Department of Psychiatry, University Hospital Waterford

Annual Inspection Report 2023

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coimisiún meabhair - shláinte
mental health commission

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, UNIVERSITY HOSPITAL WATERFORD

Dunmore Road, Waterford, X91ER8E

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2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Conditions Attached:
None

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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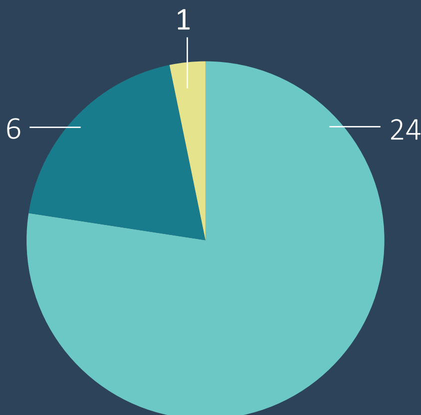
Inspection Date:
19 – 22 September 2023

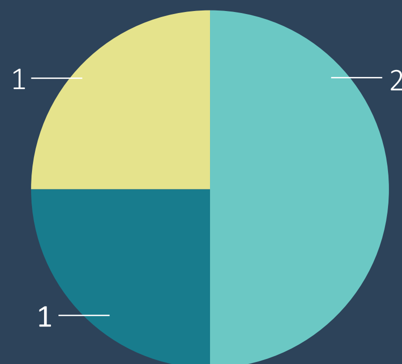
Previous Inspection date:
5 – 8 July 2022

Inspection Type:
Announced Annual Inspection

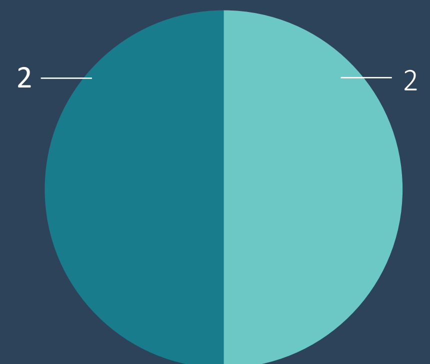
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



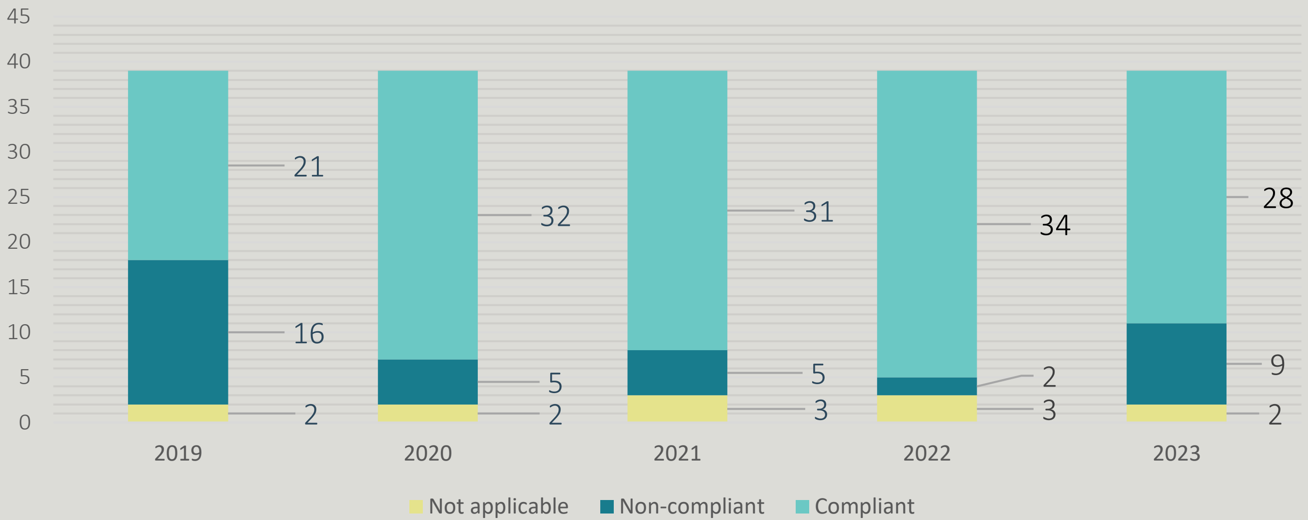
CODES OF PRACTICE

Compliant | Non-Compliant | Not applicable

RATINGS SUMMARY 2019 – 2023

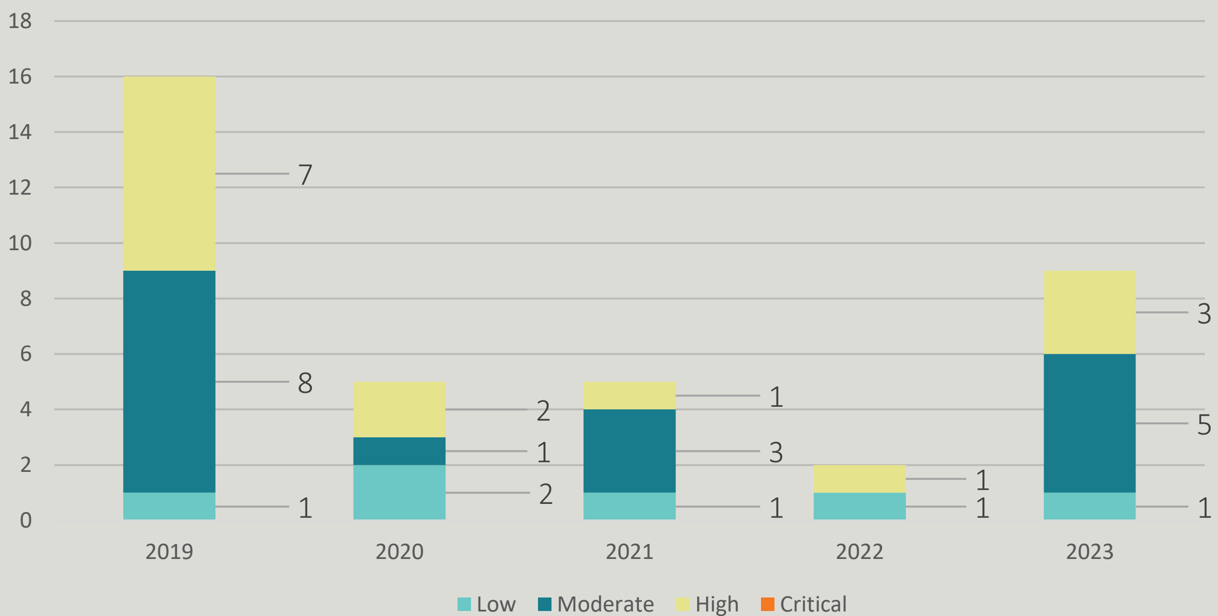
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services | Professor James V Lucey

In brief

The approved centre was located on the lower ground floor of University Hospital Waterford. It had 44 beds in two areas: an acute unit with 14 beds (Brandon Unit) and a sub-acute unit with 30 beds (Comeragh Unit). Fourteen teams had admitting rights and residents from their respective team remained under the care of the community teams on an in-reach basis. The approved centre's registered proprietor was the Health Service Executive (HSE) and it was registered to provided the following services: Acute Adult Mental Health Care Psychiatry of Later Life, Mental Health Rehabilitation, and Mental Health Care for People with Intellectual Disability.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	57%	86%	86%	94%	76%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Regulatory compliance meeting	*05/07/2023*	*To discuss numerous Serious Reportable Event (SRE) notifications submitted to the MHC.*	*The approved centre provided a series of assurances with regard to the SREs and the MHC continues to follow up with the approved centre.*

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

The approved centre demonstrated that they provided safe care in the following areas:

- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** All staff were trained in fire safety, safeguarding, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Ligature anchor points:*** Ligature points were minimised to the lowest level, based on individual risk assessment.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Infection control*****:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Maintenance:*** There was not an adequate programme of routine maintenance. The saddle board at the door into communal space from the garden in Comeragh Ward was a trip hazard, the floor in one toilet was stained and damaged from leaks and the floor in one shower was stained and damaged, and two sets of fire doors did not close properly.
- ***Cleanliness***: The approved centre was not clean in the garden areas, with cigarette butts , dirty paving and ingrained dirt in some doorways.
- ***Access to essential information:*** Records were not all maintained in good order, in clinical files inspected there was a loose confidential lettered document and writing errors that were not initialled.

Appropriate care and treatment of residents

The approved centre demonstrated that they provided appropriate care and treatment in the following areas:

- ***Physical assessment****:* Each resident had a physical examination on admission and all residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.
- ***Individual care plans:*** Each resident had an individual care plan and there was evidence of significant engagement with residents in respect of their individual care plan.
- ***Multi-disciplinary team working:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, a psychologist, community occupational therapist, a private dietitian via the Webex video call, and social work (agency staff). There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan.

- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Individual Care Plans:*** In two individual care plans, the resident's care and treatment was not updated to reflect the resident's changing needs, condition and circumstances.
- ***General health: Access to other medical services:*** Adequate arrangements were not in place for residents to access all general health services and for their referral to all other health services as required. While residents in the approved centre could access medical and surgical specialities as required such as radiology, palliative care, physiotherapy and dietetics. residents did not have adequate arrangements to access speech and language therapy if required.

Respect for residents' privacy, dignity and autonomy

The approved centre demonstrated that they respected people's privacy, dignity and autonomy in the following areas:

- ***Sleeping accommodation:*** Accommodation within the approved centre was a mixture of single and two, four and six-bedded shared bedrooms. Bathroom facilities were a combination of en suite and shared bathrooms.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** Residents' dignity and privacy were respected.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Mechanical restraint was not used in the approved centre. Physical Restraint and separately seclusion was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The approved centre was not compliant with the Code of Practice on Physical Restraint for two different reasons in a sample of three physical restraint episodes inspected. In addition, the approved centre was not compliant with the Rule on Seclusion for two different reasons in a sample of three seclusion episodes inspected.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

Responsiveness to residents' needs

The approved centre demonstrated that they were responsive to people's needs in the following areas:

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms and rooms were ventilated.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise different religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities were accessible on weekdays and during the weekend.
- ***Residents' feedback:*** The inspection team spoke with seven people residing within the service. Overall verbal feedback was very good and residents were happy with the food, staff interaction and the activities and programmes during the week. Four questionnaires were received by the inspection team and feedback was mixed. *(Please refer to section 5.0 of the report for detailed-service user feedback including verbal, questionnaire and advocacy report feedback).*

However:

- **Information:** Not all minor complaints were recorded by the approved centre.
- **However: Rights-based care: Child Admission:** The clinical file of one child who had been admitted to the approved centre was inspected. While provisions were in place to ensure the safety of the child, to respond to a child's needs as young person in an adult setting and to ensure the right of the child to have their views heard, age-appropriate facilities were not provided as the child was admitted to an adult approved centre.
- **Environment:** Furnishings were not suitable and did not support residents independence and comfort. The covering on an armchair was torn in Brandon Ward. The Comeragh Ward garden only three benches however there was inadequate seating in the Brandon Ward garden which consisted of a planter with inbuilt seating and one bench.

Governance, Leadership and Accountability

The approved centre had the following governance structures and processes in place:

- ***Structure in place:*** The Department of Psychiatry (DOP) was part of South East Community Healthcare, formerly known as Community Healthcare Organisation 5 and was governed under the Waterford/Wexford Mental Health Services.
- ***Leadership:*** There were three core monthly meetings, the Waterford/Wexford Executive Management Team Meeting (EMT), the Quality Patient Safety Committee (QPSC) and the Quality and Safety Executive Committee meeting (QSEC). All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development.

Systems for performance appraisal and clear supervision processes for all staff were in place within the approved centre.

- ***Restrictive practices reduction:*** The approved centre had a reduction of restrictive practices strategy.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed, there was a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. Six quality initiatives had been implemented by the approved centre since the last inspection. *(Please refer to Section 2.0 of the report for details).*
- ***Staff training:*** All staff had received mandatory training.
- ***Residents' involvement in their own care:*** Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. As far as possible residents were involved in their own care. Within the approved centre, weekly resident community meetings, suggestion boxes, service user surveys and engagement with the complaints process were used to support service improvement.
- ***Advocacy services:*** A designated advocate from the Peer Advocacy in Mental Health organisation contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 86% over the last 4 years. The compliance rate dropped by 18% since last year (2022). The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risk:*** Not all health and safety risks were identified, as two sets of fire doors were found not to function properly when closing, and a fire exit couldn't to be unlocked when inspected, which comprised fire safety. This was not documented on the approved centre's risk register.
- ***Restrictive practices reduction:*** The approved centre was not compliant with the Code of Practice on Physical Restraint and the Rule on Seclusion.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A “Wake and Shake” group was introduced by the activity nursing department to promote stretching and social interaction.

2. An “Introduction to Yoga” group commenced in October 2022 with a qualified yoga instructor to promote well being.

3. A “Better with Age” group facilitated by the nursing department occurred twice weekly, specifically catered to Psychiatry of Later life residents. The group included age appropriate activities such as chair exercises, reminiscence therapy and music.

4. The nursing department established and facilitated a “My Care Plan, My Recovery, My Discharge” group to educate and support residents to engage with their care and treatment.

5. A “Service User Satisfaction Scale” was implemented to measure satisfaction feedback from residents. This was co-produced by the nursing department, the Recovery College South East, Peer Advocacy in Mental Health and service users.

6. A Wellness Book was translated into Polish for adults and separately, a child admission wellness book (if required) which included education and helpful tools such as exercise and mindfulness.

7. A reflective practice group for nursing staff was facilitated by psychology staff to support learning and development.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the lower ground floor of University Hospital Waterford. It consisted 44 beds in two areas: an acute unit with 14 beds (Brandon Unit) and a sub-acute unit with 30 beds (Comeragh Unit).

Accommodation within the approved centre was a mixture of single and two, four and six-bedded shared bedrooms. Bathroom facilities were a combination of en suite and shared bathrooms. Residents had access to internal communal areas. The Comeragh unit had access to a dining and sitting room facility with a cosy corner consisting of four armchairs and shelving containing DVDs and books, jigsaw puzzles and games. This led to a canopy-covered garden. Recreation and therapy rooms located in the Comeragh unit were accessible Monday to Friday and could be used on the weekend depending on staff availability. The Brandon Unit had access to a sitting room, dining room, therapy room and an internal garden. A family room was utilised for visits and all residents had access to a dedicated room for tribunals which was located behind the Brandon unit.

14 teams had admitting rights and residents from their respective team, remained under the care of the community teams on an in-reach basis. There were nine general adult teams, two rehabilitation teams, and three psychiatry of later life teams. The approved centre also accepts referrals from the Mental Health Intellectual Disability Team (MHID).

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

Resident Profile	
Number of registered beds	***44***
Total number of residents	**43**
Number of detained patients	13
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	11
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The Department of Psychiatry (DOP) was part of South East Community Healthcare, formerly known as Community Healthcare Organisation 5 and was governed under the Waterford/Wexford Mental Health Services. There were two core monthly meetings, the Waterford/Wexford Executive Management Team Meeting and the Quality and Safety Executive Committee meeting (QSEC). The DOP had established

governance structures in place and a number of senior management meetings regularly took place within the approved centre in order to deliver the governance processes. Committee meetings were held through several forums including a Quality and Patient Safety Committee meeting, a local compliance meeting, a Restrictive Practice Reduction Committee meeting and a Health and Safety Committee meeting. Quality improvement working groups such as Policies Procedures Protocols and Guidance (PPPG) and clinical audit were in place.

The Executive Management Team (EMT) met on a monthly basis. Minutes from the EMT meetings reported strategic agenda items such as HR, recruitment for vacant positions, escalations from QSEC, financial planning, Key Performance Indicators (KPIs) and mental health engagement. The Quality & Safety Executive Committee (QSEC) meeting also took place on a monthly basis. This committee reported and reviewed items such as quality indicators and outcome measures, regulation and compliance, complaints and compliments, health and safety, staff training, oversight committee for restrictive practices, clinical audit and quality improvements, incidents and near misses, discussion on items escalated from the Quality and Patient Safety Committee (QPSC) meeting, items for escalation to the EMT, maintenance, recovery, and risk management processes.

Management at a local level held a monthly Quality and Patient Safety Committee (QPSC) meeting and a weekly compliance meeting. These meetings had multi-disciplinary attendance from the medical, nursing, psychology, social work and occupational therapy departments alongside service and business management and the Mental Health Act administrator. Agenda items discussed at these meetings included regulation and compliance, risk management, quality initiatives, complaints and compliments, training, bed occupancy and health and safety.

The approved centre had a standardised process for the management of risks and incidents. The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register. Risk management procedures actively reduced identified risks to the lowest practicable level of risk; however, not all risks were identified. Health and Safety risk identified compromised fire safety due to a set of fire doors not closing properly and the inability to open a separate fire exit door, containing two bolts and a key, were not recorded on the maintenance log or the risk register. The set of fire doors indicated above was remedied on the first day of inspection. Training in risk management had been provided to staff. Examples of identified risks for the approved centre were ligature points, staff training, the lack of maintenance structure for the DOP and risk to resident's dignity and wellbeing if overcapacity should occur. At the time of inspection, there was a national capital plan to replace the DOP building with a new 60 bed unit which was in the planning stage. Access to speech and language therapy had been withdrawn by University Hospital Waterford in early 2023. This issue had been escalated up through the appropriate Governance Structures and was documented on the joint SECH Executive Management Team (EMT) Minutes in July 2023.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. There were 14 admitting teams to the service. Health and social care professionals included occupational therapy, psychology, social work, physiotherapy and dietetics.

Speech and language therapy was not readily accessible to all residents. At the time of inspection, both in-patient occupational therapy posts were vacant. The service had been unsuccessful in filling these posts since the previous inspection. Occupational therapy services were being provided to residents through cross-care cover from admitting community teams and agency staff. Two social-work posts within the admitting teams were vacant at the time of inspection but these posts were covered by agency staff. There was an increase in non-consultant hospital doctors since the last inspection. There was a full complement of psychology staff across the admitting teams.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included nursing, medical, occupational therapy, social work, and psychology. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. Annual staff training plans were completed to identify and address training needs. Operational risks highlighted within these questionnaires included staff recruitment and retention, significant demand for bed availability, staff mandatory training, maintenance programme of the premises and the risk of COVID-19 outbreaks due to the limited number of isolation rooms. The identified risks were effectively mitigated, escalating potential risks to senior management meetings through the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, weekly resident community meetings, suggestion boxes, service user surveys and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Peer Advocacy in Mental Health organisation contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre. A peer family support worker was available to residents. Resident input was enhanced by the Area Lead for Mental Health Engagement in management and governance processes.

Quality improvement was evidenced in the progression and development of various quality initiatives in the approved centre and was also a standing agenda item at the local compliance meeting. A programme of audit was implemented by the multi-disciplinary team throughout the service. A local policy group provided a multi-disciplinary approach to policy development, review, approval and dissemination, and all policies were up to date at the time of inspection. Systems for performance appraisal and clear supervision processes for all staff were in place within the approved centre.

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 2019 and 2023 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 15: Individual Care Plan	✓		✗	High	✗	High	✓		✗	Moderate
Regulation 19: General Health	✗	Moderate	✓		✓		✓		✗	High
Regulation 22: Premises	✗	High	✓		✗	Moderate	✗	Low	✗	High
Regulation 27: Maintenance of Records	✓		✗	Low	✓		✓		✗	Low
Regulation 31: Complaints Procedures	✓		✓		✓		✓		✗	Moderate
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	High
Rules Governing the Use of Seclusion	✗	Low	✓		✗	Moderate	✓		✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	High	✓		✓		✓		✗	Moderate
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	✗	High	✗	High	✗	Moderate	✗	High	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation 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.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engage with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- The Peer Advocacy in Mental Health representative was contacted to obtain residents' feedback about the approved centre.

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

The inspection team spoke with seven people residing within the service. Overall feedback was very good and residents were happy with the food, staff interaction and the activities and programmes during the week. Individuals reported they were happy with their bed space and reported the team to be kind and generous. A general feeling of safety on the unit was commented on, as was knowing members of their multi-disciplinary team and being part of their individual care plan. Comments and suggestions reported residents felt there was not enough to do on the weekend and that the use of the recreation and rehabilitation space depended on staff availability, and it would be nice for it to be open on the weekends. Some residents indicated that there was not enough seating in the garden areas. Residents reported visiting hours at times were expressed as short, detailing half hour slots. Floors were reported to be overly wet when being cleaned at times. One resident reported they would like to see more talking therapies.

Four questionnaires were received by the inspection team. Three respondents reported they did not recall if a staff member explained what was happening on admission in a way they could understand; however, one respondent reported that the staff did explain in a way that was helpful for them. Two of four respondents reported that staff gave information about their diagnosis, care and treatment in a way they could understand; one individual reported that this was the case sometimes. Three of four respondents indicated that they understood what their individual care plan was but only one individual reported that they were always involved in setting goals for their individual care plan. Two respondents reported that they were sometimes involved, and one indicated that they were never involved. Three of four respondents indicated that they knew their multi-disciplinary team and keyworker.

Two of four of residents reported that they were always able to discuss worries or concerns with a member of staff; two or four indicated that this was only sometimes the case. Three of four residents reported that there were enough activities during the day. One resident said that they were not happy with how staff spoke with them. Two residents indicated they had space for privacy while one resident reported this was sometimes the case and a fourth resident reported they did have space for privacy. Three residents reported that they felt their privacy and dignity were respected. Three of four respondents reported that they were able to communicate freely with family, friends and advocates. When reporting on feeling safe in the approved centre, two of four of respondents indicated that they always felt safe whilst the other two of four expressed this as sometimes being the case. All respondents reported they were always able to make complaints when or if they were not satisfied with any part of their stay in the approved centre.

When asked to rate the service on a scale of 1–10, with 1 being poor and 10 being excellent, regarding their experience of care and treatment respondents scored the service ‘10’, ‘9’, ‘9’ and ‘7’ respectively.

Additional comments regarding their experience of care and treatment included:

“I found the staff very helpful and friendly. The activities were great, I really enjoyed them and being part of a group.”

“The activities are good. Could be better with more day hospital time at the weekends.”

“The discharge plan is difficult.”

5.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative. The advocacy report detailed individual statements reported by residents of their experience. A summary is contained below.

Residents reported the food was good and plentiful. In regard to groups and activities, residents reported to enjoy the music and expressed the gym, and the piano were a great asset and residents enjoyed having a variation of groups. Residents enjoyed the art group. Other groups which were praised by residents included the coping skills group, the occupational therapy groups and the self-care group. A resident reported they were able to meet with the priest which they expressed was a great support for them.
Residents reported to the advocate the multi-disciplinary team (MDT) meeting was very helpful and it was helpful to get a copy of their individual care plan (ICP). A resident reported they had participated in their ICP through their MDT meeting.

Residents expressed they were kept informed about what was happening and how things worked. Residents reported their privacy was respected. Regarding the environment, residents expressed the building was kept very clean and they enjoyed the garden.

Staff were reported to be supportive, helpful, kind and listening. One resident reported the care as excellent, and a resident reported they were looked after very well. Some comments made by residents included "The staff here make you feel so comfortable, you can ask them anything and there is a great comfort in that", "I give the staff 101% for the work they do here", "The doctor listens to me and is very supportive" "I couldn't fault the staff here, superb care" and "The nurses are very good and supportive".
The advocacy report highlighted some areas for improvement which included accessing a cup of tea when needed was not always available which a resident reported as slightly frustrating at times. A resident expressed a lack of variety in the food on offer. With regard to activities a resident reported they would like more activities during the day and at weekends and more activities should be made available particularly on the acute unit. One resident suggested a pack of cards and another resident expressed colouring pencils to complete the work assigned by occupational therapists. One resident reported they would like more access to a computer.

A residents reported to the advocate more attention should be paid to the person's physical health and one resident expressed "There is too much of a reliance on medication, instead there should be a psychologist available to provide support to you".

One resident reported, in their opinion, their privacy was not respected. Another resident reported "no privacy, my medical chart was left in full view where people congregate and when I raised it with staff it was put away, but I got no apology from any of the staff".

Regarding the environment, two residents reported they found the noise level "overwhelming" and "sometimes very noisy". The resident also stated they could find it difficult to sleep with the noise and suggested there should be separate rooms for patients. The family room was often locked as reported by a resident. Two residents expressed comments on the garden reporting "There should be tables and chairs in the garden area so people can sit outside and enjoy their cup of tea or coffee" and "The outdoor space is a bit drab it could be brightened with some flowers".

Some improvements in relation to staff interaction reported to the advocate reports an individual did not feel listened to. The availability of nursing staff as reported by one resident "The nurses say they'll be back to you in a couple of minutes. That never happens as they may not come back to you for several hours. I find this very frustrating". One resident commented on their care and treatment expressing "I had been discharged too soon. My doctor didn't listen to me when I said I was not well enough to go home. I was discharged and then ended up back in hospital within a couple of days".

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:

- Executive Clinical Director
- Clinical Director
- Head of Service/ Registered Proprietor Nominee
- General Manager
- Area Director of Nursing
- Principal Social Worker
- Psychology Manager
- Occupational Therapy Manager
- Maintenance Manager
- Risk Advisor
- Deputy Service Manager
- Assistant Director of Nursing
- Assistant Director of Nursing - Compliance Manager
- Clinical Nurse Manager III

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate.

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs. Stickers, which included name, address, date of birth and medical record number, were used to identity residents.

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 the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Nursing staff used the MUST Nutritional Assessment Tool where indicated. Residents had access to a dietitian via the Webex video call platform when required.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents’ Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents’ personal property and possessions. The policy was last reviewed in April 2021. A resident’s personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident’s monies, valuables, personal property, and possessions, as necessary.

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 on weekdays and during the weekend. Activities included yoga, guided relaxation, Wake and Shake exercise, Move your Mood, employment specialist information, and Better with Age groups. An arts and craft box were available at weekends, alongside weekend resource boxes and individualised resource packs provided to residents in both the Comeragh and Brandon units. There was a treadmill and exercise mats which could be used where a nurse was available to supervise.

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 practicable. A chaplain visited the approved centre, and residents could attend the church in the main hospital. Other religions could be accommodated if required.

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 policy and procedures in relation to visits. The policy was last reviewed in July 2022.

Visiting times were appropriate and reasonable and flexible on consultation with the clinical team. A family room was available for visits on the Sub-Acute unit. The Acute unit could also use the Tribunal Room for receiving visitors. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The family room was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in February 2021.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. On Brandon Ward, residents had access to the ward phone and mobile phone. A computer and two electronic tablets with Wi-Fi access were also available. On Comeragh Ward, residents had access to their own mobile phones, the ward mobile and electronic tablets. Residents had access to the communication hub in the day hospital and there was a phone box located on the ward that residents could use to make calls in private.

It was the approved centre's policy that the clinical director (or senior staff member designated by the clinical director) only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others. There was no monitoring of incoming or outgoing calls for any residents at the time of inspection.

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 policy and procedures on the conducting of searches. The policy was last reviewed in June 2021, 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.

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and consent received were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A written record was kept

of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

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 policy and procedures on care of the dying. The policy was last reviewed in August 2023.

No end-of-life care was provided in the approved centre since the last inspection. The death of a resident was 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

Each resident had an individual care plan (ICP). Ten ICPs were inspected. All ICPs were a composite set of documentation.

Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews. The ICPs were developed by the MDT following a comprehensive assessment and 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 were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes.

Appropriate goals, care and treatment was identified in all ICPs, which document the resources required to provide it. The ICPs were subject to weekly review by the MDT in consultation with the resident. Not all ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances or goals. One ICP was not updated following an episode of physical restraint. One ICP was updated following a post-physical restraint debrief; however, not all the resident's preferences regarding restrictive interventions were updated on the ICPs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that each individual care plan specified the treatment and care required. In two care plans, the care and treatment was not updated as indicated by the resident's changing needs, condition and circumstances.

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 detailed in their individual care plans (ICPs). The psychologists in the approved centre ran three weekly groups. Referrals for individual psychology could be made for inpatients where necessary. An occupational therapist (OT) and assistant OT were based in the approved centre. The OT manager was onsite one day a week and facilitated groups. There was social work input into the groups, and individual social work input was accessible via referral. A therapeutic group programme meeting was held quarterly, with social work, psychology, and social care work in attendance. An OT service user's survey was also completed quarterly, and the results were shared with therapeutics meetings.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Psychology groups included a coping skills group which ran twice weekly in Comeragh Ward and a grounding skills group which ran once weekly on Brandon Ward. Individual work in psychology was also conducted. Psychology assessments were completed by senior psychologists. Groups co-facilitated by OT, social work and psychology included a horticultural programme and a summer sounds group. A recovery workshop was co-facilitated by the recovery college, recreational and recovery nurse, and OT. Social work and OT groups included a weekly conversation club, weekly bingo, creative art and self-care.

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. Residents had access to a private dietitian via the Webex video call platform. Physiotherapy was accessible via referral to the general hospital. Residents did not have access to speech and language therapy at the time of inspection but the approved centre could contact the general hospital for support and advice where required.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in November 2022.

The clinical file of one resident who had been transferred from the approved centre in an emergency situation was inspected. Communications between the approved centre and the receiving facility were documented and followed up with a written referral. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in April 2021. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Five clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, body-mass index, weight and waist circumference. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin and electrocardiogram (ECG) heart function.

Adequate arrangements were not in place for residents to access general health services and for their referral to other health services as required. Residents in the approved centre could access a private dietitian via the Webex video call platform. However, residents did not have access to a speech and language therapist in the event of an assessment being required.

Residents could access national screening programmes that were available according to age and gender, including retina checks for diabetics and bowel screening.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that adequate arrangements were in place for residents to access general health services and for their referral to other health services as required, as residents did not have access to a speech and language therapist, 19 (1)(a).

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 provision of information policy and procedures in place. The policy was last reviewed in March 2021.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs.

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation 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 the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. Where residents shared a room, bed screening was provided to ensure that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Not all hazards were minimised in the approved centre: the saddle board on the way into the communal space from Comeragh garden was high and constituted a trip hazard for those using mobility aids or at risk of falling. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in a good state of repair externally or internally. Brandon garden was very dirty, and only power-hosed on a monthly basis. The power hose was broken; a replacement was purchased on the second day of inspection. Gardens at Comeragh were stained. A contract had been agreed for the painting of the garden walls.

The approved centre did not have an adequate programme of general maintenance, cleaning, decontamination or repair of assistive equipment. Fire doors were not checked regularly, and malfunctioning fire doors had not been reported. Two sets of fire doors didn't close when the magnetic

locks released. These were repaired on the first day of inspection. The exit door for Brandon Ward was locked with one key and two bolts; two staff members were unable to open it, when inspected.

The approved centre's schedule of decorative maintenance was adequate. The centre was not clean, hygienic, and free from offensive odours. Dirt was ingrained at the doors from the gardens to communal space. Drainage channels at doors were blocked with cigarette butts and debris, the linoleum flooring in one toilet was stained and needed replacing and the linoleum flooring in a shower was stained, damaged and unsuitable for standing in bare feet while showering.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were adequately sized to address the resident needs. The approved centre did not provide suitable furnishings to support resident independence and comfort: the covering of an armchair in Brandon Ward was torn and there was limited seating in Brandon garden consisting of a planter with in built seating and a bench. The Comeragh garden had three benches.

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

a) **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, as there was ingrained dirt in the doorways from the gardens to the main communal areas with drain channels full of cigarette butts and debris, the gardens were dirty with cigarette butts in Brandon, the paving stones and floor surface in gardens were dirty, and fire doors that did not close properly, 22 (1)(a).**
b) **The registered proprietor did not ensure that a programme of routine maintenance and renewal of the fabric and decoration of the premises was developed and implemented, as the floor in one toilet was stained and damaged from leaks and the floor in one shower was stained and damaged, 22 (1)(c).**
c) **The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings, as the covering on an armchair was torn and there was insufficient seating in Comeragh and none in Brandon, 22 (2).**
d) **The registered proprietor did not ensure that the condition of the physical structure of the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and their safety and wellbeing, the saddle board at the door into communal space from garden in Comeragh was a trip hazard, 22 (3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in October 2021, and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible and included the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified and Scheduled 2 and 3 controlled drugs were secured separately from other medications 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 health and safety policy and procedures in place. The policy was last reviewed in March 2022. The approved centre also had a site-specific safety statement, last reviewed in March 2023.

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 relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in February 2022.

The inspection found that there were clear signs in prominent positions where CCTV cameras or other monitoring devices were utilised throughout the approved centre. The approved centre’s use of CCTV and any other monitoring system was disclosed to residents, residents’ representatives and the Mental Health Commission. Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed solely by the health professional with responsibility for the resident. CCTV was not used to monitor a resident in the event of their dignity being compromised. All monitoring systems in the approved centre were incapable of recording or storing a resident’s image on tape, disc or hard drive.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in February 2023, and included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. The approved centre had 14 multi-disciplinary teams. This included psychiatry, psychology and social work on an in-reach basis. There was no inpatient occupational therapist at the time of inspection but cross cover was provided by the community occupational therapists. There were vacancies within social work; however, these posts were filled through agency staff.

All healthcare staff were trained in basic life support, fire safety, the management of violence and aggression, and the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The table following gives a breakdown of the numbers and percentages of staff trained in each of the mandatory areas.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (43)	43	100%	43	100%	43	100%	43	100%

Consultant Psychiatrist (16)	16	100%	16	100%	16	100%	16	100%
Medical (25)	25	100%	25	100%	25	100%	25	100%
Occupational Therapist (8)	8	100%	8	100%	8	100%	8	100%
Social Worker (16)	16	100%	16	100%	16	100%	16	100%
Psychologist (14)	14	100%	14	100%	14	100%	14	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating LOW

(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 policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in June 2021, and included the following:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure, up-to-date and constructed, maintained and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence. Not all records were not kept in good order with no loose pages: in one clinical file, there was a confidential enveloped letter loose in the file, this was remedied on inspection. In other clinical files, there were written errors that were not initialled by staff, and times in seclusion booklets which were not legible.

Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorised access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained in good order, as there was a loose confidential lettered document and writing errors that were not initialled, 27 (1).

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

The approved centre was compliant with this regulation.

Regulation 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. Staff attended Mental Health Tribunals and assisted the patient where necessary. The approved centre provided resources and facilities to access the Mental Health Tribunals remotely where required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in June 2021, and included the process for raising, handling and investigating complaints from any person, regarding any aspect of the services, care or treatment provided in or on behalf of the approved centre.

A nominated person was available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre.

Residents, their representatives, family and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. However, minor complaints were not consistently documented: one minor complaint had been logged since May 2022.

All complaints which were not minor 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 (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented. The registered proprietor ensured that the quality of service, care, and treatment was not adversely affected by reason of the complaint being made.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all minor complaints were recorded, 31 (6).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in April 2022, and included the following:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known 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.

Not all health and safety risks were identified, assessed, treated, reported, monitored and documented within the risk register as appropriate. Fire doors located on the corridors within the sub-acute ward were found to be unable to close independently when the magnetic locks were disabled. Another fire door

contained two of the same locks and a bolt on the top and bottom of the door; two staff members were unable to unlock this door on inspection. This compromised fire safety but was not documented on the maintenance log or the risk register. No record could be located of a routine check by maintenance of fire doors. The concerns with the fire doors were resolved on the first day of inspection.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during resident seclusion, physical restraint, specialised treatments (Electro-Convulsive Therapy), resident transfer and resident discharge. 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.

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, 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 non-compliant with this regulation because not all health and safety risks were identified, as two sets of fire doors were found not to function properly when closing, and a fire exit couldn’t to be unlocked when inspected, which comprised fire safety. This was not documented on the risk register, 32 (1).

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 which was displayed prominently in Comeragh Ward.

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 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also 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.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was last reviewed in May 2023. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. Materials and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia were prominently displayed. A named consultant psychiatrist (CP) had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical record of one involuntary patient receiving ECT was reviewed. As the patient had been assessed as not having capacity to provide consent, ECT was administered according to the relevant of the Mental Health Act 2001, and a *Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) –Unable to Consent* was completed by two CPs. The *Form 16* was placed in the patient’s clinical file and a copy was sent to the Mental Health Commission within five days. Both CPs assessed and recorded how ECT would benefit the patient, any discussion with and views expressed by the patient, any assistance provided in relation to the discussion and views expressed, and the patient’s capacity to consent to ECT.

The programme of ECT was only prescribed by the responsible CP. The prescription for ECT was recorded in the patient's clinical file, and the record included: the reason for the decision to use ECT; alternative therapies that were considered or proved ineffective; and documentation of discussion with the patient and, where appropriate, their next of kin or representative.

The initial stimulus dose was discussed and considered by the treating CP and CP responsible for ECT in advance of treatment and prescribed accordingly. Cognitive assessments were completed before each programme of ECT, and the patient's clinical status assessed before and after each ECT treatment session. The patient's cognitive functioning was monitored throughout the ECT programme. Cognitive assessment, in line with best international practice, was completed after each ECT programme. The reasons for continuing or discontinuing ECT were recorded.

The approved centre was compliant with this rule.

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating **MODERATE**

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

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was last reviewed in December 2022. It included all of the policy requirements for the rules governing the use of seclusion.

The policy and procedures for training all staff involved in seclusion documented who would receive training, the identification of appropriately qualified persons to give the training and the areas to be addressed within the training programme.

The approved centre had a policy on the reduction of seclusion. It included all the policy requirements for the rules governing the use of seclusion.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy. All staff who participated, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

Monitoring: A multi-disciplinary review and oversight committee had been established to analyse every episode of seclusion in detail, and was meeting on a quarterly basis. However, the review and oversight committee did not identify any areas for improvement, or identify the actions to be carried out, the persons responsible nor the timeframes for completion of the actions.

Evidence of Implementation: The seclusion facilities were furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's privacy was respected. The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There was an anti-barricade door. There were no ligature points or electrical fixtures. The room allowed for staff to clearly observe the resident in the

seclusion room. The seclusion room had externally controlled heating and air conditioning which enabled those observing the resident to monitor the room temperature.

All other aspects of the seclusion room facility and furnishings met the requirements of the rule. Seclusion facilities were not used as bedrooms, nor bedrooms used as seclusion facilities.

Orders for Seclusion: Three episodes of seclusion were reviewed on inspection. Seclusion was only initiated following as comprehensive an assessment of the resident as practicable. This included a risk assessment, the outcome of which was recorded in the clinical file. Seclusion was initiated by a registered medical practitioner (RMP) or the most senior registered nurse (RN) on duty. The RMP or RN recorded the seclusion orders in the clinical files and on the seclusion register. Where seclusion was initiated by a RN, a RMP was notified of the seclusion episode as soon as practicable, no less than 30 minutes following the commencement of the seclusion episode.

Upon commencement of each episode of seclusion, a seclusion care plan for the resident was developed by a RN. For one resident, the seclusion plan did not include details of how potential risks might be managed.

There was a medical examination of the resident by a RMP as soon as practicable, and no later than two hours after the commencement of each episode. The examination included an assessment and record of any physical, psychological or emotional trauma caused to the resident as a result of the seclusion. Where the CP ordered the continued use of seclusion, they advised the duration of each order. Seclusion orders were not made for any period of time longer than four hours from the commencement of each seclusion episode. The orders of the CP confirmed that there were no other less restrictive ways available to manage the resident's presentation.

The CP undertook a medical examination of the resident and signed the seclusion register within 24 hours of the commencement of each episode. In all episodes of seclusion, the residents were informed of the reasons for, the likely duration and the circumstances which would lead to the discontinuation of seclusion, a record was documented in the residents' clinical files.

As soon as practicable, and at the resident's wishes in accordance with their individual care plans (ICPs), the resident's representatives were informed of the seclusion and a record of this communication was entered in the clinical files.

Monitoring of the Residents: The residents placed in seclusion were kept under direct observation by an RN for the first hour following the initiation of seclusion. After the first hour, an RN kept the resident under continuous observation and remained within sight and sound of the seclusion room throughout the episode. A comprehensive written record of the resident was made by the RN every 15 minutes.

Ending of Seclusion: The residents were informed of the ending of each episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date the seclusion was ended. The residents had the opportunity to participate in an in-person debrief following the episodes of seclusion – one resident declined to participate, and another was unable to do so. Appropriate emotional

support was provided to the residents in the direct aftermath of each episode. Staff also offered support, if appropriate, to other residents who may have witnessed the seclusion.

Clinical Governance: All three episodes of seclusion inspected were reviewed by the members of the multi-disciplinary team involved in the resident's care and treatment and this was documented in the clinical file no later than five working days after the seclusion.

The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of seclusion.

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

a) **The seclusion plan for one episodes of seclusion did not include how potential risks might be managed, 5.7 vi.**
b) **The multi-disciplinary review and oversight committee did document areas for improvement and identify actions but did not document the persons responsible and the timeframes for the completion of the actions, 10.8 iii and iv.**

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 files of four patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment for each patient, and that all four were unable to consent.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for all four patients. It documented the following:

- 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.

- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an 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.

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

Use of Physical Restraint

NON-COMPLIANT

Risk Rating **MODERATE**

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 was last reviewed in December 2022, and included all the policy-requirements for this code of practice.

The approved centre had a written policy on the reduction of physical restraint (Seclusion and Physical Restraint Reduction Policy). The policy was last reviewed in June 2023, and included all the policy-requirements for this code of practice.

Policies and procedures regarding staff training included the identification of who would receive training based on the identified needs of residents who were restrained and staff, the identification of appropriately qualified individuals to give the training, the mandatory nature of training for those involved in physical restraint and the areas to be addressed within the training programme.

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. All staff who participated, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

Monitoring: A multi-disciplinary review and oversight committee had been established to analyse every episode of physical restraint in detail and was meeting on a quarterly basis. The multi-disciplinary review and oversight committee's reported and document areas for improvement and identify the actions however, the report did not detail persons responsible nor timeframes for completion of any actions decided upon.

Evidence of Implementation: Three episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there were no other less restrictive methods available to manage the residents' presentation. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical files. A physical examination of the residents had been completed no later than two hours after the start of each episode of restraint.

The orders for physical restraint did not exceed a duration of 10 minutes. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode, and were signed by the consultant psychiatrist within 24 hours. The

residents were informed of the reasons for the physical restraint and the circumstances which would lead to its discontinuation. This was recorded in the clinical file as soon as was practicable.

Where the resident's representative was not informed of the physical restraint, there was a record explaining why this did not occur in the clinical file. The Mental Health Commission was notified of the start time and date, and end time and date, of each episode of physical restraint in the correct format and within three days of each episode.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the residents' individual care plans (ICPs), where applicable, pertaining to specific requirements or needs in relation to the use of physical restraint. There was documented evidence that, where applicable, the principles of trauma-informed care were used during the episode of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy. The residents were continuously assessed throughout the uses of restraint to ensure their safety, and this was documented.

Ending Physical Restraint: The physical restraint in each instance was ended by the person who had led it. The residents were given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. One of the three residents declined to participate in the debrief, and this decision was respected.

For the two residents who did participate, the debrief included a discussion regarding their preferences in the event of a restrictive intervention being required in the future (noting which restrictive intervention they would not like to be used.) for one resident, the ICP was updated, but not all of the resident's preferences were reflected in the ICP.

Appropriate emotional support was provided to the residents following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

Recording of the Use of Physical Restraint: The episodes of restraint were recorded in the clinical files. The episodes of restraint were clearly recorded in the clinical practice forms. There was a copy of the clinical practice forms in the clinical files and they were available to the Mental Health Commission on request.

Clinical Governance: Each episode of physical restraint was reviewed by the members of the MDT involved in the resident's care and treatment and documented in the clinical files within five working days of the date of restraint.

The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of physical restraint.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **In one episode of physical restraint, the resident's individual care plan was not updated to reflect all of the outcomes of the debrief, 5.5.**
b) **The multi-disciplinary review and oversight committee's report did identify and document areas for improvement and identify the actions but did not document the persons responsible, and timeframes for completion of any actions, 7.8 iv.**

Admission of Children

NON-COMPLIANT

Risk Rating **MODERATE**

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in January 2023. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: The inspection team reviewed the clinical file of one child who had been admitted to the approved centre since the last inspection. The approved centre was an adult facility, therefore age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.

Provisions were in place to ensure the safety of the child, to respond to a child's needs as young person in an adult setting and to ensure the right of the child to have their views heard.

Staff who had contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated, including age- and gender-segregated sleeping and bathroom areas. Staff observation acknowledged gender sensitivity. Observation arrangements, including assignment of designated staff member, was provided as considered clinically appropriate.

The child had their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical file recorded this child's understanding of the explanation given. Advice from the Child and Adolescent Mental Health Service was available, where necessary, to the approved centre. Appropriate visiting arrangements for families, including children, were available. The Mental Health Commission was notified of all children admitted to approved centre within 72 hours using the appropriate notification form. Consent for treatment was obtained from one or both parents.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided to a child admission, 2.5(b).

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was last reviewed in May 2023. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in basic life support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. Materials and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist (CP) had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary resident who had received ECT was examined. The CP assessed the resident’s capacity to consent to receiving treatment, and this was documented in the resident’s clinical file. The resident was deemed able to consent to receiving ECT. Capacity to consent ensured that the resident could understand the nature of ECT (including risks, benefits, and alternatives), understand why ECT was proposed, and the broad consequences of not receiving ECT, and make a free choice to receive or refuse ECT. Consent was obtained in writing for each ECT treatment session, including anaesthesia. All consent was obtained by the CP, or registered medical practitioner (RMP) under supervision of the CP, prior to each ECT treatment session and recorded in the clinical file.

A programme of ECT was prescribed by the responsible CP and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the resident and next of kin and a current mental

state examination. Cognitive assessments, in line with best international practice, were completed and recorded before and after each ECT session.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant-current brief-pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file. The ECT register was completed on conclusion of the ECT programme. All pre-ECT assessments, including capacity to consent, pre-anaesthetic assessments, anaesthetic risk, and mental state were detailed and placed in the clinical file. All post-ECT assessments, including clinical status and patient progress, were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT were recorded.

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 August 2022, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in November 2022, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in June 2021, 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, discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, risk assessment and all other relevant information. A key worker system was in place, a full physical examination was carried out and a family member or carer was involved in the admission process with the resident's consent.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and other risks and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team and family or representative, where appropriate.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10005216		**The registered proprietor did not ensure that each individual care plan specified the treatment and care required. In two care plans, the care and treatment was not updated as indicated by the resident's changing needs, condition and circumstances.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Discussed at DOP Compliance Meeting on 27/03/2024- Action: All teams contacted in writing by the Clinical Director to make them aware of this non-compliance and to ensure that the care and treatment for all residents changing needs is reviewed and updated at minimum 7 day intervals/ as required. This was also discussed at the Consultants Meeting of 27/03/23	Quarterly Internal Reg.15 Audits and part of weekly compliance check list outcomes and actions plans discussed at Compliance Meetings, QPSC and QSEC forums	Yes to both	31/03/2024	Clinical Director
Preventative Action	Offer support and training to all MDTs through Compliance Team Core Staff and Clinical Placement Co-Ordinators. La Touche Record Keeping Training approved	Individual Care & Recovery Plans will continue to be audited and monitored through the DOP internal audit schedule with oversight by DOP	Yes	30/06/2024	Clinical Director, MDT Compliance Team & HOS

	and will take place 22/05/2024	Compliance/ QPSC and QSEC forums. Outcome of weekly checks specifically related to Regulation 15 will be shared with HOS every Monday. Outcome of audits and any attached action plans to be submitted to MHC via CIS on request.			

Regulation 19 General Health

Reason ID : 10005217		The registered proprietor did not ensure that adequate arrangements were in place for residents to access general health services and for their referral to other health services as required, as residents did not have access to a speech and language therapist, 19 (1)(a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	HOS has put in place provisions for the DOP to access a private Speech & Language Therapist	Internal audit schedule for DOP oversight provided by MDT Compliance Team, QPSC and QSEC forums	Yes Achieved	31/03/2024	HOS
Preventative Action	HOS to ensure that funding stream remains in place for DOP to access private SALT Services	Evidenced through Reg.19 Internal Audit Schedule and through regular reviews of the residents individual needs specific to SALT which will be documented in the Individual Care Plan. Oversight provided by MDT Compliance Team, QPSC and QSEC forums	Yes	30/06/2024	HOS and all MDT members

Regulation 22: Premises					
Reason ID : 10005209		**The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, as there was ingrained dirt in the doorways from the gardens to the main communal areas with drain channels full of cigarette butts and debris, the gardens were dirty with cigarette butts in Brandon, the paving stones and floor surface in gardens were dirty, and fire doors that did not close properly, 22 (1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Technical Services manager contacted and fire doors were rectified immediately on day of inspection. Garden Power washed at time of the inspection to address issues Garden swept and cigarette butts removed.	Visual of the completed work observed by approved centre and technical services staff and inspector	Yes Achieved	22/09/2023	HOS & Technical Services Manager
Preventative Action	A) Regular power washing schedule in place and updated to a fortnightly basis rotating between Comeragh and Brandon garden areas. B) Fire Doors: • Weekly Fire Checklist which includes fire doors to be completed weekly by CNM/ Senior Nurse on duty. These checklists are keep on unit in Fire Folder. (FSR7 checklist attached) • Weekly	Regulation 22 Premises audit as per schedule; regular Compliance Senior Management Walk rounds take place with feedback through Compliance, QPSC and QSEC Forums. Updates via CIS will be sent to MHC as required in relation to audit outcomes and any action plans.	Yes	30/06/2024	A) Technical Services Manager and GM B) GM Fire Officer Tech Services Manager and Unit CNMs

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
	Compliance Checklist updated under Regulation 22 to include weekly checks of Fire Doors by CNM2 for Compliance. • Fire Officer to be contacted by GM to discuss the schedule of fire door maintenance for 2024/2025.				
Reason ID : 10005210		**The registered proprietor did not ensure that a programme of routine maintenance and renewal of the fabric and decoration of the premises was developed and implemented, as the floor in one toilet was stained and damaged from leaks and the floor in one shower was stained and damaged, 22 (1)(c).**			
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.					
Reason ID : 10005211		**The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings, as the covering on an armchair was torn and there was insufficient seating in Comeragh and none in Brandon, 22 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	HOS will discussed replacement and funding of furnishings in identified areas as discussed during site visit 27/03/24	Funding will be put in place to purchase the necessary furnishings and once purchased this will be audited through Regulation 22 Premises audit as per schedule; regular Compliance Walk rounds to continue with CD/ADON and Senior Management Walk rounds take place with feedback through Compliance,	Yes	04/08/2024	HOS & GM

		QPSC and QSEC Forums. Updates via CIS be sent to MHC as required in relation to audit outcomes and any action plans.			
Preventative Action	Meeting held with HOS, GM, DOP ADON & ADON Compliance Support 26/05/2024 to discuss detailed inventory of furniture and funding required-funding agreed and quotations will now be sought via Purchasing & Procurement ensuring service is compliant with Purchasing Rules and NFRs	Funding will be put in place to purchase the necessary furnishings and once purchased this will be audited through Regulation 22 Premises audit as per schedule; regular Compliance Walk rounds to continue with CD/ADON and Senior Management Walk rounds take place with feedback through Compliance, QPSC and QSEC Forums. Updates via CIS be sent to MHC as required in relation to audit outcomes and any action plans.	Yes	04/08/2024	GM & HOS
Reason ID : 10005212		**The registered proprietor did not ensure that the condition of the physical structure of the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and their safety and wellbeing, the saddle board at the door into communal space from garden in Comeragh was a trip hazard, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Saddle Board to Comeragh rectified and completed by Technical Services	Visual of completion and will continue to be monitored as per Regulation 22 Premises audit as per	Yes	31/03/2024	HOS & GM

		schedule; Compliance walk rounds will continue with CD/ADON Senior Management Walk rounds take place with feedback through Compliance, QPSC and QSEC Forums. Updates via CIS be sent to MHC as required in relation to audit outcomes and any action plans.			
Preventative Action	Technical services walk round: DOP 23/04/24 with ADON DOP, GM, CD and Technical Services Manager updated list of outstanding maintenance items discussed- annual maintenance schedule in place	Regulation 22 Premises audit as per schedule; regular Compliance Walk rounds to continue with CD/ADON and Senior Management Walk rounds take place with feedback through Compliance, QPSC and QSEC Forums. Updates via CIS be sent to MHC as required in relation to audit outcomes and any action plans.	Yes	04/08/2024	HOS, CD & Senior Management Team

Regulation 27:Maintenance of Records

Reason ID : 10005213		The registered proprietor did not ensure that records were maintained in good order, as there was a loose confidential lettered document and writing errors that were not initialled, 27 (1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Discussed at length at QSEC January 2024- a focused quality piece and audit schedule was implemented from Jan 2024 and outcomes reported from a 7 week period at QSEC in March 2024. Evidenced by weekly audit tools carried out by Ward Clerk and CNM2 for Compliance, actions plan documented on audit tools; minutes of Jan to March QSEC have been uploaded to CIS	Monitor through Internal Audit System and QPSC and QSEC forums	Yes achieved	30/04/2024	ECD as QSEC Chair
Preventative Action	All staff are aware of the requirements of Record Keeping as per HSE National Guidelines. Specialised Training in Health Care Records sourced through La Touche and same has been discussed at QSEC March 2024- budget for same has been approved by	Regulation 27 will continue to be monitored by Regulation 27 audit via DOP schedule. Oversight through DOP Compliance, QPSC and QSEC forums.	Yes to both	30/06/2024	All staff accessing Health Care Records

	HOS 27/03/24 training date is 22/05/24 x 2 sessions , this is in addition to training offered via HSEland and CPCs.				

Regulation 31: Complaints Procedures

Reason ID : 10005214		The registered proprietor did not ensure that all minor complaints were recorded, 31 (6).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff in DOP made aware of the importance of recording all minor complaints received in the unit complaints log and outcome of same to documented in Minor Complaints Log	Audit completed on Reg.31 24th January 2024 achieved full compliance included on Weekly Compliance Checks	Yes to both	07/04/2024	ADON DOP and all staff on unit
Preventative Action	Reg. 31 to be audited monthly as part of audit schedule from May 2024 with oversight at DOP Compliance, QPSC and QSEC Forums- outcome of non compliant audits and any action plans will be submitted to MHC via CIS on request	Internal audit of Reg 31 to be repeated in June 2024 included on Weekly Compliance Checks	Yes	30/06/2024	ADON DOP & DOP Compliance Team

Regulation 32: Risk Management Procedures					
Reason ID : 10005215		Not all health and safety risks were identified, as two sets of fire doors were found not to function properly when closing, and a fire exit couldn’t to be unlocked when inspected, which comprised fire safety. This was not documented on the risk register, 32 (1).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Technical Services manager contacted and fire doors were rectified immediately on day of inspection on 19/04/23; lock was upgraded and changed on fire exit which was observed to fully functioning-therefore not placed on Risk Register as it is no longer a risk	Rectified immediately and it was observed that both doors were fully functioning by approved centre staff in presence of inspector and lock upgraded and changed on fire exit.	Yes achieved	19/09/2023	GM & Technical Services Manager
Preventative Action	Fire Doors: • Weekly Fire Checklist which includes fire doors to be completed weekly by CNM/ Senior Nurse on duty. These checklists are keep on unit in Fire Folder. • Weekly Compliance Checklist updated under Regulation 22 to include weekly checks of Fire Doors by CNM2 for Compliance. • Fire Officer to be contacted by GM to discuss the schedule	Documented door checks weekly in Fire Safety Folder on FSR7 and on updated weekly compliance checklist	Yes	30/05/2024	GM, Fire Officer and Unit CNMs.

	of fire door maintenance for 2024/2025.				

Rules Governing the Use of Seclusion					
Reason ID : 10005220		**The seclusion plan for one episodes of seclusion did not include how potential risks might be managed, 5.7 vi.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Discussed at DOP Compliance Meetings on 27/03/24; all staff made aware by CD following this meeting of the requirement to include documentation in HCR on how potential risks might be managed.	As per Rules Governing the use of Seclusion published in September 2022 all episodes of Seclusion will continue to be audited and reviewed at the DOP Oversight Committee Meetings which are recorded. These audits and oversight minutes and any actions arising in relation to non-compliances with Rules Governing the use of Seclusion will be shared with MHC via CIS on request. Governance provided through Compliance QPSC and QSEC Forums	Yes	30/06/2024	Clinical Director, all staff involved in documenting in HCRs
Preventative Action	As per Rules Governing the use of Seclusion published in September 2022 all episodes of Seclusion will continue to be audited and reviewed at the DOP Oversight Committee Meetings which are recorded.	These audits and oversight minutes and any actions arising in relation to non-compliances with Rules Governing the use of Seclusion will be shared with MHC via CIS on request. Governance provided	Yes	30/06/2024	Clinical Director , DOP Oversight Committee and DOP Compliance Team

		through Compliance QPSC and QSEC Forums			
Reason ID : 10005221		**The multi-disciplinary review and oversight committee did document areas for improvement and identify actions but did not document the persons responsible and the timeframes for the completion of the actions, 10.8 iii and iv.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Oversight Committee Template will be updated to include Action Owner and timeframes sections, please see attached document	As per Rules Governing the Use of Seclusion published in September 2022 all episodes of Seclusion will continue to be audited and reviewed at the DOP Oversight Committee Meetings which are recorded. These audits and oversight minutes and any actions arising in relation to non-compliances with Rules Governing the Use of Seclusion will be shared with MHC via CIS on request.	Yes	05/04/2024	Clinical Director- DOP Compliance Team- DOP Oversight Committee
Preventative Action	Oversight Committee Template will be updated to include Action Owner and timeframes sections which will be completed going forward	As per Rules Governing the Use of Seclusion published in September 2022 all episodes of Seclusion will continue to be audited and reviewed at the DOP Oversight Committee Meetings which are recorded. These audits and	Yes	30/06/2024	Clinical Director DOP Compliance Team and DOP Oversight Committee

		oversight minutes and any actions arising in relation to non-compliances with Rules Governing the Use of Seclusion will be shared with MHC via CIS on request.			

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10005218		**In one episode of physical restraint, the person's individual care plan was not updated to reflect the outcome of the debrief, 5.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All teams contacted in writing by the Clinical Director to make them aware of this non-compliance and discussed at consultants meeting and DOP Compliance Meeting 27/03/24. ICP doc has been reviewed to include a section/prompt around debrief outcomes and document has gone to printers (V3 ICP Doc attached for evidence pg 3 and on every review page there after).	Every episode of physical restraint is reviewed and audited as per COP Physical Restraint MHC 2022 as part of internal audit schedules discussed at Oversight Committee Meetings and QPSc & QSEC forums these meetings are minuted	Yes	31/05/2024	Clinical Director & DOP Compliance Team
Preventative Action	All teams contacted in writing by the Clinical Director to make them aware of this non-compliance and discussed at consultants meeting and DOP Compliance Meeting 27/03/24. ICP doc has been reviewed to include a section/prompt	Every episode of physical restraint is reviewed and audited as per COP Physical Restraint MHC 2022 as part of internal audit schedules discussed at Oversight Committee Meetings and QPSc & QSEC forums these meetings are minuted	Yes	30/06/2024	Clinical Director & DOP Compliance Team

	around debrief outcomes and document has gone to printers (V3 ICP Doc attached for evidence pg 3 and on every review page there after).				
Reason ID : 10005219		**The multi-disciplinary review and oversight committee's report did identify and document areas for improvement and identify the actions but did not document the persons responsible, and timeframes for completion of any actions, 7.8 iv.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Oversight Committee Template will be updated to include Action Owner and timeframes sections. Please see attached document	As per Code of Practice on the use of Physical Restraint published in September 2022 all episodes of Physical Restraint will continue to be audited and reviewed at the DOP Oversight Committee Meetings which are recorded. These audits and oversight minutes and any actions arising in relation to non-compliances with Code of Practice on the use of Physical Restraint will be shared with MHC via CIS on request.	Yes	05/04/2024	Clinical Director, DOP Compliance, Team and DOP Oversight Committee.
Preventative Action	The Oversight Committee Template will be updated to	As per Code of Practice on the use of Physical Restraint	Yes	30/06/2024	Clinical Director, DOP Compliance, Team and DOP Oversight Committee.

	include Action Owner and timeframes sections. Please see attached document	published in September 2022 all episodes of Physical Restraint will continue to be audited and reviewed at the DOP Oversight Committee Meetings which are recorded. These audits and oversight minutes and any actions arising in relation to non-compliances with Code of Practice on the use of Physical Restraint will be shared with MHC via CIS on request.			

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10005208		**Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided to a child admission, 2.5(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It has always been the case the Admission to the Adult Approved Centre of the Department of Psychiatry is a last resort based on clinical risk and assessment; all other avenues are explored e.g. urgent CAMHS Outpatient Appointment and all CAMHS Inpatient Units receive a referral prior to child being admitted to the adult unit.	No Child Admission since September 2023 Inspection will continue to monitor through internal audit system QPSC and QSEC governance forums	Yes both achievable and realistic	30/06/2024	Clinical Director
Preventative Action	The adult approved centre medical staff will continue to assess in the emergency department as per protocol. It has always been the case the Admission to the Adult Approved Centre of the Department of Psychiatry is a last resort based on clinical risk and	No Child Admission since September 2023 Inspection will continue to monitor through internal audit system QPSC and QSEC governance forums	Yes to both	30/06/2024	Clinical Director

	assessment; all other avenues are explored e.g. urgent CAMHS Outpatient Appointment and all CAMHS Inpatient Units receive a referral prior to child being admitted to the adult unit.				

Appendix 2: Background to the inspection process

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

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

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

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

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

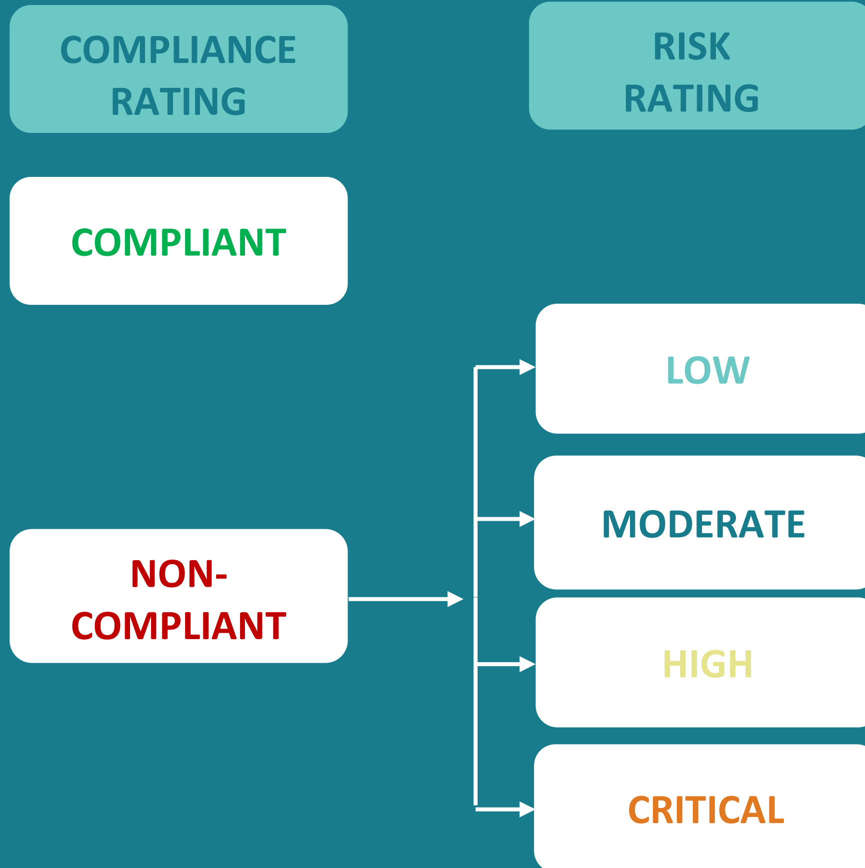
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.