was located in Meelin, a small rural village, approximately eight kilometres from Newmarket, Co. Cork. Accommodation consisted of 10 single en suite bedrooms and 6 self-contained apartments. It was a tertiary service and accepted referrals from other mental health services for the purpose of rehabilitation.

Compliance Summary	2018	2019	2020	2021
% Compliance	90%	73%	94%	90%
Regulations Rated Excellent	6	3	N/A	N/A

The average rate of compliance across all approved centres in 2020 was 87%.

Conditions to registration

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

Escalation and enforcement actions since last inspection

There were no escalation or enforcement actions since the previous inspection.

Escalation and enforcement actions since this inspection

There were no escalation or enforcement actions since this inspection.

Safety in the approved centre

We found that the approved centre mostly operated safe practices which reduced risk of harm and that effective systems were in place to safeguard residents.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However, the approved centre's ligature audit documented there were three high risk ligature points in the approved centre, and these three high risk ligature points had not been minimised at the time of the inspection.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to needs of residents.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- Therapeutic services available to residents included the following: creative sessions, gardening, emotive regulations, vocational rehabilitation, community integration, cognitive rehabilitation groups, cooking assessments, yoga, and psychoeducation.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre mainly provided services in a way that respected residents' privacy, dignity and autonomy.

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However, a noticeboard positioned in one of the sitting room areas displayed the full names of some residents. Visitors accessing one of the designated areas for visiting could see the names of residents on the noticeboards.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of residents.

- Recreational activities available included books, games, TV, music, quiz, outings, badminton, baking, arts, walks, shopping, meals, newspaper, relaxation. The approved centre provided access to recreational activities on weekdays and during the weekend.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance of the approved centre

- The approved centre was under Nua Healthcare's overall governance structure. There was a weekly national governance meeting, which was attended by Nua Healthcare's Senior Management and Executive Management Team (EMT). There were quarterly meetings between the EMT and Local Management Team and fortnightly Quality and Safety Meetings.
- A service planning meeting met monthly which was attended by the multi-disciplinary team (MDT).
- The Director of Operations had overall responsibility for risk management, however, responsibilities were delegated to the Director of Nursing onsite. There was a local risk register which identified current risks.

- The centre had an Automated Incident Report System (AIRS) to record incidents and undertook the Dynamic Appraisal of Situational Aggression (DASA) to carry out risk assessments relating to the residents.
- Audits were completed by independent auditors within the Quality and Safety Department every three months.
- Resident forums were undertaken weekly, and this was documented. The complaints, compliments and feedback arrangements were publicly displayed. Minor complaints had been dealt with and documented. Formal complaints were dealt with by the designated complaints officer who was not based in the approved centre.
- Advocacy services were available if a resident required them.

COVID-19 response

The approved centre abided by public health guidance regarding COVID-19 and the prevention of infection.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A new gym was set up by the occupational therapy department for the residents to access physical fitness on site.

2. Two hens were bought by Cois Dalua in 2021. Residents of Cois Dalua support staff in caring for the hens.

3. A nest swing was purchased and installed in the sensory garden for the residents

4. The sensory room equipment was updated to include a sensory cart, focused on mental health needs to support the regulation of mood.

5. An 'Operation Transformation' project was commenced for one week in February 2021 which focused on healthy eating, daily challenges and cooking healthy meals. Both staff and residents participated.

6. The psychology department supported all staff on a monthly basis in a reflective practice session focusing on professional development. This commenced in December 2020.

7. In April 2021, the social work department supported residents to commence placements in social farming. This benefited the residents by supporting social contact and developing skills.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Cois Dalua was a sixteen bed privately operated approved centre run by Nua Healthcare. It was located in a small rural village called Meelin, approximately eight kilometres from Newmarket, Co. Cork. Accommodation consisted of four single en suite bedrooms and four self-contained apartments in the old building. A new modern build had a further six en suite bedrooms and two self-contained apartments.

The approved centre was located in its own grounds and was surrounded by fencing with a keypad-controlled gate accessible by the residents when required. Communal areas included a day room, a TV lounge, two dining rooms, a therapy room, a sensory room, and two training kitchens. Outdoor facilities included a smoking area and a sensory garden which could be accessed by residents in both the new and old buildings. This was separated by a swipe accessed door internally.

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**13**
Number of detained residents	0
Number of wards of court	6
Number of children	0
Number of residents in the approved centre for more than 6 months	11
Number of residents on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under Nua Healthcare's overall governance structure. The approved centre's local governance matrix was consolidated into a weekly national governance meeting, which was attended by Nua Healthcare's Senior Management and Executive Management Team (EMT). There were quarterly meetings between the EMT and Local Management Team and fortnightly Quality and Safety Meetings with standing agenda items such as reportable incidents, corporate risk register, COVID-19, audits, fire safety and staff retention. Other committees that contributed information to the governance matrix included the health and safety committee and the IT Cyber Security Steering Group. Governance questionnaires were submitted by the Clinical Director, Director of Nursing, Clinical Psychologist, Occupational therapist, Social Worker and Director of Operations which indicated that there were clear reporting systems for all disciplines.

A local management meeting took place weekly to discuss issues relating to the approved centre. A service planning meeting met monthly which was attended by the multi-disciplinary team (MDT). The Director of

Operations had overall responsibility for risk management however responsibilities were delegated to the Director of Nursing onsite. Cois Dalua retained a local risk register which identified current risks. This was monitored and reviewed appropriately. Escalations of risks were referred to the EMT where appropriate. The centre had an Automated Incident Report System (AIRS) to record incidents and undertook the Dynamic Appraisal of Situational Aggression (DASA) to carry out risk assessments relating to the residents.
The approved centre demonstrated adequate processes to identify, assess, treat and monitor risks.

There was a formal system of performance appraisal for staff in the approved centre annually and through supervision. Staffing shortages were acknowledged and were mitigated with the use of overtime. Efforts were made by the team to improve staff training, difficulties in achieving this was evident due to COVID-19 restrictions. All disciplines were up to date with the Mental Health Act training.

Audits were completed by independent auditors within the Quality and Safety Department every three months. Audits for admission, transfer and discharge were not completed when inspected, however, this was remedied and completed immediately within the Quality and Safety Department when the team were notified.

Resident forums were undertaken weekly, and this was documented. The complaints, compliments and feedback arrangements were publicly displayed. Minor complaints had been dealt with and documented. Formal complaints were dealt with by the designated complaints officer who was not based in the approved centre. Advocacy services were available if a resident required them. The approved centre updated their restrictive practices policy which implemented resident access and egress to the front door and front gate.

3.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2017 and 2021 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 21: Privacy			✓		✗	Moderate	✓		✗	Moderate
Regulation 22: Premises			✓		✗	High	✓		✗	High
Code of Practice on Admission, Transfer and Discharge to and from the approved centre			✓		✓		✗	Moderate	✗	Low

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 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 have a seclusion facility, 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 residents in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre was a child and adolescent facility, this code of practice was not applicable.

Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.

The information was used to give a general picture of residents' experience of the approved centre as outlined below.

The inspection team received six questionnaires completed by residents. No resident chose to speak with the inspection team. 50% of the respondents reported they understood what their individual care plan was and were always involved in their goal setting. All respondents knew their multi-disciplinary team members and keyworker. Five respondents reported they were always able to discuss worries or concerns with a member of staff as soon as they needed too, whilst one individual reported they were able to sometimes.

Four of six respondents reported there were enough activities whilst two individuals felt there were not. All respondents were happy with how staff spoke to them.

Five of six respondents reported they had space for privacy and their privacy and dignity were respected. Four respondents expressed they felt safe in the approved centre whilst two individuals reported they felt safe sometimes.

Four residents indicated in their questionnaire they felt able to give feedback to staff and make a complaint when they were not satisfied with a part of their stay in the approved centre. One resident reported this was sometimes and one expressed they did not know how to make a complaint.

The residents were asked on a scale of 1-10 with one being poor and 10 being excellent how they rate their overall experience of their care and treatment. The questionnaires scored a 6,7,8,10,10 and 10 respectively.

5.2 Advocacy

The approved centre had access to advocacy services should an individual require them.

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
- Chief Operating Officer
- Director of Operations
- Director of Services
- Social Worker
- Psychologist
- Occupational Therapist
- Occupational Therapy Assistant
- Team Leader
- Mental Health Act Administrator

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

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. A source of safe, fresh drinking water was available at all times from easily accessible locations in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during the day, unless otherwise specified in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in July 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities including a safe were provided for the safe keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. Recreational activities available included books, games, TV, music, quiz, outings, badminton, baking, arts, walks, shopping, meals, newspaper, relaxation.

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 2020. Visiting times were appropriate and reasonable, and the visiting process took account of COVID-19 precautions. A separate visitor's room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting room was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in July 2020. Residents had access to two of the approved centre's electronic tablets, Wi-Fi internet and their own mobile phone 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 would 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 July 2020. It included all of 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.

Documentation relating to one search was examined on inspection. Risk was assessed prior to the search of the resident, appropriate to the type of search being undertaken. Resident consent was sought prior to this search and the request for consent and the received consent were documented for this search. The resident search policy and procedure was communicated to all residents and relevant staff were documented to have read and understood the policy on searches.

The resident was informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance when the search was being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every search of a resident and every property search was available, which included the reason for the search, the names of both staff members who undertook the search and details of who was in attendance for the search. A written record was kept of all environmental searches. Policy requirements were

implemented when illicit substances were found as a result of a search and no illicit substances were found since the last inspection.

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 July 2020. As no resident had passed away in the approved centre since the last inspection, compliance for this regulation 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

Each resident had an Individual Care Plan (ICP). Five ICPs were inspected. All ICPs were a composite set of documentation, with allocated space and sections for goals, treatment, care, resources required, and reviews. ICPs were stored within the clinical file, were identifiable and were not interrupted. ICPs were not integrated with progress notes.

All ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of each resident admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

All ICPs identified appropriate goals for the resident. All ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICP's identified the resources required to provide the care and treatment.

A multi-disciplinary team reviewed and updated individual care plans in all five ICPs. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances and goals, this was documented.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

At the time of the inspection, Cois Dalua therapeutic services available to residents included the following: creative sessions, gardening, emotive regulations, vocational rehabilitation, community integration, cognitive rehabilitation groups, cooking assessments, yoga, and psychoeducation.

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 2021. The clinical file of one resident who had been transferred was examined.

Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer to a named individual, which included a list of current medications.

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 July 2021. The approved centre had an emergency resuscitation 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.

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Residents received appropriate general health care interventions in line with individual care plans. The clinical files of five residents who were residing in the approved centre for more than six months were inspected. All five residents had received a six-monthly general health assessment which documented a physical examination, family or personal history, blood pressure, smoking status, nutritional status, a medication review, body mass-index, weight, waist circumference, and dental health.

Residents on anti-psychotic medication received an annual assessment of their glucose regulation, blood lipids, electrocardiogram (ECG) heart function assessment and prolactin levels. Adequate arrangements were in place for residents to access general health services and for their referral to other health services 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 a policy and procedures in relation to the provision of information to residents. The policy was last reviewed in July 2021.

Residents were provided with a resident information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on their diagnosis. Medication information sheets as well as verbal information were provided in a format appropriate to residents' 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

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

The way in which staff spoke with residents was respectful. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Staff sought resident's permission before entering their room. All bathrooms, showers, and toilets had locks on the inside of the door unless there was an identified risk to a resident.

Residents were facilitated to make private phone calls. Rooms were not overlooked by public areas. A noticeboard positioned in one of the sitting room areas displayed the full names of some residents. Visitors accessing one of the designated areas for visiting – i.e. the kitchenette, in this part of the building would have to walk through the sitting room area to access this visiting area and could therefore see the names of residents on the noticeboards.

The approved centre was non-compliant with this regulation because residents' privacy and dignity was not respected at all times. A notice board located in one of the sitting room areas displayed the full names of some of the residents.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(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

The approved centre was adequately lit, heated, and ventilated. Appropriate signage and sensory aids were provided to help residents orientation needs. Hazards were minimised. There was a sufficient number of toilets and showers for residents in the approved centre. Resident bedrooms were appropriately sized to address resident needs. Residents were accommodated in six single occupancy apartments and 10 single occupancy bedrooms; all were en suite.

The registered proprietor did not ensure that the physical structure and the overall approved centre environment was developed with due regard to the safety of residents as not all ligature points were minimised to the lowest practicable level based on risk assessment. The approved centre's ligature audit documented there were three high risk ligature points in the approved centre, and these three high risk ligature points had not been minimised at the time of the inspection.

Residents had access to sufficient indoor and outdoor space. The approved centre was kept in a good state of repair inside and outside. It was clean, hygienic, and free from offensive odours. Suitable furnishings were provided to support resident independence and comfort.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the physical structure and the overall approved centre environment was developed with due regard to the safety of residents. Not all ligature points were minimised to the lowest practicable level based on risk assessment, 22 (3).

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 operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in July 2020.

Each resident had a Medication Prescription and Administration Record (MPAR), and five of these were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, frequency of medication, and the date of discontinuation for each medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently, where there was a significant change in the resident's care or condition, and this was documented in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage press unless it required refrigeration.

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 policy, and procedures relating to the health and safety of residents, staff and visitors. The health and safety policy was last reviewed in July 2020. The Safety Statement was reviewed in July 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the use of CCTV. The policy was last reviewed in July 2020. The policy included the purpose and function of using CCTV for observing residents in the approved centre.

There were clear signs in prominent positions where CCTV cameras were located throughout the approved centre. A resident was monitored solely for the purposes of ensuring the health, safety, and welfare of that resident. The use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras used to observe a resident were incapable of recording or storing a resident's image on a tape, disc, hard drive. CCTV did not transmit images other than to a monitor that was viewed solely by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

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 the recruitment, selection and Garda vetting requirements. The policy was last reviewed in July 2020.

The number and skill mix of staffing were sufficient to meet resident needs. The approved centre had one multi-disciplinary team. This included psychiatry, nursing, occupational therapy, social work, and psychology staff. An appropriately qualified staff member was on duty at all times, and this was documented. 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.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022. The following is a table showing the numbers and percentages of staff trained in the Mental Health Act 2001.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (22)	22	100%
Medical (1)	1	100%
Occupational Therapist (1)	2	100%
Social Worker (1)	1	100%
Psychologist (1)	1	100%
Social Care Workers (10)	10	100%
Assistant Support Workers (13)	13	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in July 2021. All residents' records were secure, up to date, in good order, with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements.

Resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation relating to 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 and up-to-date register of residents which was held electronically and in paper form. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 to the Mental Health Act 2001.

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 required by the regulations were reviewed within the required three-year time frame.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission or soon thereafter. The complaints procedure and how to contact the nominated individual was available within the resident information booklet and on a complaints process poster which 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, minor or formal were recorded and 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. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s ICP.

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 operational policy and procedures in relation to risk management. The policy was last reviewed in June 2021 and addressed all of the requirements of this regulation. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed, or effectively mitigated.

Individual risk assessments were completed during admission - to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm – as well as at discharge, and prior to any physical restraint episode and in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Requirements for the protection of children within the approved centre were appropriate and implemented as required.

Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission. The information provided

was anonymous at the resident level. There was an emergency plan in place that 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 house is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre's insurance certificate and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered by a private insurance company 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 foyer area of the entrance.

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.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in July 2021. The policy covered:

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

Training and Education: There was a written record that all staff involved in physical restraint had read and understood the policy.

Monitoring: The annual report on the use of physical restraint was submitted to the approved centre.

Evidence of Implementation: The clinical file of one resident who had been physically restrained was inspected. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident's unsafe behaviour.

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered medical practitioner (RMP), and a designated staff member was responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident. The consultant psychiatrist (CP) was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the resident within three hours after the start of the episode of physical restraint.

The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after episode.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating LOW

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, all of which were last reviewed in July 2021.

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 not been completed on the implementation of and adherence to the transfer policy and the 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's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: current mental health state, risk assessment, presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstances, work situation, education, 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 coordinated by the resident's key-worker. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident's family. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, informational needs, a current mental state examination, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was appropriate multi-disciplinary team input into discharge planning. A preliminary discharge summary was sent to the relevant health care provided within three days of discharge. A comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, prognosis, medication, mental state at discharge, follow-up arrangements, and names and contact details of key people for follow-up. The discharge summary also included risk issues such as signs of relapse.

The approved centre was non-compliant with this code of practice because an audit had not been completed on the implementation of and adherence to the transfer policy and the admission and discharge policies, 4.19.

Appendix 1: Corrective and Preventative Action Plan

Regulation 21: Privacy					
Reason ID : 10002380		**Residents' privacy and dignity was not respected at all times. A notice board located in one of the sitting room areas displayed the full names of some of the residents.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The notice with the full names was removed immediately and replaced with one including initials prior to the end of the inspection.	The DON and QA Department will monitor this on an ongoing basis.	This action has been achieved.	08/09/2021	Director of Nursing (DON) and Quality Assurance (QA) Department.
Preventative Action	The notice with the full names was removed immediately and replaced with one including initials prior to the end of the inspection.	The DON and QA Department will monitor this on an ongoing basis.	This action has been achieved.	08/09/2021	Director of Nursing (DON) and Quality Assurance (QA) Department.

Regulation 22: Premises					
Reason ID : 10002379		The registered proprietor did not ensure that the physical structure and the overall approved centre environment was developed with due regard to the safety of residents. Not all ligature points were minimised to the lowest practicable level based on risk assessment, 22 (3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The ligature points in question were all in resident rooms who had no previous history of the use of ligatures or suicidal ideation. However, in order to reduce the risk rating, immediate actions were put in place and the said locations were made ligature proof. • Curtain poles were replaced by Velcro curtains. • UPVC door handles were replaced in apartments and bedrooms with ligature proof handles. • Paper towel dispensers have been removed therefore removing the risk. For the purpose of the CAPA, this non-	The DON and QA Department will monitor this action on an ongoing basis.	This action ha been achieved.	27/10/2021	Director of Nursing (DON) and Quality Assurance (QA) Department.

	compliance was completed on the 27th October 2021.				
Preventative Action	The ligature points in question were all in resident rooms who had no previous history of the use of ligatures or suicidal ideation. However, in order to reduce the risk rating, immediate actions were put in place and the said locations were made ligature proof. • Curtain poles were replaced by Velcro curtains. • UPVC door handles were replaced in apartments and bedrooms with ligature proof handles. • Paper towel dispensers have been removed therefore removing the risk. For the purpose of the CAPA, this non-compliance was completed on the 27th October 2021.	The DON and QA Department will monitor this action on an ongoing basis.	This action ha been achieved.	27/10/2021	Director of Nursing (DON) and Quality Assurance (QA) Department.

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10002378		**An audit had not been completed on the implementation of and adherence to the transfer policy and the admission and discharge policies, 4.19.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The QA audit on ADT had not been completed within the previous 12 months, this was immediately rectified by the QA team and the proof document was provided to the inspectors by email, this was acknowledged within the report. To ensure best practice, an ADT audit is to be completed quarterly by the Approved Centre Management, ensuring all points within the code of practice are covered. The proof document will be provided as part of the CAPA. The QA department will also	The QA Department will monitor on an ongoing basis and complete ADT audit on an annual basis.	This action has been achieved	14/09/2021	Director of Nursing (DON) & Quality Assurance (QA) Department.

	complete an ADT audit on an annual basis this is in line with the code of practice 4.19. For the purpose of the CAPA, this non-compliance was completed and proof sent to the inspectors on the 10th September 2021. In regard to the Cois Dalua internal quarterly ADT audit document will be completed by the 30th November and the proof document will be uploaded.				
Preventative Action	The QA audit on ADT had not been completed within the previous 12 months, this was immediately rectified by the QA team and the proof document was provided to the inspectors by email, this was acknowledged	The QA Department will monitor on an ongoing basis and complete ADT audit on an annual basis.	This action has been achieved	14/09/2021	Director of Nursing (DON) & Quality Assurance (QA) Department.

	within the report. To ensure best practice, an ADT audit is to be completed quarterly by the Approved Centre Management, ensuring all points within the code of practice are covered. The proof document will be provided as part of the CAPA. The QA department will also complete an ADT audit on an annual basis this is in line with the code of practice 4.19. For the purpose of the CAPA, this non-compliance was completed and proof sent to the inspectors on the 10th September 2021. In regard to the Cois Dalua internal quarterly ADT audit document will be completed by the 30th				

	November and the proof document will be uploaded.				

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.

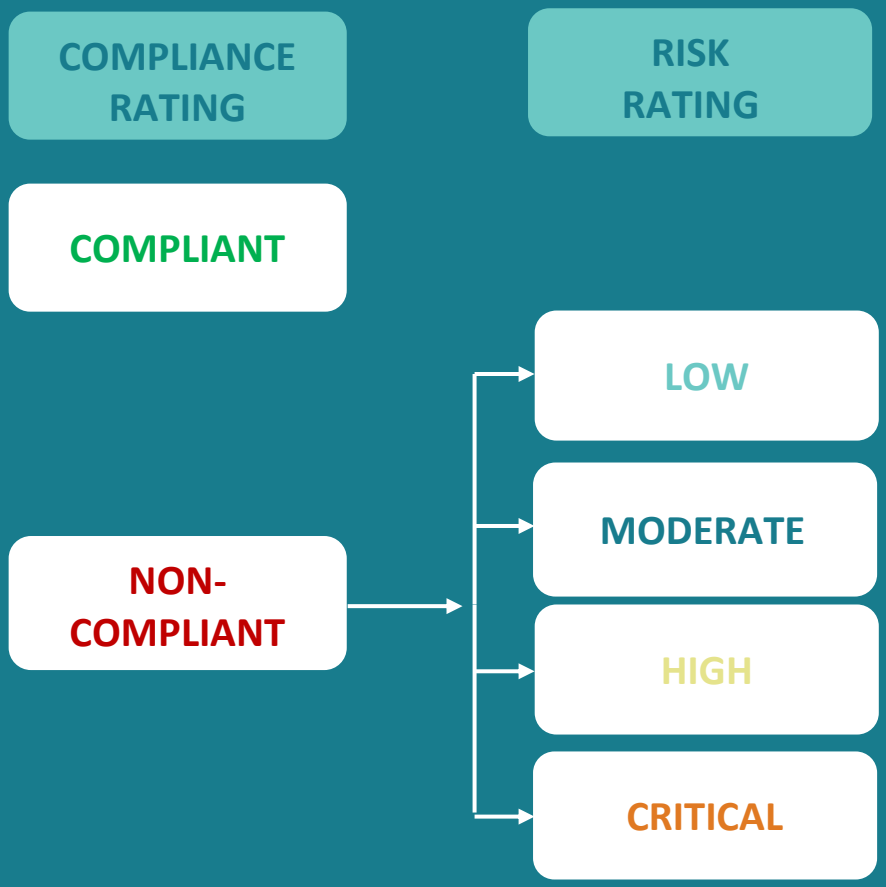
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation, and interview to assess compliance with the requirements.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