MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

St. Edmundsbury Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

ST. EDMUNDSBURY HOSPITAL

St. Edmundsbury Hospital, Lucan, Co Dublin

Date of Publication:
Thursday 11 March 2021

ID Number: AC0127

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Most Recent Registration Date:
25 May 2019

Conditions Attached:
None

Registered Proprietor:
Mr Paul Gilligan, Chief Executive Officer

Registered Proprietor Nominee:
n/a

Inspection Team:
Noeleen Byrne, Lead Inspector
Sarah Jones

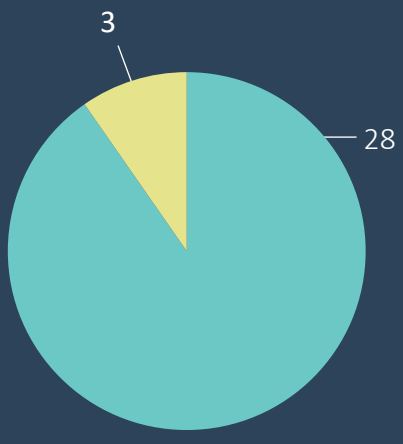
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
1 – 4 September 2020
23 October 2020

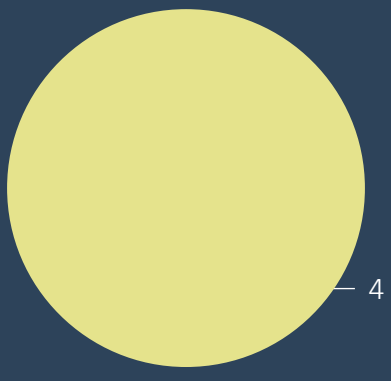
Previous Inspection Date:
11 – 14 June 2019

Inspection Type:
Announced Annual Inspection

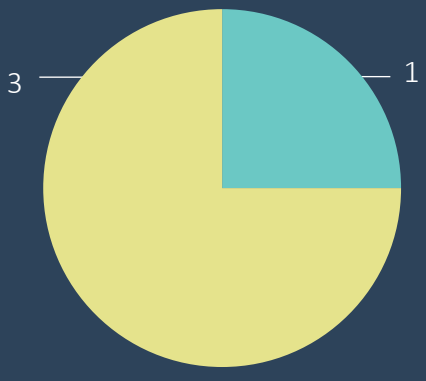
2020 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



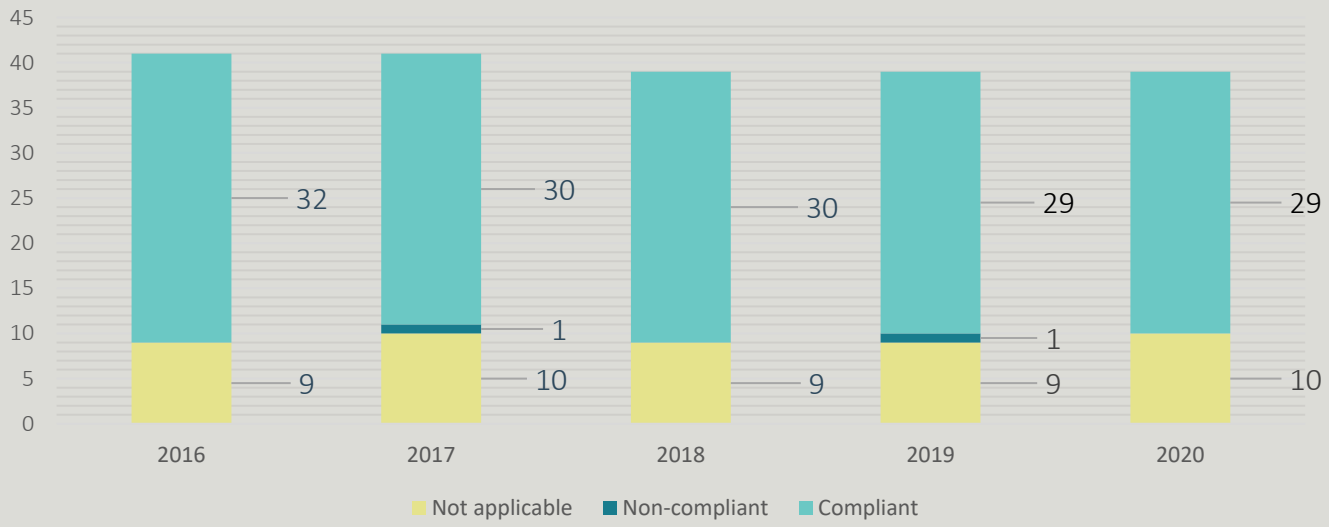
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2016 – 2020

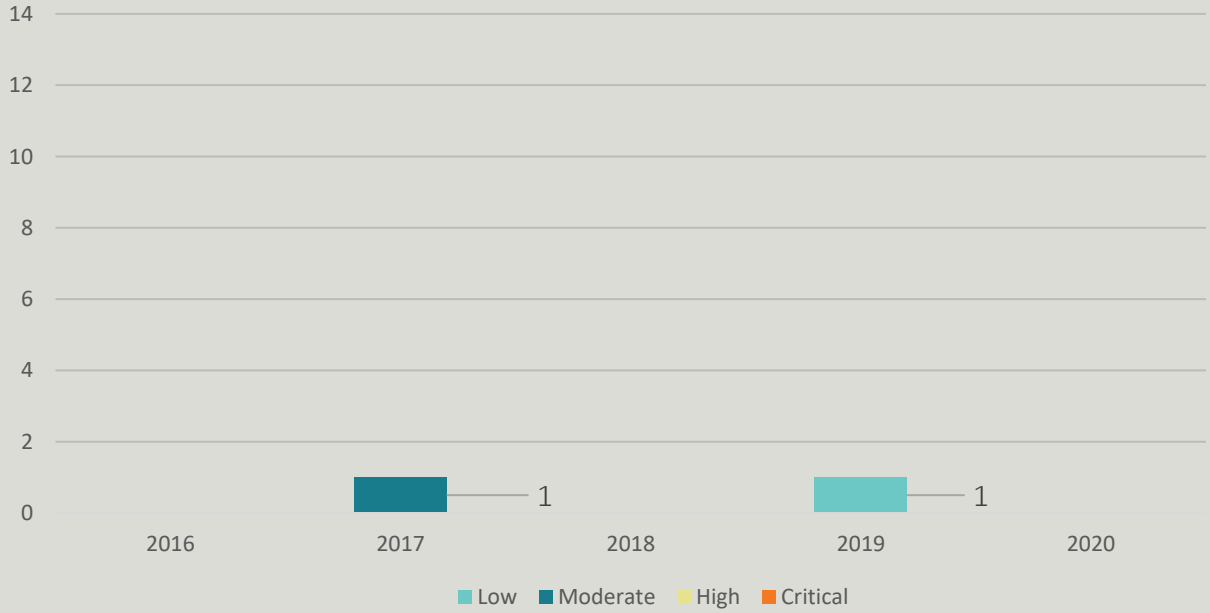
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

St. Edmundsbury Hospital was located within extensive grounds in Lucan, Co. Dublin. It was part of St. Patrick's Mental Health Services and shared management structures within the larger service. The approved centre consisted of a refurbished 19th century Georgian house as well as modern purpose-built resident accommodation. The approved centre provided treatment for voluntary residents. Residents requiring higher levels of observation or different clinical treatments to those offered in St. Edmundsbury, would be transferred to St. Patrick's University Hospital.

As part of the St. Patrick's Mental Health Services Pandemic Plan, St. Edmundsbury Hospital was closed to admissions since March 2020 and instead was set up to cohort residents from St. Patrick's Hospital, with suspected or confirmed cases of COVID-19. St. Edmundsbury Hospital continued to manage their mental health needs. The multi-disciplinary team that admitted the resident to St. Patrick's continued to provide their care and treatment during their stay in St. Edmundsbury.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	100%	97%	100%	97%	100%
Regulations Rated Excellent	23	19	24	23	N/A

Conditions to registration

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

Safety in the approved centre

- There were suitable facilities for the refrigeration, storage, preparation, cooking, and serving of food. Kitchen areas were clean.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- All staff had been trained in Basic Life support, fire safety, prevention and management of violence and aggression and the Mental Health Act 2001.
- Medication was ordered, prescribed, stored and administered in a safe manner.
- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre.
- Ligature points were minimised to the lowest practicable level, based on risk assessment.

Appropriate care and treatment of residents

- Each resident had a multi-disciplinary care plan which was developed and reviewed with the resident.
- Due to pandemic events and infection control measures, there were no group activities in the approved centre at the time of the inspection. Instead, residents were provided with therapeutic programmes through video calls, on a one-to-one basis.
- At the time of the inspection, no residents had been in the approved centre for more than six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

Respect for residents' privacy, dignity and autonomy

- The approved centre comprised three double bedrooms and forty-six single rooms; each bedroom had its own en suite.
- 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.
- The approved centre was kept in a good state of repair externally and internally.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Residents could make private phone calls.
- Noticeboards did not display resident names or other identifiable information.

Responsiveness to residents' needs

- There was a choice of food at mealtimes.

- The approved centre provided access to a range of recreational activities appropriate to the resident group profile. As residents were in isolation at the time of inspection due to pandemic events, recreational activities were provided in an activity pack to residents in their rooms and through electronic tablets.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.

Governance of the approved centre

- St. Edmundsbury Hospital was part of St. Patrick's Mental Health Services. The approved centre was formed in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a board of governors consisting of both ex officio and appointed members.
- The senior management team (SMT) was responsible to the board for the direct operation of the approved centre. Governance processes made provision for the involvement of service users and their representatives where appropriate.
- The SMT process evidenced a robust governance process with outcomes and actions documented. In addition to the SMT process, the governance structure included a clinical governance committee and a risk and safety committee.
- A number of subordinate committees focussed on specific aspects of service governance. Policies were reviewed and updated as required.
- Each clinical discipline had its own governance structure, with clear line management processes in place. There was an active clinical audit process documented.
- Emphasis was placed on facilitating and ensuring that staff training requirements were met notwithstanding the difficulties posed by the present COVID-19 risk situation.
- All heads of discipline had received training on clinical risk management and each department maintained a risk register.
- Key performance indicators assisted the approved centre to measure how well they were doing in relation to achieving set goals. Clear systems were in place to support quality improvement.
- With the onset of COVID-19 the service had developed a dedicated Pandemic Plan for the operational management of associated risks. This included the conversion of St. Edmundsbury Hospital to a COVID-19 isolation facility, an increase in home care packages and therapeutic leave where feasible, and the re-organisation of therapeutic provision in the context of social distancing needs.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A resident Information Café, a non-clinical information forum, was set up to reduce pre-discharge anxiety. COVID-19 restrictions had placed limitation on the functioning of this information platform, and it was functioning on a remote access basis.

2. A Patient Portal to facilitate and empower the involvement of residents in their clinical care had been developed.

3. An electronic falls risk care plan library was implemented. This pre-populated care plan generates actions from best practice. Falls Champions have been introduced to increase resident safety by reducing the risk of falls.

4. A horticulture therapy programme has been initiated.

5. Technology Mediated Interventions (TMI) have been developed to facilitate the provision of care programmes in the context of COVID-19 limitations as part of Extended Therapeutic Leave (ETL) and Home Care Packages (HCP).

6. An Infection Control Isolation Record has been developed to assist in the management of COVID-19 related issues within the approved centre.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Edmundsbury Hospital was located within large grounds in Lucan, Co. Dublin. St. Edmundsbury was part of St. Patrick's Mental Health Services and shared management structures within the larger service. The approved centre consisted of a refurbished 19th century Georgian house (including sitting rooms, recreational rooms, therapy rooms and kitchen-dining room facilities) as well as modern purpose-built resident accommodation. The approved centre comprised three double bedrooms and forty-six single rooms; each bedroom had its own en suite. The approved centre provided treatment for voluntary residents only and had a service agreement that residents requiring higher levels of observation or different clinical treatments to those offered in St. Edmundsbury, would be transferred to St. Patrick's University Hospital.

As part of the St. Patrick's Mental Health Services Pandemic Plan, St. Edmundsbury Hospital was closed to admissions since March 2020 and instead was set up to cohort residents from St. Patrick's Hospital, who were isolating, as they were suspected as having COVID-19. At the time of the inspection St. Edmundsbury Hospital continued to manage the mental health needs of those with suspected or confirmed cases of COVID-19 In line with Public Health guidance. Residents were transferred back to St. Patricks when they had clear test results or completed their isolation. On the first day of the inspection eight residents were suspected of having COVID-19 and the walkabout of the premises was postponed.

Allied Health Professionals delivered services to residents by technology mediated interventions (TMI). The multidisciplinary team that admitted the resident to St. Patrick's continued to provide their care and treatment when they resided in St. Edmundsbury.

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

Resident Profile	
Number of registered beds	***52***
Total number of residents	**8**
Number on residents on extended therapeutic leave	2
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

St. Edmundsbury Hospital was part of St. Patrick's Mental Health Services. The approved centre was formed in 1746 and was governed by charter. The charter outlined the governance of the approved centre through a board of governors consisting of both ex officio and appointed members. The senior management team were responsible to the board for the direct operation of the approved centre. A detailed clinical and corporate governance structure was in place. This provided clarity in relation to areas of responsibility within the approved centre. Governance processes made provision for the involvement of service users and their representatives where appropriate.

The senior management team (SMT) met fortnightly. These meetings were attended by representatives of various disciplines and interests within the approved centre. The minutes from these meetings were provided to the inspection team and outlined an active governance process involving senior management and, as appropriate, members of various disciplines within the approved centre. Issues such as service development, health and safety, facilities, and risk management, including review of the overall risk register were discussed at these meetings. In more recent times the minutes emphasised various issues relating to the management of COVID-19 risk within the approved centre. The SMT process evidenced a robust governance process with outcomes and actions documented.

In addition to the SMT process the governance structure included a clinical governance committee which was held weekly and a risk and safety committee which was held monthly. A number of subordinate committees (a resuscitation committee which was held every two months; an infection control committee which was held monthly; a research ethics committee which was held quarterly; a falls committee which was held every two months; and a drugs and therapeutics committee which was held every two months) focussed on specific aspects of service governance. Policies were reviewed and updated as required.

An organisational chart was available which identified the leadership and management structure and lines of authority and accountability within the approved centre. Each clinical discipline had its own governance structure, with clear line management processes in place. There was an active clinical audit process documented.

The inspection team met with heads of clinical disciplines during the inspection process. This provided a clear overview of the governance issues and current risks within their respective departments. Each head of discipline was based in the approved centre. Each head of discipline met with staff on a regular basis and there were clear processes for escalating issues of concern to heads of discipline and to the senior management team. The medical, nursing and psychology departments had formal staff performance appraisals in place. The occupational therapy and social work department did not have staff performance appraisals, but relevant heads of discipline stated that this process was informally facilitated or addressed through supervision. All disciplines reported that their staffing numbers were currently in accordance with agreed numbers. Emphasis was placed on facilitating and ensuring that staff training requirements were met notwithstanding the difficulties posed by the present COVID-19 risk situation.

All heads of discipline had received training on clinical risk management and each department maintained a risk register. All heads of discipline identified strategic aims for their teams and discussed potential

operational risks with their departments. Key performance indicators assisted the approved centre to measure how well they were doing in relation to achieving set goals. Clear systems were in place to support quality improvement.

With the onset of COVID-19 and the limitations and restrictions inherent in safely managing such a scenario the service had developed a dedicated Pandemic Plan for the operational management of associated risks. This plan, including its operational implications, was reviewed on a regular basis by the SMT. Overall governance in the context of the pandemic was focused on operational initiatives to maintain a safe and effective service while observing public health requirements. These initiatives included the conversion of St. Edmundsbury Hospital to a COVID-19 isolation facility, an increase in home care packages and therapeutic leave where feasible, and the re-organisation of therapeutic provision in the context of social distancing needs.

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

There were no areas of non-compliance on this inspection.

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As no resident in the approved centre had been physically restrained since the last inspection, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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. As the residents had been transferred from St Patrick's Hospital and any completed questionnaires were returned there.
- Residents could engage with the inspection team over the telephone on any matter relating to their care whilst in the approved centre. No residents engaged with the inspection team by telephone.

6.0 Feedback Meeting

A shared feedback meeting covering the three approved centres within the St Patrick's Mental Health Service (SPMHS) was facilitated prior to the conclusion of the inspection. This meeting was held remotely by Microsoft Teams video conference. It was attended by the inspection team and the following representatives of the service and approved centres:

- Registered Proprietor
- Clinical Director
- Director of Nursing
- Director of Services
- Programme Manager for Clinical Governance
- Consultant Psychiatrist x 2
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Principal Psychologist
- Principal Social Worker
- Occupational Therapy Manager (designate)
- Mental Health Act Administrator

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. No specific queries were raised.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. 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 took 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 written operational policies and procedures relating to residents' personal property and possessions, which were last reviewed in September 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.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a range of recreational activities appropriate to the resident group profile. As residents were in isolation at the time of inspection due to pandemic events, recreational activities were provided in an activity pack to residents in their rooms and through electronic tablets.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in August 2020. There were no visits permitted to the approved centre due to pandemic events and infection controls measures.

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 written operational policies and procedures relating to communication: the policy on the opening of service users mail was last reviewed in January 2019; the policy on accessing interpreting and translation services was last reviewed in June 2020, and; the policy on service user access to communication facilities was last reviewed in March 2020. Residents had access to mail, the internet, and phones unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication would result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches. The policy was last reviewed in March 2020 and 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 in the approved centre since the last inspection, and as a result the approved centre was assessed for compliance on the policy aspect of the legislation only

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures on care of the dying, which were last reviewed in August 2018 and January 2019. The clinical file of a resident that had died suddenly in the approved centre was examined on inspection. The sudden death was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident's representatives, family, next of kin, and friends. 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

COMPLIANT

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were an electronic composite set of documents and they included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinic 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 appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICP was reviewed by the MDT weekly, in consultation with the resident. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Therapeutic programmes ran on weekdays and the weekend. Due to pandemic events and infection control measures, there were no group activities in the approved centre at the time of the inspection. Instead, residents were provided with recreational activities and therapeutic programmes through video calls, on a one-to-one basis.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures relating to the transfer of residents. The policy was last reviewed in May 2019. The clinical file of one resident who had undergone an emergency transfer was examined. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer to a named individual, which included a resident transfer form and letter of referral that contained a list of current medications. Where necessary, 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 January 2020. It also had a policy on checking the emergency trolley and equipment, which was last reviewed in May 2019. The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED), both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

At the time of the inspection, no residents had been in the approved centre for more than six months. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes according to age and gender, including Breast Check, retina check, cervical screening, and bowel screening.

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 written operational policies and procedures on the provision of information to residents, including: service user orientation to care setting policy, which was last reviewed in March 2019; service user and family education journey policy, which was last reviewed in March 2020, and; service user access to communication facilities, which was last reviewed in March 2020.

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 arrangements, 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

The general demeanour of staff was respectful and staff were discreet 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. 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

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents had access to personal space and 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.

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. The approved centre provided assisted devices and equipment to address resident needs, as well as suitable furnishings to support resident independence and comfort.

Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were all minimised in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment. The approved centre was kept in a good state of repair externally and internally. There was a 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 guarded. Current national infection control guidelines were followed.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had several written policies and procedures on the ordering, prescribing, storing and administration of medicines, all of which were in date. Together, the policies included:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. 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 electronic 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, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator.

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. The policy was last reviewed in March 2019.

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 multitude of written operational policies and procedures in relation to staffing, all if which were in date, including the general staffing policy, which was last reviewed in May 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.

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

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

Staff in Approved Centre		
Staff Grade	**Day**	**Night**
Director of Nursing	1 WTE	
Clinical Nurse Manager 2	1	
Registered Psychiatric Nurse	5	3

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Consultant Psychiatrist		
Occupation Therapist		

Social Worker
Psychologist

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 several written operational policies and procedures in relation to the maintenance of records, all of which were in date. Residents' electronic records were secure, up-to-date, and in good order. 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 were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures requiring a three-yearly review were reviewed appropriately.

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 2019 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. 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 individual care plan. Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them: this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management as well as a Safety Statement. The policy and Safety Statement were last reviewed and dated May 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 in conjunction with medication requirements or administration, resident transfer and discharge, as well as at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of 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. Servicing of fire extinguishers was overdue as contractors did not attend

premises due to residents' cohorting with suspected Covid-19. This was rectified as soon as all residents received negative Covid-19 test result and contractors serviced all equipment. Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission 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 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. 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)

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.3 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

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

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.

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 November 2019, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in May 2019, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2019, 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, current mental state, and social and housing circumstances. A risk assessment and full physical examination had been completed. A key working system was in place. With the resident's 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 was examined. The discharge plan included the estimated date of discharge, a follow-up plan, and documented communication with the relevant general practitioner, primary care team, or community mental health team (CMHT). The discharge meeting was attended by the resident, their key worker, relevant members of the multi-disciplinary team (MDT), and their family, carer, or advocate.

The discharge assessment addressed the resident's psychiatric and psychological needs, informational needs a current mental state examination, and a comprehensive risk assessment and risk management plan. The discharge was coordinated by a key worker and a comprehensive discharge summary was sent on the day of discharge to the relevant general practitioner, primary care team, or CMHT that detailed the resident's diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, the names and contact details of key people for follow-up, and risk issues. A follow up appointment was arranged for the resident.

The approved centre was compliant with this code of practice.

Appendix 1 Background to the inspection process

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

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

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

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

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

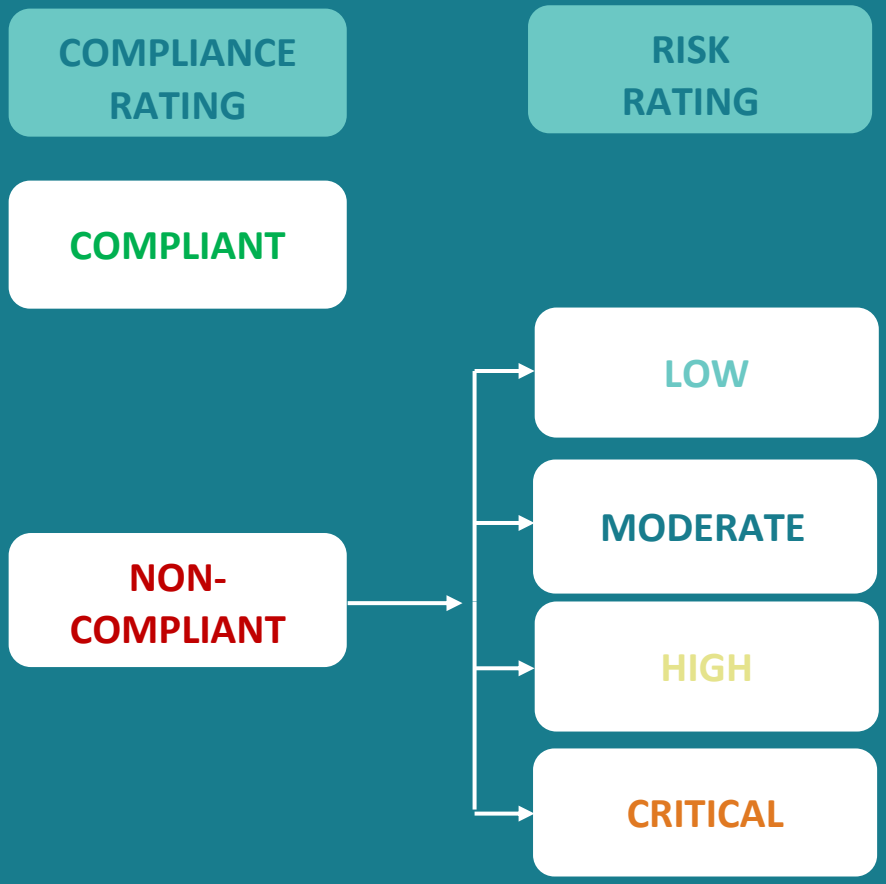
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, 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.