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Coimisiún Meabhair-Shláinte | Mental Health Commission

Grangemore Ward, St Otteran's Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

GRANGEMORE WARD, ST OTTERAN'S HOSPITAL

Grangemore Ward, St Otteran's Hospital, John's Hill, Waterford

Date of Publication:
Friday 29 January 2021

ID Number: AC0153

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care/Long Stay Mental Health Rehabilitation

Most Recent Registration Date:
1 March 2020

Conditions Attached:
None

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr David Heffernan, General Manager, CHO5 Mental Health Services

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Susan O'Neill

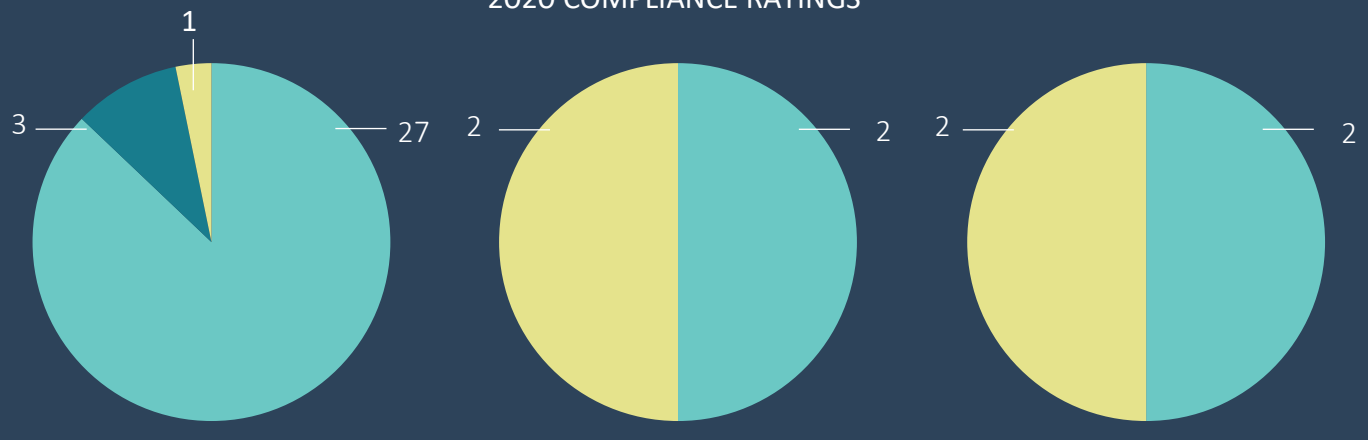
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
21 – 24 July 2020

Previous Inspection Date:
N/A

Inspection Type:
Announced Annual Inspection

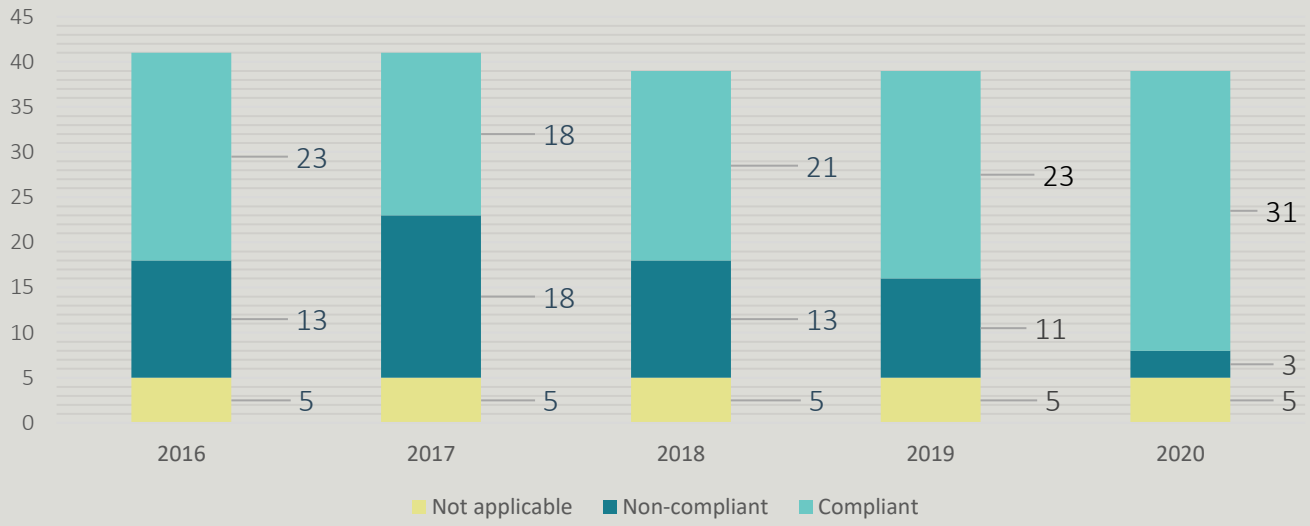
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

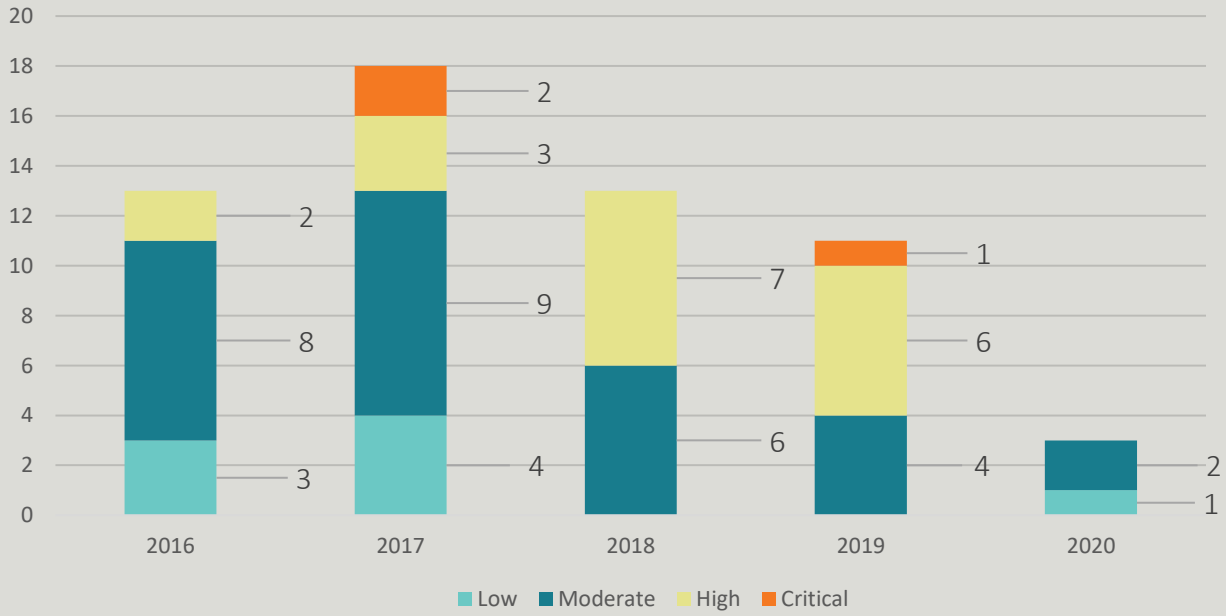
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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

The approved centre was located within St. Otteran's Hospital campus on the outskirts of Waterford city. Grangemore ward was a Rehabilitation and Recovery unit, which accommodated 16 residents at full capacity. There were 11 residents in the approved centre at the time of inspection to allow extra space for social distancing due to the COVID-19 pandemic. Not all bedrooms were en suite. At the time of inspection, the two four-bedded rooms accommodated two residents each. Plans were in place to convert the four-bedded rooms into single occupancy rooms.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	64%	50%	62%	68%	91%
Regulations Rated Excellent	0	1	0	1	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

- Kitchen areas were kept clean and food was stored in a safe manner.
- Medication was ordered, prescribed, stored, and administered in accordance with safe procedures.
- Current infection prevention and control guidelines were followed and included a protocol for the COVID-19 pandemic.

- Hazards were not all minimised in the approved centre. The non-smoking garden had a very large crack in the concrete that posed a trip hazard and there was lack of storage space for hoists, wheelchairs and trolleys, which were stored in the corner of a shared bedroom.
- There was a minimisation of ligature points to the lowest practicable level, based on risk assessment.

Appropriate care and treatment of residents

- Each resident had a multi-disciplinary individual care plan (ICP) that was developed and reviewed as far as possible with the resident and their families.
- Therapeutic services and programmes were provided according to assessed needs and as outlined in the residents' ICPs. Groups included a music therapy group, a brunch-lunch group, a creative group, a social and leisure group, and a walking group. The COVID-19 pandemic had limited some activities.
- Residents general health needs were monitored and assessed every six months or more frequently as indicated by the residents' specific needs. Each assessment included a record of a physical examination, body mass index, weight, waist circumference, blood pressure, smoking status, and dental health. For residents who were prescribed antipsychotic medication, there was an annual assessment of glucose regulation, blood lipids, prolactin levels, and an electrocardiogram.
- Adequate arrangements were in place for access by residents to general health services and for their referral to other health services.

However:

- Two ICPs were not reviewed by the full MDT in consultation with the resident, while one ICP was not reviewed within the required six-month timeframe.

Respect for residents' privacy, dignity and autonomy

- There were areas in the approved centre where residents could meet their visitors in private.
- The approved centre was clean, hygienic, and free from offensive odours and a cleaning schedule was implemented within the approved centre.
- The approved centre was kept in a good state of repair externally and internally. There was no programme of general maintenance but a maintenance log was kept and monitored.
- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door and where residents shared a room, bed screening ensured that their privacy was not compromised. 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 and residents were facilitated to make private phone calls.

However:

- Not all residents had a single en suite bedroom.

Responsiveness to residents' needs

- There was a choice of food at mealtimes.
- Appropriate recreational activities were provided. These included self-directed activities in the sitting rooms, such as TV, radio, jigsaws, board games, and books. A resource box containing arts and crafts materials and mindfulness colouring books was available for residents. Written and verbal information was provided about the approved centre and residents' diagnoses and medication.
- There was a comprehensive complaints process in place.
- A tablet was purchased for residents to keep in touch with their families during the COVID-19 restrictions. The tablet was also used to support external recovery college courses e.g. wellness toolboxes and mindfulness for residents.
- Online shopping was introduced in response to the COVID-19 restrictions.

Governance of the approved centre

- The approved centre was part of South East Community Healthcare, formerly known as Community Healthcare (CHO) 5.
- A sub group of the Executive Management had been set up to manage COVID-19.
- The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed. Grangemore Ward had a schedule of audits in place.
- The person with responsibility for risk was identified and known by all staff. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate.
- Incidents were recorded and risk-rated on the National Incident Report Form (NIRF), and incidents were reviewed to identify any trends or patterns occurring in the service.
- Regular community meetings were documented which outlined a process where residents were provided with an opportunity to bring issues of concern to staff attention. The complaints procedure was publicly displayed within the approved centre and a new suggestion box was centrally located.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The resident welcome pack was updated to include bus timetables and national screening programme information.
2. The approved centre introduced regular education sessions and updates for residents regarding COVID- 19.
3. A tablet was purchased for residents to keep in touch with their families during the COVID-19 restrictions. The tablet was also used to support external recovery college courses e.g. wellness toolboxes and mindfulness for residents.
4. Online shopping was introduced in response to the COVID-19 restrictions.
5. A safety mirror was installed on the narrow internal stairs to ensure safer access to the ground and first floors.
6. The approved centre had introduced an activity booklet to inform residents of recreational activities.
7. A secure suggestion box was purchased to encourage resident feedback.
8. The approved centre introduced a gardening project where window boxes and a water feature were added to the garden. The garden furniture was painted by the residents.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located within St. Otteran's Hospital campus on the outskirts of Waterford city. Grangemore ward was a Rehabilitation and Recovery unit, which accommodated 16 residents at full capacity. There were 11 residents in the approved centre at the time of inspection to allow extra space for social distancing due to the CODID 19 pandemic.

Grangemore ward comprised of two communal sitting/visitors rooms, a dining room and a quiet room. The residents had access to two well maintained gardens, one was for residents who wished to smoke and the other for non-smoking residents. The accommodation in Grangemore ward consisted of two four-bedded rooms, one two-bedded room and six single bedrooms. Not all bedrooms had en suites. At the time of inspection, the two four-bedded rooms accommodated two residents each.

The approved centre was maintained in a good structural and decorative condition, however, it was reported that there was no routine programme of maintenance. At the time of the inspection, the residents and staff were preparing to move to another facility to allow renovations to the bedroom areas to proceed. Plans were in place to convert the four-bedded rooms into single occupancy rooms.

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

Resident Profile	
Number of registered beds	***16***
Total number of residents	**11**
Number of detained patients	1
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	10
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of South East Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 5, and was governed under the Waterford/Wexford Mental Health Services. Waterford/Wexford Mental Health Service's governance processes encompassed two core monthly meetings: the Waterford/Wexford Executive Management Team Meeting and Quality and Safety Executive Committee meeting. Governance was strengthened by a local Quality and Patient Safety Committee meeting and a Health and Safety Committee meeting, which addressed issues within Grangemore. In terms of COVID

19 governance structures, a sub group of the Executive Management had been set up. Initially this group met three times a week; meetings have become less as restrictions ease. Minutes were taken and were disseminated to staff in Grangemore Ward.

The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed. Grangemore Ward had a schedule of audits in place.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify any trends or patterns occurring in the service. Identified risks for the approved centre were the COVID 19 pandemic, the recruitment and retention of staff, and lack of a routine maintenance programme.

At the time of inspection the numbers and skill mix of staff was sufficient to meet the residents' needs. Health Care Assistants had been included in the cohort of staff since the last inspection. Health and social care disciplines, including occupational therapy, psychology and social work, were accessible to all residents. At the time of inspection there was no Principal Social Worker for the Waterford/Wexford Mental Health Services; responsibilities for this post lay with the service manager. Plans were in place to recruit and fill this role.

Residents were involved in the development and review of their individual care plans. Regular community meetings were documented which outlined a process where residents were provided with an opportunity to bring issues of concern to staff attention. The complaints procedure was publicly displayed within the approved centre and a new suggestion box was centrally located.

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 2016 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 15: Individual Care Plans	✗	Moderate	✓		✓		✓		✗	Moderate
Regulation 22: Premises	✓		✗	Moderate	✗	High	✗	High	✗	Moderate
Regulation 28: Register of Residents	✗	High	✗	Low	✗	High	✗	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.
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.
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.

Three service user experience questionnaires were completed. All residents reported feeling safe in the approved centre. The majority of residents indicated that there was space for privacy and that their privacy and dignity was respected. The residents reported that they understood their care plans and knew the members of their multidisciplinary team. Two residents stated that they weren't always involved in setting goals for their individual care plans. One resident reported not knowing their keyworker. Two residents indicated that they always felt able to give feedback to staff or make complaints when dissatisfied with the service. Two respondents stated that there were not enough activities during the day.

The inspection team received a resident feedback report from the Irish Advocacy Network. There were positive comments around the food in the approved centre and generally there was good feedback regarding the nursing staff.

The residents also identified areas for improvement. Two residents stated that there wasn't enough to do in the approved centre during the day and one resident mentioned that they would like to go out more. In terms of accommodation one resident expressed a wish to have their own bedroom, stating it would give them some privacy; another resident wanted to move to a place of their own. One individual reported that the nursing staff did not listen. Several individuals expressed a wish for toast in the evenings.

Feedback from the Area Lead for Mental Health Engagement suggested that the residents were complimentary of the care and treatment in the approved centre.

6.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. This was attended by the inspection team and the following representatives of the service:

- Registered Proprietor
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Principal Psychologist
- Acting Manager for occupational therapy and social work.

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 were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. 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 and a source of safe, fresh drinking water was available at all times in 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, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements and residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and takes account of their preferences, dignity, bodily integrity, and religious and cultural practices. No residents wore nightclothes during the day.

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 relating to residents' personal property and possessions, which was last reviewed in May 2018. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities 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 recreational activities appropriate to the resident group profile, including self-directed activities in the sitting rooms, such as TV, radio, jigsaws, board games, and books. A resource box containing arts and crafts materials and mindfulness colouring books were available for residents and located in the nurses' station. Group activities included outings on the bus, as well as an art group, music group, bingo, and walking group. The approved centre provided access to recreational activities on weekdays and during the weekend.

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, which was last reviewed in September 2016.

Visiting times were appropriate and reasonable, though due to ongoing infection control and pandemic events, visiting was by appointment only. A separate visitors' 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. Appropriate steps were taken to ensure the safety of residents and visitors during visits.

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, which was last reviewed in January 2018. Residents had access to mail, fax, e-mail, internet, telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health.

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, which was last reviewed in May 2018. It included all requirements related to:

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

No searches had been conducted since the previous 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, which was last reviewed in May 2018.

The clinical file of one resident who had died in the approved centre was examined. The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs: this was documented in the resident's individual care plan. Religious and cultural practices were respected and the privacy and dignity of residents was protected, with end of life care provided in a single room.

Representatives, family, next of kin, and friends were involved, supported and accommodated during end of life care. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified the appropriate goals for the resident, as well as the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICPs also identified the resources required to provide the care and treatment identified. Two ICPs were not reviewed by the full MDT in consultation with the resident, while one ICP was not reviewed within the required six month timeframe. All ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

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

a) **Two ICPs were not reviewed by the full MDT.**
b) **One ICP was not reviewed by the MDT within the required 6 month timeframe.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. Services included occupational therapy (OT), social work (SW), psychology, and music therapy. The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Groups included a music therapy group, a brunch-lunch group (OT), a creative group (OT), a social and leisure group (SW), a walking group (co-facilitated by OT and SW).

A psychology drop-in service was also operated by the psychologist once a week on the Grangemore site where residents could speak with the psychologist without prior appointment. 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, which was last reviewed in May 2018.

The clinical file of one resident who had undergone an emergency transfer from the approved centre was examined on inspection. Full and complete written information for the resident was transferred when they moved from approved centre to another facility. Communications between the approved centre and the receiving facility were documented and followed up with a written referral.

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 medical emergencies policy, which was last reviewed in May 2018. The approved centre had an emergency trolley and staff had access at all times to an AED, both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Three clinical files were examined in relation to provision of general health services during the inspection process. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The six monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, nutritional status, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, an electrocardiogram, 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. Records were available demonstrating residents' completed general health checks and associated results, including records of any clinical testing, e.g. lab results. Residents could access national screening programmes according to age and gender, including Breast Check and bowel screening. Information was provided to residents regarding the national screening programmes available through the approved centre and residents had access to smoking-cessation supports.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents, which was last reviewed in May 2018.

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

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, 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 resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

Residents were called by their preferred name and the general demeanour of staff and the way in which they dressed and communicated with residents was respectful. Staff were discrete when discussing the resident's condition or treatment needs and sought the resident's permission before entering their room, as appropriate.

The layout and furnishings of the approved centre were conducive to resident privacy and dignity. All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident, and where residents shared a room, bed screening ensured that their privacy was not compromised. 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 and residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space, though not to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre and it was well ventilated. Private and communal areas were suitably sized and furnished to remove excessive noise or acoustics and the lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were not all minimised in the approved centre. The non-smoking garden had a very large crack in the concrete that posed a trip hazard and there was lack of storage space for hoists, wheelchairs and trolleys, which were stored in the corner of a shared bedroom. There was a minimisation of ligature points to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally, though there was no programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The approved centre was clean, hygienic, and free from offensive odours and rooms were centrally heated with pipe work and radiators were guarded. Current national infection control guidelines were followed.

There was a sufficient number of toilets and showers for residents in the approved centre and there was at least one assisted toilet per floor. The approved centre had a designated sluice room and cleaning room. All resident bedrooms were appropriately sized to address the resident needs. While the approved centre provided assistive devices and equipment to address resident needs, it did not provide suitable furnishings

to support resident independence and comfort as resident wardrobes were too small to allow for sufficient storage space.

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

a) **The approved centre did not have access to a programme of routine maintenance, 22(1).**
b) **There was lack of storage space for residents' belongings, 22 (2).**

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident; and, a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

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: 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 and, 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. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

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 operating procedures relating to health and safety, which was last reviewed in January 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 on the use of CCTV, which was last reviewed in March 2019 and included the purpose and function of using CCTV for observing residents.

There were clear signs in prominent positions where CCTV cameras or other monitoring systems 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 or other monitoring systems had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras or other monitoring systems used to observe a resident were incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and 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 began 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 written operational policy and procedures in relation to staffing, which was last reviewed in March 2019. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

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. 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.

As the impact of COVID-19 affected the ability of the approved centre to fulfil its regulatory requirements in relation to staff training on this inspection, Section 26(4) and 26(5) was deferred until 2021.

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

Staff in Approved Centre			
	Staff Grade	**Day**	**Night**
Grangemore Unit	Assistant Director of Nursing	0.5	0
	Clinical Nurse Manager 2	1	1
	Clinical Nurse Manager 1	1	0
	Registered Psychiatric Nurse	5	3
	Health Care Assistant	1	0
	Occupation Therapist	0.4	0
	Social Worker	0.25	0
	Psychologist	0	0

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Consultant Psychiatrist	2	1
Non Consultant Hospital Doctor	2	1
Psychologist	Sessional	0

Whole time equivalent (WTE)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

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 maintenance of records, which was last reviewed in May 2018.

Resident records were secure, up-to-date, and in good order, and were physically stored together. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating LOW

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

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

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up-to-date. It did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, the admission date of one resident was inaccurate and, in addition, one resident was listed as having been discharged when they had in fact been transferred and were due to return to the approved centre. The diagnosis on discharge of one resident was not documented on the register.

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

a) **The register did not include all information specified in Schedule 1 of the regulations, as the diagnosis on discharge was not documented for one resident from the approved centre, 28(2).**
b) **The admission date specified on the register was not accurate in all cases, 28(1).**

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 requiring a three-yearly review were reviewed appropriately.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process, including remote access to the tribunals. Staff attended Mental Health Tribunals and provided assistance, as necessary, when the patient required assistance to attend or participate in the process.

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 May 2018 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 complaints procedure to residents and their representatives at admission or soon thereafter. This information was available within the resident information booklet and noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s ICP. The complainant was informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them; this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management, which was last reviewed in July 2019 and addressed all requirements.

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 prior to and during transfer, discharge, physical restraint, mechanical restraint, and in conjunction with medication requirements or administration. This also included resident admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults 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. 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 in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency 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 with three conditions to registration attached. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

COMPLIANT

Mental Health Act 2001
Bodily restraint and seclusion
Section 69
(1) "A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.
(2) The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.
(3) A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.
(4) In this section "patient" includes –
(a) a child in respect of whom an order under section 25 is in force, and
(b) a voluntary patient.

INSPECTION FINDINGS

Evidence of Implementation: One episode of mechanical restraint was examined on inspection. There was evidence that a lap-belt, for enduring risk of harm to self or others, was only used to address an identified clinical need. There was documentary evidence to indicate that mechanical restraint was only used when less restrictive alternatives were deemed unsuitable. There was a record of the less restrictive alternatives implemented without success. Mechanical restraint was ordered by a registered medical practitioner, under supervision of consultant psychiatrist or by the duty consultant psychiatrist acting on their behalf. The clinical file contained a record of the type of mechanical restraint, the situation in which mechanical restraint was being applied, and the duration of the order. The clinical file also indicated the duration of the mechanical restraint order and a review date.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

56.- In this Part "consent", in relation to a patient, means consent obtained freely without threat or inducements, where –

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

57. - (1) The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition, or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is incapable of giving such consent.

(2) This section shall not apply to the treatment specified in section 58, 59 or 60.

60. – Where medicine has been administered to a patient for the purpose of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either-

a) the patient gives his or her consent in writing to the continued administration of that medicine, or

b) where the patient is unable to give such consent –

i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent, or as the case may be, approval and authorisation shall be valid for a period of three months and thereafter for periods of 3 months, if in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

61. – Where medicine has been administered to a child in respect of whom an order under section 25 is in force for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration shall not be continued unless either –

a) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the child, and

b) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist, following referral of the matter to him or her by the first-mentioned psychiatrist,

And the consent or, as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

INSPECTION FINDINGS

The clinical file of a patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment and that the patient was unable to consent.

A Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed and documented: the names of the medications prescribed; a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications; and, details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the patient in relation to the discussion and their decision-making. The form also included approval by a consultant psychiatrist and authorisation by a second consultant psychiatrist.

The approved centre was compliant with Part 4 of the Mental Health Act 2001: Consent to Treatment.

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: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated June 2020. It addressed the following:

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: The clinical file relating to an episode of physical restraint was inspected. Physical restraint had been used in rare, exceptional circumstances and in the best interest of the resident. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident had been completed no later than three hours after the start of the episode of restraint. The clinical practice form had been completed by the person who had initiated and ordered the use of the physical restraint and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episode. Completed clinical practice forms had been placed in the resident's clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in October 2018, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2018, included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. Admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. This assessment included presenting problem, past psychiatric history, family and medical history, current and historic medication and current mental state. A risk assessment and full physical examination had been completed. A key working system was in place. With consent, the resident's family member was involved in the admission process.

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

Discharge: The clinical file of a resident who had been discharged evidenced a discharge plan with an estimated date of discharge. The discharge had been coordinated by a key worker and the discharge meeting had been attended by the resident and relevant members of the multi-disciplinary team. A preliminary discharge summary had been sent to the relevant agencies and a comprehensive discharge

summary had been sent within 14 days that detailed diagnosis, prognosis and medication. As applicable, a follow up appointment had been arranged for the resident.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001425		**Two ICPs were not reviewed by the full MDT. One ICP was not reviewed by the MDT within the required 6 month timeframe.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The ICPs identified by the MHC during inspection were retrospectively signed by those present at the meeting reflecting that the ICP was reviewed by the full MDT. A review of the ICP schedule was undertaken on identification of one ICP was not reviewed by the MDT within the required 6 month timeframe by the MHC during inspection.	The schedule for 2020 was checked and amended to avoid any further ICP falling outside the required 6 month time frame.	Achievable and Realistic: Complete.	24/07/2020	CNM/Key Worker/ Rehab CNS for ICP development and RCP.
Preventative Action	A schedule of ICPs is drawn up for 2021. A governance board has been posted in the CNM/CP office in Grangemore to reflect ICP scheduling.	ICP Audits Quarterly in Grangemore	Achievable and Realistic :Complete	01/12/2020	CNM/ Key Worker/ Rehab CNS for ICP development and RCP

Regulation 22: Premises					
Reason ID : 10001423		The approved centre did not have access to a programme of routine maintenance, 22(1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The routine maintenance log in Grangemore has been reviewed, a risk assessment of outstanding issues has been completed. Catogery 1,2 ,and 3 risks have been identified.	The QPSC will risk assess monthly and put clear actions in place to achieve desired outcomes for outstanding maintenance issues. Category 1 for completion December 2020, Category 2 for completion January 2021, and Category 3 for completion Feburary 2021.	The oversight provided by QPSC will ensure completion and allow for MHS managment to liaise direct with Maintenance Manager	28/02/2021	QPSC have completed risk assessment, the CNM has resubmitted Catrgory 2 ,3, maintenance issues through Technical services.
Preventative Action	All maintenance will be logged through Technical Services, the job number will be recorded on the maintenance log. The CNM will make reasonable efforts to include new monthly meetings with Technical Services Manager to ensure the tasks are completed,. where on initall assessment	The QPSC will risk assess and put clear actions in place to achieve desired outcomes for outstanding maintenance issues. Maintenance will be esclated to QSEC as necessary for further service managemnt inputs.	It is realistic to clear the back log of Category 2 and 3 maintenance issues by 28/02/2021. There are no Category 1 maintenance issues on the list. Monthly review of maintenance log by QPSC will avoid further backlogs into the future,	28/02/2021	The CNM will highlight outstanding maintenance issues through Technical Service dept and esclate to ADON where necessary. ADON will esclate to Service Managment for action. QPSC will review Grangemore maintenance log monthly and risk assess.acordingly.

	there is consideration re high risk (eg) Category 1 this item will be immediately esclated to the ADON for onward to Service Managment as necessary. The routine maintenance log will be reviewed monthly at the Grangemore QPSC				
Reason ID : 10001424		**There was lack of storage space for residents' belongings, 22 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Lack of storage space for residents personal belongings was added to the annual maintenance plan 01/07/2020. It was agreed that an assessment of space for residents personal belongings would be assessed by CNM and Keyworker following return to Grangemore from Grange, where all residents would be returning to single occupancy bedroom.	There is a scheduled monthly compliance walk round in Grangemore in attendance CD, CNM and Compliance Support ADON. Storage for residents is monitored here.	Achievable and realistic alongside Nursing support, psychology supports will continue to be offered through the ICP process (one resident in particular has a large amount of personal belongings and has developed attachments to same which makes keeping her space and belongings tidy an ongoing challenge for the service).	28/02/2021	Keyworkers have completed an assessment of storage space with each resident. This information has been fedback to the CNM. The CNM has esclated to QPSC where funding has been approved for identifiable residents who require additional storage solutions.

Preventative Action	At the scheduled monthly compliance walk rounds in attendance CD, CNM and Compliance Support ADON. Storage for residents is monitored here.	Keyworkers will hilghlight any issues with residents access to storage space as it arises.	Achievable and realistic by the faciliation of single dwelling bedrooms for residents in Grangemore and provision of additioanal storage.	28/02/2021	Compliance support ADON cordinates the walk round monthly and feeds back through QPSC.

Regulation 28:Register of Residents					
Reason ID : 10001427		**The register did not include all information specified in Schedule 1 of the regulations, as the diagnosis on discharge was not documented for one resident from the approved centre, 28(2). The admission date specified on the register was not accurate in all cases, 28(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Register of Residents was amended to reflect the Commissions findings	The Registrer of residents was checked by the Compliance support ADON and found to be complete for all information specified in Schedule 1 of the regulations 24/07/2020	Achievable and Realistic: Complete	24/07/2020	CNM and Administration staff
Preventative Action	Daily recording of the Register of Residents for Grangemore since 01/12/2020	The Register is available on the P-Drive for revelent staff to view. The Register will be reviewed and audited at the monthly Grangemore Compliance Meeting and issues esclated to QPSC as necessary.	Achievable and Realistic complete	01/12/2020	The CNM will provide daily figures to the Administrator of the register. A register label has been developed and is now recorded in the daily diary for action.

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.

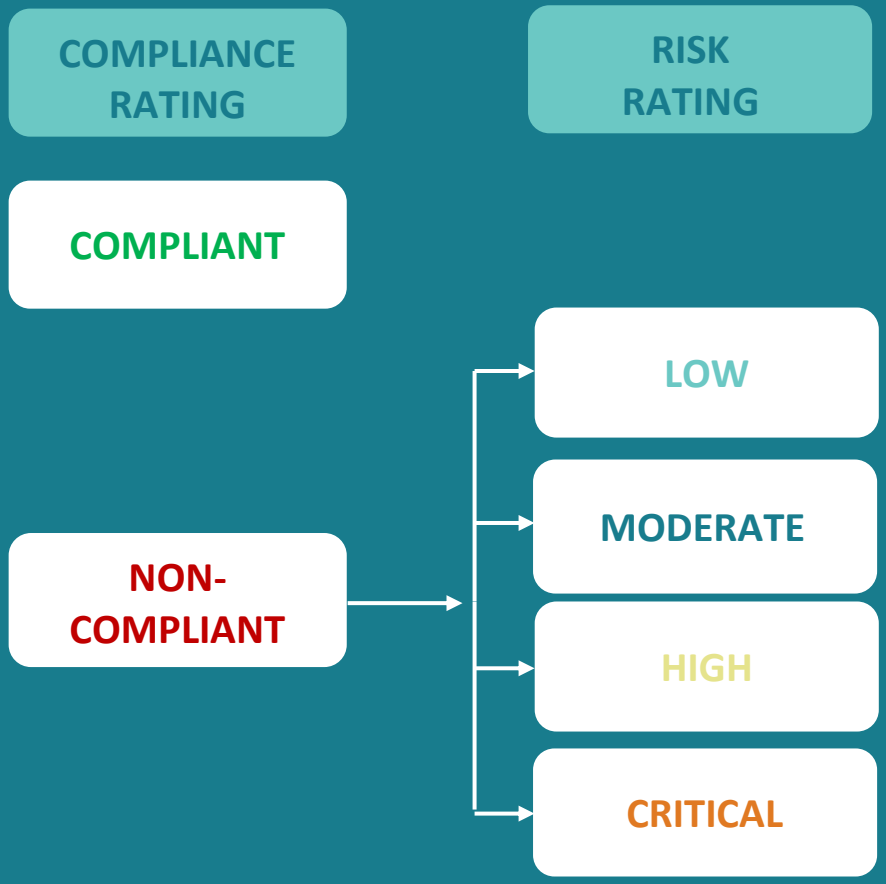
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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