MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Cois Dalua

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

COIS DALUA

Cois Dalua, Meelin, Knockduff Upper
Newmarket, Co Cork

Date of Publication:
Thursday 01 April 2021

ID Number: AC0128

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Forensic Mental Health Care
Mental Health Care for People with Intellectual Disability

Most Recent Registration Date:
1 June 2018

Conditions Attached:
None

Registered Proprietor:
Nua Healthcare Services

Registered Proprietor Nominee:
Mr Noel Dunne, Chief Executive

Inspection Team:
Rajeev Ramasawmy, Lead Inspector
Carol Brennan-Forsyth

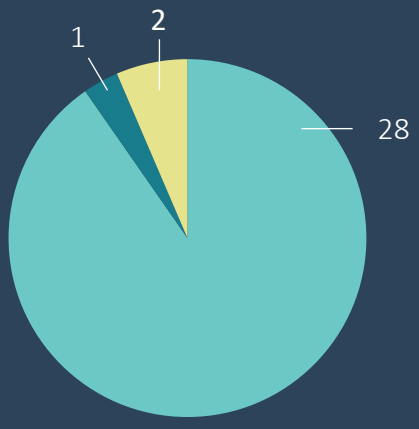
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
6 – 9 October 2020

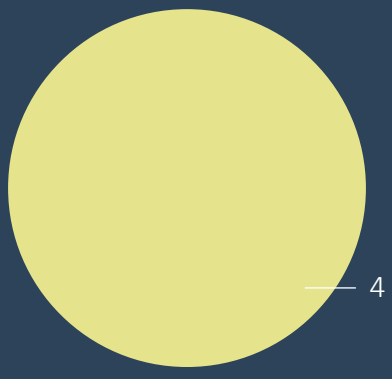
Previous Inspection Date:
1 – 3 October 2020

Inspection Type:
Announced Annual Inspection

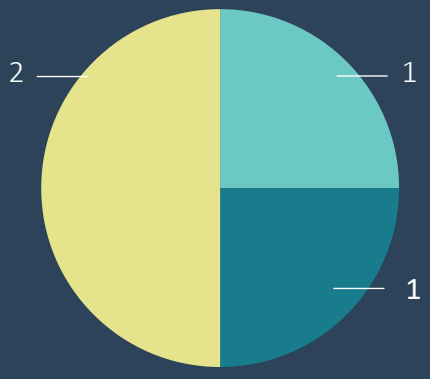
2020 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



CODES OF PRACTICE

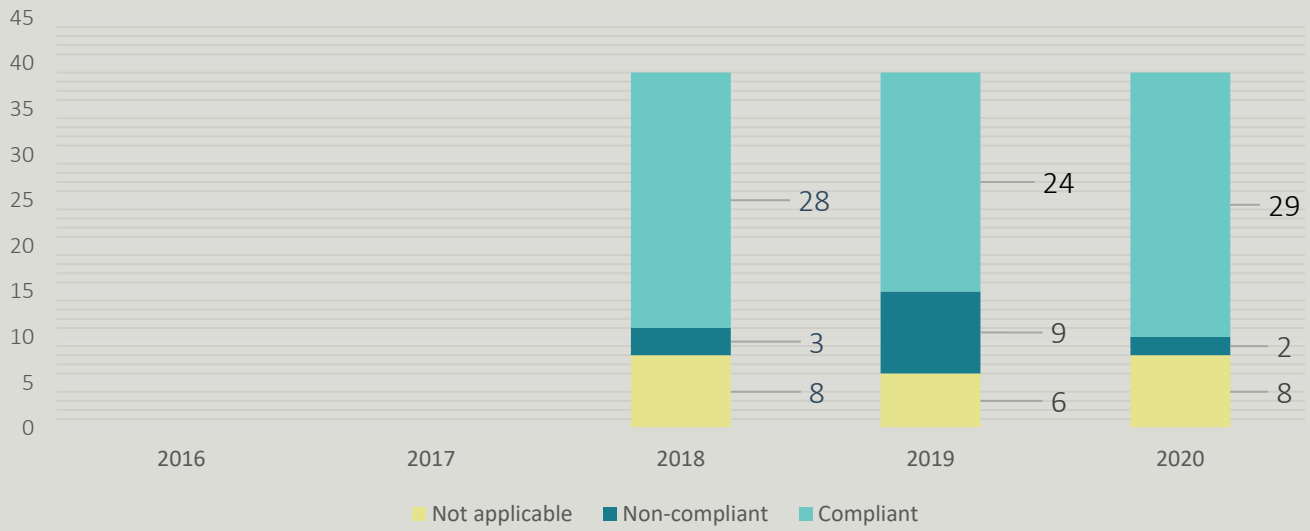
Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2016 – 2020

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

Please note the approved centre opened in June 2018.

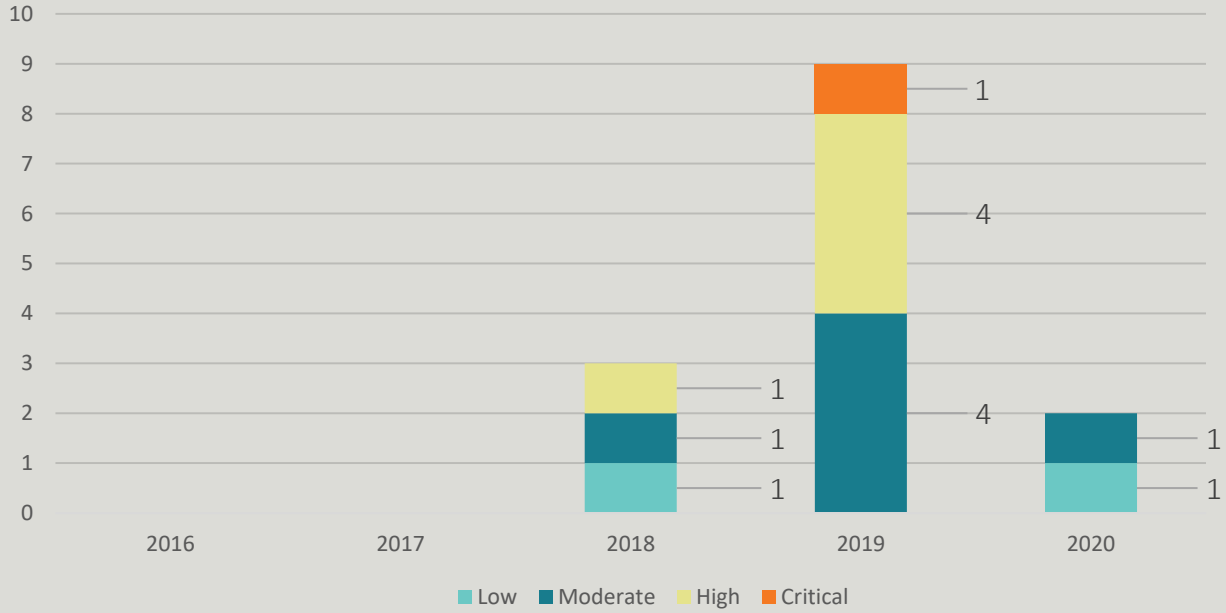
CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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 2016 – 2020

Please note the approved centre opened in June 2018.



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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 sixteen bed privately operated approved centre. Run by Nua Healthcare, it provided rehabilitation mental health inpatient services. It was located in a small rural village on its own grounds and was surrounded by high fencing with a key pad controlled gate and side entrance. The front door of the residence was locked.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	N/A	N/A	90%	73%	94%
Regulations Rated Excellent	N/A	N/A	6	3	N/A

Conditions to registration

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

Safety in the approved centre

- There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Kitchen areas were clean.
- 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.

- Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre.
- There was a minimisation of ligature points to the lowest practicable level, based on risk assessment.
- Medication was ordered, prescribed, stored and administered in a safe manner.
- The centre had adopted the Dynamic Appraisal of Situational Aggression (DASA) to carry out risk assessments for the residents.

Appropriate care and treatment of residents

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident.
- Cois Dalua had a full-time social worker, occupational therapist and psychologist. During the COVID-19 lockdown the allied health team used Microsoft Teams online platform, and the phone to keep in touch with the staff and to deliver sessions to the residents. Since June 2020, the allied health team had resumed 1:1 and group sessions using public health guidelines.
- 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 and weight. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

However, the six-monthly general health assessment did not document waist circumference.

Respect for residents' privacy, dignity and autonomy

- Accommodation consisted of four single, en suite bedrooms and four self-contained apartments. A further new modern build, recently completed, had a further six en suite bedrooms and two self-contained apartments.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- 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.

Responsiveness to residents' needs

- Recreational activities available in the approved centre included TV, music, quizzes, outings, badminton, baking, arts, walking, shopping, newspaper reading and 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.

Governance of the approved centre

- 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 matrix, which enabled effective monitoring by Nua Healthcare's Senior Management and Executive Management Team (EMT).
- A weekly management meeting was held locally and was attended by the Consultant Psychiatrist, Director of Nursing and the Allied Professionals discussed issues that arose within the centre.
- Risk management was governed by the Director of Operations centrally in Nua. Locally however, the responsibility was assigned to the Director of Nursing. There was a current risk register in place which was site specific. The centre had an Automated Incident Report System (AIRS) to record incidents.
- Staff were provided with training by Nua Healthcare Training Department which was centre specific. A full training induction was provided upon commencement.
- A weekly resident meeting provided residents with the opportunity to relay any issues. These were documented and actions were taken. There were two nominated complaints officers, and their details were displayed. Formal complaints were sent to nominated officers and there were no outstanding complaints at time of inspection.
- The policies were updated recently by the Policy Development Group including all COVID-19 related national guidelines. The approved centre had a COVID-19 Organisation meeting once a week to discuss contingencies and affected changes as required.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Cois Dalua's relaxation room had been fully refurbished to include sensory items to meet the assessed needs of the service users.

2. The approved centre, since the last inspection, had a full multi-disciplinary team (MDT) inclusive of a full time Psychologist, a full time Occupational Therapist and a full time Social Worker.

3. A new services information leaflet, formulated by the Occupational Therapist, had been made available to all service users.

4. The Social Functioning Questionnaire was devised and implemented by Cois Dalua's MDT to assess quality outcomes as part of service users' rehabilitation programme.

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 which resided the current cohort of residents. A further new modern build which was recently completed and had a further six en suite bedrooms and two self-contained apartments. At time of the inspection no residents were in the new build. The centre was located in its own grounds and was surrounded by high fencing with a key pad controlled gate and side entrance. The front door of the residence was locked.

Communal areas where current residents were within the centre included a day room, 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 only be accessed through the locked front door of the premises.

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**8**
Number of detained patients	0
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	7
Number of patients 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 matrix, which enabled effective monitoring by Nua Healthcare's Senior Management and Executive Management Team (EMT). This took the form of quarterly meetings between the EMT and Local Management Team and quarterly Quality and Safety Meetings. Governance questionnaires were submitted by the Consultant psychiatrist, Director of Nursing, Clinical Psychologist, Occupational therapist and Social worker which indicated that there were clear reporting systems for all disciplines. Furthermore, locally a weekly management meeting attended by the Consultant Psychiatrist, Director of Nursing and the Allied Professionals discussed issues that arose within the Centre.

Service wide, risk management was governed by the Director of Operations. Locally however, the responsibility was assigned to the Director of Nursing. There was a current risk register in place which was site specific. The centre had an Automated Incident Report System (AIRS) to record incidents. The centre had adopted the Dynamic Appraisal of Situational Aggression (DASA) to carry out risk assessments for the residents. A Health and Safety Champion worked closely with the Quality and Safety Department to ensure risks was adhered to.

Since the last inspection the approved centre had employed a full-time occupational therapist, clinical psychologist and a social worker dedicated to the unit only. There was a staffing plan which clearly identified each roles and responsibilities in place. It was reported to the inspection team that nursing recruitment was ongoing to enable the staffing of the new build when fully functional. Staff were provided with training by Nua Healthcare Training Department which was centre specific. A full training induction was provided upon commencement.

A weekly resident meeting provided residents with the opportunity to relay any issues. This was documented and actions were taken. There were two nominated complaints officers, and their details were displayed. Formal complaints were sent to nominated officers and there were no outstanding complaints at time of inspection.

The entrance door to Cois Dalua was locked, at the time of the inspection, and access was by requested access or PIN code keypad. This restriction was implemented in consideration of the residents' assessed clinical needs and to ensure their safety. It was reported that residents could go out if they wanted to but generally were accompanied by staff. The unit had a restrictive policy which was monitored and updated and it was reported to the inspection team that the main entrance is left open on a daily basis for a period of time.

The policies were updated recently by the Policy Development Group including all COVID-19 related national guidelines. The approved centre had a COVID-19 Organisation meeting once a week to discuss contingencies and affected changes as required.

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

The approved centre opened in June 2018; therefore, there was no inspections in 2016 and 2017. Non-compliant (✗) areas on this 2020 inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2018 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 19: General Health					✓		✗	High	✗	Low
Code of Practice on Admission, Transfer and Discharge to and from the approved centre					✓		✓		✗	Moderate

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 3: 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 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

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:

- 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 Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

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

The inspection team spoke to two residents informally and they were very positive about the service. Eight questionnaires were returned from residents and were rated between three and ten on the overall experience of care and treatment, mostly on the upper range on a scale of one to ten. One questionnaire was rated three, one rated five, four was rated seven and two rated ten.

Three questionnaires indicated that they only 'sometimes' were involved in setting goals for their individual care plan.

One questionnaire had 'sometimes' written for how happy they were when staff talk to them.

Although information about advocacy services was evident, no input was noted.

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:

- Consultant Psychiatrist
- Director of Operations
- Director of Nursing
- Assistant Director of Nursing
- Psychologist
- Occupational Therapist
- 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

Each resident was easily identifiable by staff when receiving medication, health care and other services. A minimum of two resident identifiers appropriate to the resident group profile were used. The approved centre used name, photograph, medical record number, and date of birth of each resident as identifiers. The identifiers, detailed in each resident's clinical file, were checked when staff administered medications, undertook medical investigations, and provided 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 options within the approved centre's menus. Food was properly prepared and comprised of servings from different food groups as per the Food Pyramid. They were provided with at least two choices for meals. Residents had sufficient supplies of safe and fresh drinking water in easily accessible locations throughout the approved centre. The needs of residents identified as having special nutritional and dietary requirements were assessed where necessary, and in the resident's individual care plan. Residents had access to a dietitian and speech and language therapy, if required.

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 appropriate and adequate catering equipment, crockery, and cutlery to suit the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements.

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 did not wear nightclothes during the day, unless otherwise specified in their individual care plan. Residents were supported to keep and use their personal individualised clothing, which was adequate in supply. The approved centre did not keep a stock of emergency clothing due to all admission being pre-planned and residents arrived to the approved centre with sufficient personal clothing. Funds were available to purchase clothing for residents should the need arise.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures detailing the processes for managing residents' personal property and possessions. The policy was last reviewed in August 2020.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP).

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. Residents could bring in personal possessions, as agreed with staff, on admission. The approved centre had secure facilities, including a resident safe in the administration office, for the safe-keeping of residents' valuables.

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

Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. The activities available in the approved centre included TV, music, quizzes, outings, badminton, baking, arts, walking, shopping, newspaper reading and 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

There was a written operational policy and procedures in relation to visits. The policy was last reviewed in August 2020. Visitors were not permitted to come to the approved centre at the time of the inspection due to COVID-19 restrictions.

A separate visitor room was available where private visits could take place in non-Covid-19 times, 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. The visiting rooms were suitable for children visiting residents.

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 in relation to resident communication. The policy was last reviewed in July 2020. Residents had access to mail, fax, Wi-Fi Internet and the telephone. Residents had their own mobile phones. The approved centre supplied two iPad's for residents' use, which were supplied while COVID-19 visiting restrictions took place. Individual risk assessments were completed for residents, as deemed appropriate, in relation to any risks associated with their external communication and this was documented in the individual care plan. The Clinical Director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the implementation of resident searches. The policy was last reviewed in August 2020. The policy addressed all of the requirements of the regulation, including the following:

- 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 and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. The clinical file of one resident who was searched was inspected. The resident's consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident's dignity and privacy. One of the staff members who conducted one of the searches was of the same gender as the resident being searched. Policy requirements were implemented when illicit substances were found as a result of a search.

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 procedure in place in relation to the processes in place for end of life care. The policy was last reviewed in August 2020. As there had been no deaths in the approved centre since the last inspection, compliance against this regulation was only assessed under the policy aspect (section 1) of this regulation.

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 recorded in the one composite set of documentation. Each resident had been assessed at admission by the admitting clinician and an ICP was established. The ICPs were then developed by the multi-disciplinary team (MDT) following a comprehensive assessment, as soon as was possible but within seven days of admission. All ICPs inspected evidenced resident involvement. The resident's family or representative were involved in the development of ICPs as appropriate.

The ICPs identified appropriate goals, appropriate care and treatment, and interventions. All ICPs specified the resources required to provide the care and treatment identified, including the frequency and responsibilities for implementing the care and treatment. The MDTs reviewed care plans every three months, and sooner than 3 months if necessary. 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 had a fulltime social worker, occupational therapist and psychologist. During the COVID-19 lockdown the allied health team used Microsoft Teams online platform, and the phone to keep in touch with the staff and to deliver sessions to the residents. Since June 2020 the allied health team had resumed 1:1 and group sessions using public health guidelines.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the transfer of residents. The policy was last reviewed in July 2020. As no resident had been transferred from the approved centre since the last inspection, the approved centre was only assessed under the policy aspect (section 2) of this regulation.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating LOW

(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 and procedures for responding to medical emergencies. The policy was last reviewed in July 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). Emergency equipment was checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. The clinical files of three residents who had been in the approved centre for more than six months were inspected; each of the three residents had received a six-monthly general health assessment. Residents received appropriate general health care interventions in line with individual care plans.

The six-monthly general health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index (BMI), weight, but not waist circumference. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

An electrocardiogram (ECG) heart function assessment was completed on residents who were taking antipsychotic medication and their glucose, blood lipids, and prolactin levels were checked. Residents could access national screening programmes according to age and gender, including retina check (for diabetics only).

The approved centre was non-compliant with this regulation because the six-monthly general health assessment did not measure and record the resident's waist circumference, 19 (1, b).

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

Residents were provided with a service-user 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 diagnosis unless, in the treating psychiatrist's view, the provision of such information might be prejudicial 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 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.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of staff and the manner in which staff addressed and interacted with residents indicated respect. Staff were discreet when discussing the resident's condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity. All bathrooms, showers, and toilets had locks on the inside of the door, unless there was an identified risk to a resident.

Each resident had their own single en suite bedroom (with shower and toilet facilities) and their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make and take private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was adequately lit, heated, and ventilated. It was extremely clean, hygienic and free from offensive odours. Extra cleaning was implemented due to the COVID-19 pandemic. Furnishings supported resident independence and comfort. Residents had access to personal space, and private and communal rooms were appropriately sized and furnished to remove excessive noise.

All resident bedrooms were appropriately sized to address the resident needs. Each resident had their own spacious single bedroom with an en suite shower and toilet facilities attached. There was adequate space for residents to move about, including outdoor spaces. Residents had access to well-maintained garden areas.

Appropriate signage and sensory aids were provided to help residents in finding their way around the approved centre. Hazards were minimised throughout the approved centre. Ligature points were minimised to the lowest practicable level based on a risk assessment.

The approved centre was kept in a good state of repair externally and internally and there was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre had their own maintenance staff. Records were maintained.
Current national infection control guidelines were followed. The approved centre had a designated sluice room and a designated cleaning room. Assisted devices and equipment were provided to address resident needs. Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in August 2020.

Each resident had an MPAR, and five of these were inspected. All MPARs evidenced a record of medication management practices, including a record of the following: allergies or sensitivities to any medications including if the resident has no allergy, route of medication, all medications administered to the resident, the stop date for each medication, dose of medication, and frequency of 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. When a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file. Medication was stored in the appropriate environment. 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 unit 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 policy was last reviewed in August 2020.

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 policy and procedures in relation to the use of CCTV. The policy was last reviewed in August 2020. The policy covered the purpose and function of using CCTV for observing residents in the approved centre. There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe residents were incapable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre's use of CCTV.

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 August 2020. The policy covered information and procedures in relation to the recruitment, selection and Garda vetting requirements. The number and skill mix of staffing were sufficient to meet resident needs. 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. Staff training could not be completed due to COVID-19 pandemic events and was therefore not inspected. The following is a table of clinical staff assigned to the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) & 26(5) have been deferred until 2021.

The following is a table of clinical staff assigned to the approved centre.

Ward or Unit Breakdown

Ward or Unit	Staff Grade	Day	Night
Cois Dalua	Director of Nursing	1 WTE (9-5)	
	Assistant Director of Nursing	1	
	Registered Psychiatric Nurse	2	2
	Occupation Therapist	1	
	Social Worker	1	
	Psychologist	1	
	Social Care Workers and Assistant Support Workers	5	3

Whole time equivalent (WTE)

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 2020. 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' current status and the care and treatment being provided. Resident records were developed and filed in a logical sequence, with file dividers present for each component of the records. All resident records were physically stored together in the nurses' office. Records were appropriately secured throughout the approved centre 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. 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

Operating policies and procedures required by the regulations were all reviewed within the required three-year time frame. The approved centre had a policy development group who met regularly to develop and update policies. The policy group included the Clinical Director, Director Of Nursing, Director of Operations and the Social Worker.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There were two nominated complaints officers who were based in the approved centre. The complaints officers were available and responsible for dealing with all complaints in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure including how to contact the complaints officers was publicised and accessible to residents, their representatives and families through notices 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.

The approved centre followed a complaints reporting pathway, with four stages. All complaints were handled promptly, 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. All complaints were dealt with by the nominated person and recorded in the complaints log. Minor complaints were documented and all larger official 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.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There was a comprehensive written policy and procedures in relation to risk management and incident management processes. The risk management policy was last reviewed in August 2020. The policy addressed all policy related regulatory requirements, including:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- Arrangements for responding to emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

The person with responsibility for risk, was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Risk management procedures actively reduced identified risks to the lowest level of risk, as was reasonably practicable. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes.

Clinical, and health and safety risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Corporate risks were managed by the CEO at Nua Healthcare Head Office. Individual risk assessments were completed prior to episodes of physical restraint, and at resident

admission, transfer, and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors. Structural risks, including ligature points were effectively mitigated.

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

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

The approved centre was compliant with this regulation.

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 was adequately insured against accidents and injury to residents. The approved centre's organisational insurance certificate was available to the inspection team. It confirmed that the approved centre was covered for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which was displayed prominently at the main 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 4.3 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 August 2020. The policy covered:

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

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 resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint.

The physical restraint episode was initiated by a registered medical practitioner (RMP) in accordance with the policy on physical restraint. 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) or the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner did not complete a medical examination of the resident within three hours after the start of the episode of physical restraint because the resident refused a physical examination.

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 **MODERATE**

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 single combined policy in relation to admission, transfer, and discharge. The policy was last reviewed in July 2020. The policy included the policy related criteria of the code of practice, with the exception of the discharge policy which did not include a protocol for discharging homeless people.

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

Monitoring: Audits had been completed on the implementation of and adherence to the admission, and discharge policy. There were no transfers from the approved centre since the last inspection, therefore there were no transfers to audit.

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. The resident was assigned a key-worker. An admission assessment had been completed.

The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental 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 files of residents who had been discharged since the last inspection had been sent with them to their new place of residence within Nua Healthcare and were not accessible to the inspection team at the time of inspection.

The approved centre was non-compliant with this code of practice because the discharge policy did not include a protocol for discharging homeless people, 4.12.

Appendix 1: Corrective and Preventative Action Plan

Regulation 19: General Health					
Reason ID: 10001726		**The six-monthly general health assessment did not measure and record the resident's waist circumference, 19 (1, b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The six-monthly general health record template that had been observed by the Inspector on the 6th October 2020 had no recording of a waist circumference. A previous template had been used for this particular resident. All old templates have been removed and the updated version of the template is now in line with Reg 19 (1,b) has been implemented.	Internal audits completed, quality assurance and adminisrative checks as part of KPI's.	No barriers to implementation and this action has been completed.	07/10/2020	Director of Nursing
Preventative Action	All old templates have been removed and the updated version made in line with Reg 19 (1,b) have been made available in hard and soft copy to all staff. All residents records have been checked and verified that waist circumference has been recorded.	Internal audits completed, quality assurance and adminisrative checks as part of KPI's.	No barriers to implementation and this action has been completed.	07/10/2020	Director of Nursing

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID: 10001725		**The discharge policy did not include a protocol for discharging homeless people, 4.12.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The discharge policy has been updated and approved by the multi-disciplinary team. The corrective action is to ensure that there is a protocol within the policy to provide guidelines in the event of a possible discharge of homeless services.	To monitor the process in the event of discharging homeless people, following the specialist rehabilitation unit's discharge pathway.	No barriers to implementation and this action plan has been completed.	03/02/2021	Director of Nursing
Preventative Action	Update the Admission,Discharge and Transfer policy to include a protocol for discharging homeless people	To monitor the process in the event of discharging homeless people, following the specialist rehabilitation unit's discharge pathway.	No barriers to implementation and this action plan has been completed. Please see attached updated policy PL-MHS-REG-18 Policy and Procedure on Admissions Discharges and Transfers of Patients.	03/02/2021	Director of Nursing

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.

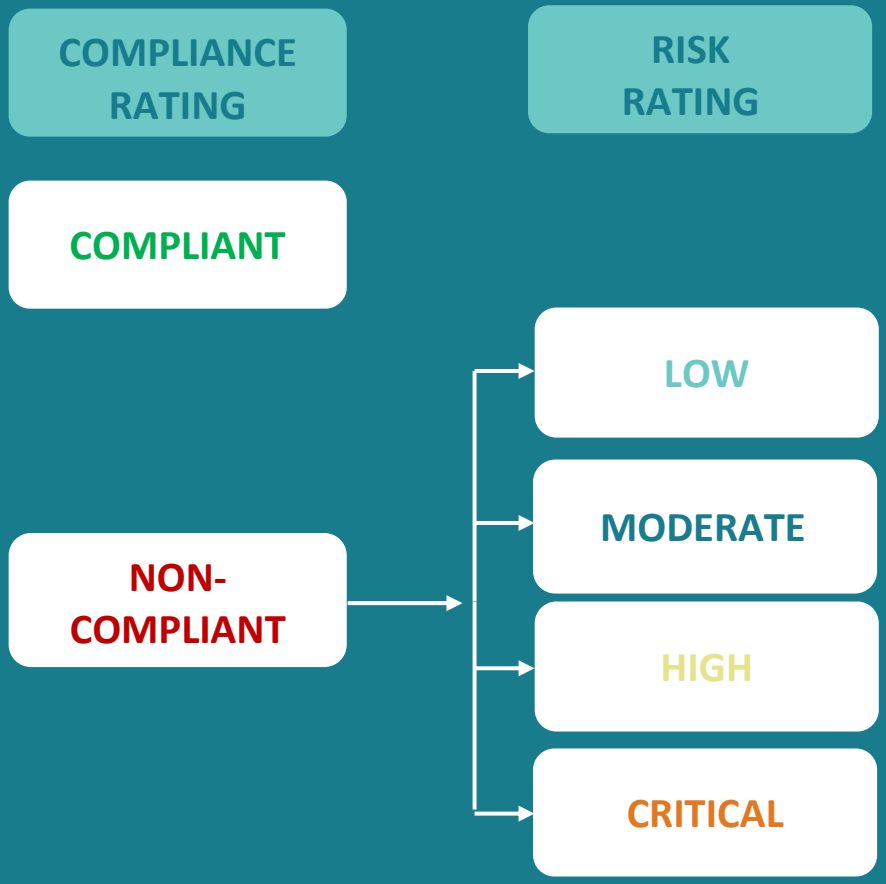
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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