Centre for Mental Health Care and Recovery, Bantry General Hospital

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Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

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CENTRE FOR MENTAL HEALTH CARE AND RECOVERY, BANTRY GENERAL HOSPITAL

Centre for Mental Health Care & Recovery, Bantry General Hospital, Bantry, Co. Cork

Date of Publication:
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2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Angela O'Neill, Acting General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
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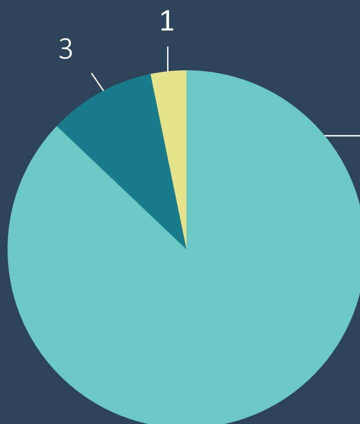
Inspection Date:
3 – 6 October 2023

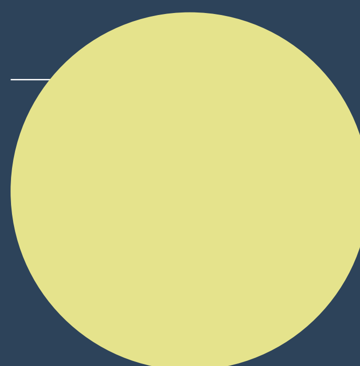
Previous Annual Inspection date:
19 – 22 July 2022

Inspection Type:
Announced Annual Inspection

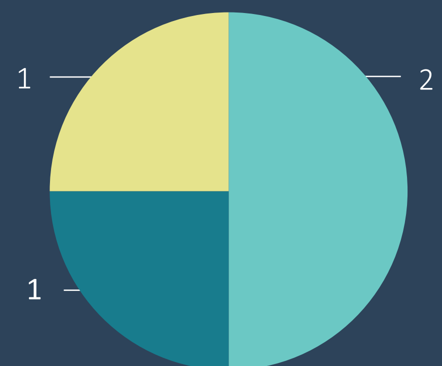
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



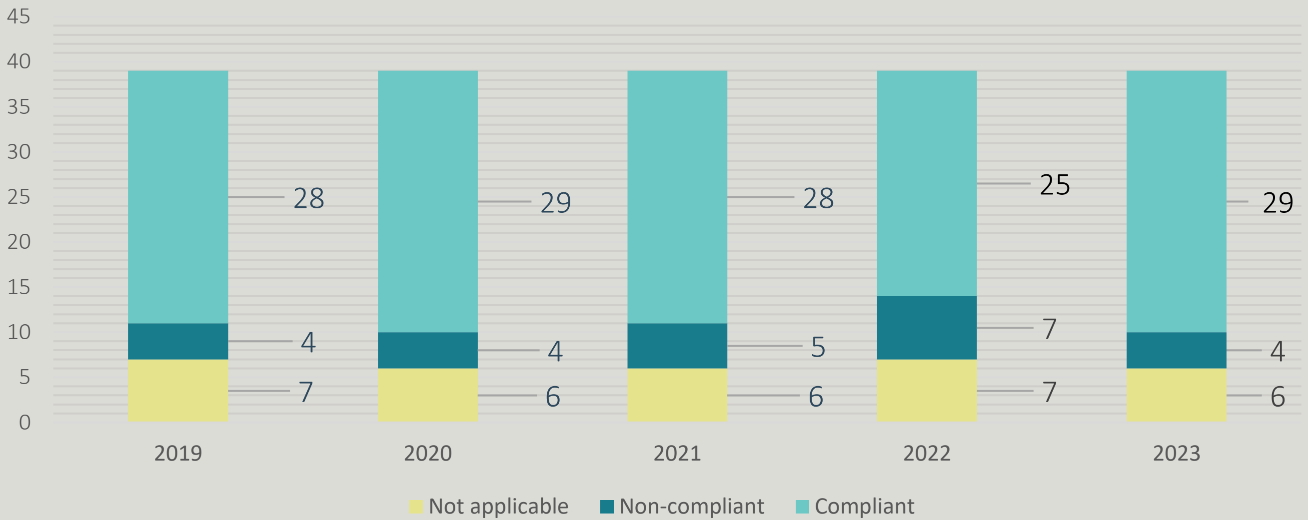
CODES OF PRACTICE

Compliant | Non-Compliant | Not applicable

RATINGS SUMMARY 2019 – 2023

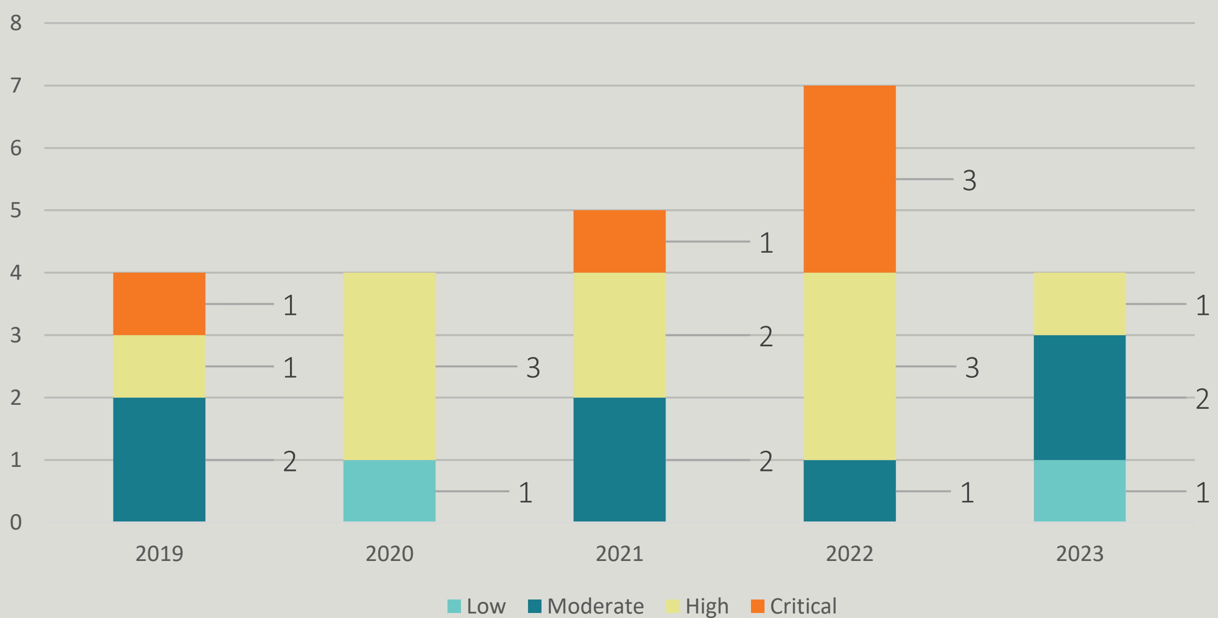
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 Centre for Mental Health Care and Recovery (CMHC&R) was a three-storey building located on the grounds of Bantry General Hospital. The approved centre was run by the HSE and provided acute adult mental health care services. Sleeping accommodation was a mix of single bedrooms and dormitory style accommodation with up to four beds in each dormitory. The approved centre was registered for 18 beds and accommodated nine residents at the time of inspection. Admissions to the approved centre were referred from one of three community mental health teams based in the catchment area.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	88%	88%	85%	78%	88%

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *The registered proprietor will carry out all necessary works to address identified ligature risk and provide additional communal space in accordance with the plans provided to the Mental Health Commission on 19 August 2021 and 9 November 2022. These works shall be completed by 31 January 2024. While works are ongoing, the occupancy of the approved centre shall be reduced from 18 to 15 beds.*	The approved centre was not in breach of Condition 1 at the time of inspection.

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate action notice 10000238	*2/08/2022*	*On inspection three regulations were risk rated as critical; Regulation 22: Premises, Regulation 25: CCTV, and Regulation 32: Risk.*	*Approved centre submitted plans to address non-compliance. These plans were mad ethe basis of a condition of registration.*
Proposal to attach a condition	*01/03/2023*	*Works needed to address risk and provide additional communal space.*	*Condition attached. Works underway.*
Regulatory compliance meeting	*24/05/2023*	*Approved centre had not completed renovation as per condition of registration.*	*Approved centre submitted a request to amend date in condition of registration and submitted plan to complete works.*

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:

- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Medication safety:*** The ordering, storing and prescription of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Access to essential information*:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***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:

- ***Cleanliness***: The approved centre was not entirely clean, as there was an offensive odour in one toilet and shower room.

- ***Mandatory training:*** Not all staff were trained in fire safety, safeguarding, basic life support or the management of violence and aggression.
- ***Medication safety:*** The administration of medication was not carried out in a safe manner as residents' Medication Prescription and Administration Records (MPARs) were not filled out correctly.
- ***Ligature anchor points:*** Ligature points were not minimised to the lowest level, based on individual risk assessment.
- ***Maintenance:*** While there was a general maintenance programme in place in the approved centre, there was no decorative maintenance programme. Furthermore, a safety hazard was observed in the approved centre.

Appropriate care and treatment of residents

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

- ***Appropriateness of environment:*** The layout and the decoration of the approved centre was being addressed to provide an environment to meet the needs of the residents. Ongoing renovation works in the approved centre continued since the last inspection.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. 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. Residents had access to general health and outpatient services in Bantry General Hospital for assessment and any treatment required.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT), with regular multi-disciplinary team meetings to discuss residents' care plans. There was a social worker, occupational therapist and psychologist on the team.
- ***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:

- ***Admission of Children:*** Age-appropriate facilities were not provided for children admitted to the approved centre.

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:*** A mix of single-bedroom accommodation and dormitory-style accommodation which had up to four single beds in each dormitory.
- ***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:*** There was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre was compliant with the code of practice on physical restraint. The approved centre did not use seclusion or mechanical restraint. The approved centre had a reduction of restrictive practices strategy.
- ***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. 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.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Residents were supported to attend Mass locally and other faiths could be accommodated on an individual basis. Residents had access to religious services in the main hospital and to multifaith ministers.
- ***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***: Residents were provided with a range of recreational activities including television, books, board games, arts and crafts and table tennis in the garden.
- ***Residents' feedback:*** No resident availed of the opportunity to speak with the inspection team but resident opinions were communicated through the approved centre's peer advocacy service. Please refer to Section 5.2 for more detailed information.

However:

- ***Environment:*** Rooms were not adequately ventilated.
- ***Private areas and areas for socialisation:*** Residents did not have sufficient spaces to move about on the first floor and residents did not have access to appropriately-sized bedrooms and communal rooms.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was part of the Cork Kerry Community Healthcare Organisation (CHO) and was governed under the Cork Mental Health Service. The approved centre was integrated with Bantry General Hospital for catering, security and maintenance purposes and the two facilities shared a common emergency and evacuation plan.
- ***Leadership:*** The Cork Mental Health Service Governance Group met monthly. A local management team in the approved centre met monthly. The Quality & Patient Safety Committee met quarterly.
- ***Clinical governance:*** There were many areas of good clinical governance: individual care planning processes were good, general health care provided met the needs of the residents and documentation was good. Clinical supervision was provided for medical staff and the health and social care professional groups.
- ***Restrictive practices reduction:*** The approved centre had commenced integrating the revised rule and code of practice in relation to physical restraint. The approved centre did not use any form of mechanical restraint.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. The approved centre had a local risk register, identified risks were documented and escalated to the area management teams risk register.
- ***Quality improvement:*** Several working committees supported and enhanced continuous quality improvement. These included a policy and procedure group and clinical audit group. The working groups reflected multi-disciplinary input.
- ***Policies:*** The approved centre's policies were up-to-date. Policies in the approved centre were developed by a policy and procedure group.
- ***Complaints:*** A complaints process was in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer engagement.
- ***Advocacy services:*** The approved centre had a peer advocacy service and a representative met with residents. Contact details for this service were displayed.
- ***Regulatory compliance and engagement:*** The approved centre has had a high average compliance rate of 85% over the last four years. The compliance rate increased by 10% since the last inspection. It had a condition on its registration regarding a ligature audit and the provision of additional

communal space while works are ongoing. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risk:*** Staff training was incomplete. Not all staff had completed mandatory training in basic life support, fire safety, or the management of violence and aggression.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A Yoga Group, facilitated by an instructor was introduced. This sought to residents alleviate stress and promoted general resident wellbeing. This new activity was based on feedback from audits with residents expressing a desire to participate in an activity that they felt would benefit their wellbeing.

2. A “Thought for the Day” notice had been developed and presented in the resident’s day room each day. These were inspiring quotations which aimed to enthuse residents who may be low in mood or feel demotivated. In the notice, staff ask patients to share if they have their own “Thought for the Day”, to foster inclusivity and empowerment.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Centre for Mental Health Care and Recovery was located on the grounds of Bantry General Hospital, within walking distance of the centre of Bantry town. The general hospital and approved centre worked collaboratively to facilitate the delivery of high-quality services in terms of both general and mental healthcare. The approved centre was a three-storey building, with the main clinical area and sleeping accommodation located on the upper floor. The dining room, the Mental Health Act Tribunal facility, and staff offices were located on the ground floor, with the occupational therapy room and resident garden on the lower ground floor. Access to the approved centre was via a reception area and a security lobby on the ground floor. Resident accommodation comprised of three single bedrooms, two two-bedded rooms, one three-bedded room and two four-bedded rooms. At the time of inspection, the approved centre was registered for 18 beds but had an agreed operational capacity of 15 beds.

The approved centre served West Cork, which included the wider areas around Skibbereen, Clonakilty/Dunmanway, and Bantry. Individuals requiring in-patient care and treatment were admitted to the approved centre via one of three community mental health teams serving the catchment area.

The centre was integrated with Bantry General Hospital for catering, security and maintenance purposes and the two facilities shared a common emergency and evacuation plan.

Ongoing renovation works in the approved centre continued since the last inspection. This included refurbishment of one of the two stairwells within the approved centre. A larger scale plan of refurbishments and enabling works had also commenced. These works were specific in meeting the condition of the approved centre's registration requirements to provide enhanced communal space and to reduce ligature risks. At the time of inspection, the plan of works and relevant time schedules were being finalised in order to achieve all required works by the 31st January 2024. This would necessitate the temporary closure of the approved centre for a period of 16 weeks.

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

Resident Profile	
Number of registered beds	***18***
Total number of residents	**9**
Number of detained patients	3
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	1
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The Cork Kerry Community Healthcare Organisation (CHO)), had introduced a revised governance structure with the introduction of an additional general manager position who acted as the Registered Proprietor for the Centre for Mental Health Care & Recovery (CMHC&R) approved centre at Bantry General Hospital. At an organisational level, there was a monthly Cork Mental Health Service Governance Group meeting. Agenda items for this meeting included; quality and patient safety, risk management, review of governance structures, human resources, finance, key performance indicators, service planning, and the MHC National Quality Framework, regulation and compliance. CMHC&R had a local management team which met monthly. These meetings were attended by the registered proprietor, area administrators, business managers, risk advisor, and heads of discipline. The Quality & Patient Safety Committee met quarterly, agenda items included; National Incident Management Systems reports (NIMS), incident reviews, identified risks, clinical audits and updates from other working committees.

There were key personnel with responsibility for risk management working in the approved centre who were identifiable and known by staff. Each discipline in the approved centre was responsible for the risks for their department. The assistant director of nursing in the approved centre was responsible for coordinating the risk register. The approved centre had a local risk register, identified risks were documented and escalated to the area management teams risk register, where applicable.

Incidents were recorded in a standardised format on National Incident Management Forms and uploaded on to the National Incident Management System (NIMs). The Quality and Patient Safety forum (QPS) and Risk Advisor provided advice and training on risk management to staff in the approved centre. All incidents were reviewed by the Incidents Review Team, whose membership included members of the multi-disciplinary team (MDT). Incident reports were reviewed, trends and analysis was provided on a quarterly basis by the Quality and Patient Safety (QPS) Department. Issues were discussed at the QPS Committee to ensure any learning from incidents was disseminated to enable mitigation of future incidents. The multi-disciplinary team (MDT) and the Serious Incident Management Team reviewed all serious incidents in the approved centre. There were established procedures in place for the management of these incidents.

There was an organisational chart defining key personnel and lines of responsibility and accountability. At the time of inspection not all staff disciplines had completed mandatory training. Governance questionnaires were completed by the heads of discipline and returned to the inspection team. The inspection team spoke with the head of discipline or their representative. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. Clinical supervision was provided for medical staff and the health and social care professional groups. Clinical support was provided by line managers for nursing staff.

There were several working committees that supported and enhanced continuous quality improvement. These included a policy and procedure group and clinical audit group. The working groups and operational groups reflected multi-disciplinary input. The approved centre had an emergency plan and a COVID-19 Pandemic Plan.

Regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal) were the principal mechanisms evident for resident and carer engagement.

Complaints and compliments were reviewed monthly at the Mental Health Service Governance Group meetings. Residents were invited to comment regarding therapeutic and recreational activities. Feedback from the residents contributed to the overall planning and development of programmes within the approved centre.

Residents in the approved centre had access to a Peer Advocacy in Mental health representative. The inspection team received a report from the advocate. At an organisational level, the area lead for mental health engagement was invited to attend the CHO Area Management Teams meetings.

Active engagement was evident in meetings with the Mental Health Commission regarding the one condition attached to the approved centres registration. This related to premises, the effect of which had reduced operational capacity to 15 beds, and it also required the approved centre to provide additional communal space and further works to address identified ligature risks.

At the time of inspection, the approved centre had commenced integrating the revised rule and code of practice in relation to physical restraint introduced on the 1st of January 2023. The clinical director of the approved centre was the named senior manager responsible for the approved centre's reduction in physical restraint. The approved centre did not use any form of mechanical restraint.

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 (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (X) 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 22: Premises	X	High	X	High	X	Critical	X	Critical	X	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✓		X	Low
Regulation 26: Staffing	X	Moderate	✓		✓		X	High	X	Moderate
Code Of Practice Relating to Admission of Children under the Mental Health Act 2001.	✓	N/A		N/A		N/A		N/A	X	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 Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

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

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. 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.

No residents availed of the opportunity to speak with the inspection team on this occasion.

5.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative.

The report submitted identified a number of issues for residents including:

'When groups take place, they can be very good',

Whilst 'the unit has a small number of clients there are times when there aren't enough things to do in the unit', 'days can be long'.

'Some clients want to know in advance if members of their multi-disciplinary team are going to see them'.

'Service users have reported having appointments with MDT members who then don't show up causing some clients to feel disappointed and trust issues can build up'.

'At times some clients find it difficult to have other medical concerns seen to while they are inpatients in the acute unit. They would like a more holistic approach, so their chances of recovery are higher'.

6.0 Feedback Meeting

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

- Registered Proprietor
- Area Administrator
- Area Director of Nursing
- Executive Clinical Director
- Clinical Director
- Head of Service
- Principal Social Worker
- Assistant Director of Nursing
- Staff Officer
- Occupational Therapy Manager

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.

Resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. A source of safe, fresh drinking water was available at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. Food was prepared in the main kitchen in Bantry General Hospital and was served from the approved centre's kitchen. There were proper facilities for the refrigeration, storage, preparation, 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 each resident's 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 2023. 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 television, books, board games, arts and crafts, and table tennis (in the garden). An electronic tablet (with limited internet access) was also available.

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. Residents were supported to attend mass in the main hospital should they wish. A list of multifaith ministers was available on request.

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 April 2023.

Visiting times were appropriate and reasonable. The approved centre provided a separate room on the ground floor where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting room was suitable for visiting children.

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 April 2023.

Residents in the approved centre resident were free to communicate at all times, having due regard to their wellbeing, safety and health. Internet access was provided via an electronic tablet which residents could utilise on request.

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 April 2023, 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 two 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 received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. 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 were 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 April 2023.

As there had been no deaths in the approved centre since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an Individual Care Plan (ICP). Five ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

The ICPs were developed by the multi-disciplinary team (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.

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to weekly review by the MDT in consultation with the resident. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs).

The approved centre's therapeutic services and programmes were centred around wellness, resilience, discharge planning and directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. The occupational therapist undertook functional and skills assessment on an individual basis. Other members of the MDT undertook interventions on a 1:1 basis based on needs.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in April 2023. 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. 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

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in April 2023. 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.

The clinical file of one resident who had been cared for in the approved centre was examined in relation to the provision of general health services during the inspection process. The six-monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, and body mass-index, weight, and waist circumference. For a resident on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, and electrocardiogram (ECG) heart function.

Adequate arrangements were in place for the resident to access general health services and for their referral to other health services as required. Residents had access to general health and outpatient services in Bantry General Hospital. A chiropodist visited the approved centre. Access to speech and language therapy and physiotherapy was provided by referral to Bantry General Hospital. Access to dietetics was via a private service. The resident could access national screening programmes that were available and applicable according to age and gender, including bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in April 2023.

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

The approved centre had a programme of ongoing maintenance. Refurbishments were actively being undertaken, with the back stairwell works completed, and preparatory works for the next stage in evidence during the inspection. Residents in the approved centre generally had access to appropriate personal space. However, the space in Bedroom 8 was insufficient as it was in temporary use as a four-bed room. Appropriately sized communal rooms were not provided. There was one sitting room area for all residents which had eight chairs on inspection. This was not sufficient to accommodate the approved centre's full capacity of 15 residents.

There was suitable and sufficient heating in day areas and bedrooms. Rooms were not adequately ventilated. Ventilation in the toilet/shower rooms was poor; windows could not be opened. 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.

Internally in the approved centre, sufficient spaces were not provided for residents to move about in. Space was limited on the first floor, with one sitting room for all residents and a narrow corridor. Access to a well-maintained garden was on the lower floor. Not all hazards in the approved centre had been minimised: one hazard was observed on inspection which had not been adequately minimised. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in a good state of repair internally, as chipped paint, marked doors, and torn lino were observed on inspection. 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 had a programme of general maintenance, cleaning, decontamination, and repair of assistive equipment. However, the approved centre did not have a programme of decorative maintenance; this had been placed on hold pending renovation works. The approved centre was observed to be clean, hygienic, and free from offensive odours, with the exception of one toilet/shower room which required a deep clean due to an offensive odour. A review of the ventilation needs of this room had also been instigated.

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 sluice room, and the centre provided assistive devices and equipment to address resident needs. Not all resident bedrooms were appropriately sized to address the resident needs: space was limited between two beds in Bedroom 8. The approved centre provided suitable furnishings to support resident independence and comfort.

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

a) **The approved centre was not kept in a good state of repair internally, as chipped paint, marked doors, and torn lino was evident, 22 (1)(a).**
b) **The approved centre was observed to be clean, hygienic and free from offensive odour, with the exception of one toilet and shower room which required a deep clean due to an offensive odour, 22 (1)(a).**
c) **The registered proprietor did not ensure that rooms were adequately ventilated, 22 (1)(b).**
d) **There was no programme of decorative maintenance in the approved centre, 22 (1)(c).**
e) **Residents did not have sufficient spaces to move about on the first floor and residents did not have access to appropriately-sized bedrooms and communal rooms, 22 (3).**
f) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, as a hazard was not minimised in the approved centre, 22 (3).**
g) **Ligatures were not minimised to the lowest practicable level based on risk assessment, 22 (3).**

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

NON-COMPLIANT

Risk Rating LOW

(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 April 2023, 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 administration of resident medication, including routes of medication.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. All MPARs contained a record of any allergies or sensitivities to medications, including if the resident had none; the frequency of administration, including the minimum dose interval for ‘as required’ (PRN) medication; a record of all medications administered to the resident; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident. On one MPAR, however, a clear record of the date of discontinuation was not recorded for one medication.

MPARs included the signature of the medical practitioner or nurse prescriber for each entry. On one MPAR, two entries were not legible. 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 non-compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices and relating to the administration of medicines to residents, as a clear record of the date of discontinuation was not recorded for one medication on one resident’s Medication Prescription and Administration Record, 23 (1).**
b) **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices and relating to the administration of medicines to residents, as two entries on one resident's Medication Prescription and Administration Record were not legible, 23 (1).**

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 April 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 April 2023.

The inspection found that there were clear signs in prominent positions where CCTV cameras or other monitoring devices were utilized 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, and 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

NON-COMPLIANT

Risk Rating MODERATE

(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 April 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 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. Not all healthcare staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. The following table 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 (21)	18	86%	11	52%	18	86%	21	100%
Medical (8)	8	100%	7	86%	8	100%	8	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%

Social Worker (3)	3	100%	3	100%	3	100%	3	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all staff had access to training to enable them to provide care and treatment in accordance with best contemporary practice, as not all healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26 (4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in April 2023, 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 and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence and kept in good order with no loose pages.

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All 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 were required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in April 2023, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person 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. No formal complaints had been submitted since the last inspection. Minor complaints were documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in April 2023, 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 and 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. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

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

physical restraint, 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. The approved centre implemented a plan to reduce risks to residents while any works to the premises were ongoing.

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 anonymised at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

There was an up-to-date certificate of registration, with one condition to registration attached, displayed prominently in the approved centre. Any changes in relation to the information detailed in the certificate were communicated to the Mental Health Commission.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: “prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

The Mental Health Act, 2001 (“the Act”) does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in January 2023. It addressed the following:

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

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

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

Evidence of Implementation: The clinical files of three residents that had been physically restrained were examined on inspection. Physical restraint was used in rare, exceptional circumstances and the best interest of the residents. Physical restraint was only used after all alternative interventions had been considered. The use of physical restraint was based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint was initiated by a registered medical practitioner (RMP), registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the residents. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the residents had been completed no later than three hours after the start of the episodes of restraint.

The orders for physical restraint lasted for a maximum of 30 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 signed by the CP within 24 hours. The residents were informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint where practicable. Where the resident was not informed, the reason for this was documented in the clinical file.

As soon as practicable and with the resident's consent, the resident's next of kin or representative was informed of the use of physical restraint, and this was recorded in the clinical file. Where the next of kin or representative was not informed, the justification for this was recorded in the clinical file. There was evidence that, where applicable, staff were aware of relevant considerations in individual care planning

pertaining to the resident’s needs and requirements in relation to the use of physical restraint. Where applicable, special consideration was given when restraining a resident who was known by the staff involved in physical restraint to have experienced physical or sexual abuse. Where practicable, same sex staff members were present during the physical restraint episodes. Completed clinical practise forms were placed in the residents’ clinical files.

The residents were afforded an opportunity to discuss the episode with members of the multi-disciplinary team involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical files no later than two working days after each episode.

The approved centre was compliant with this code of practice.

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 March 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 were not provided. However, there was evidence that the child was receiving one-to-one input while in the approved centre.

Provisions were in place to ensure the safety of the child, to respond to their needs as a 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 the 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 were not provided to a child admission, 2.5(b).

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 July 2023, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in February 2023, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in February 2023, included all of the policy-related criteria for this code of practice.

Training and Education: There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. 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, full physical examination 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 (MDT), 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. A comprehensive discharge summary was issued within 14 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 22: Premises					
Reason ID : 10004817	The approved centre was not kept in a good state of repair internally, as chipped paint, marked doors, and torn lino was evident, 22 (1)(a). The approved centre was observed to be clean, hygienic and free from offensive odour, with the exception of one toilet and shower room which required a deep clean due to an offensive odour, 22 (1)(a). The registered proprietor did not ensure that rooms were adequately ventilated, 22 (1)(b). There was no programme of decorative maintenance in the approved centre, 22 (1)(c) Residents did not have sufficient spaces to move about on the first floor and residents did not have access to appropriately-sized bedrooms and communal rooms, 22 (3). The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, as a hazard was not minimised in the approved centre, 22 (3).Ligatures were not minimised to the lowest practicable level based on risk assessment, 22 (3).				
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A comprehensive refurbishment program of works addressing communal space, ligature risk and to enhance the environment and ventilation of the centre commenced in 2023. Phase 1 of the works was completed in September, 2023. Phase 2 of the works commenced on 18th October, 2023 with the temporary closure	Refurbished premises	Achievable	31/07/2024	HSE Estates, Contractor, General Manager

	of the Unit. The Centre will reopen on the 31st July, 2024.				
Preventative Action	1.A comprehensive refurbishment program of works addressing communal space, ligature risk and to enhance the environment of the centre commenced in 2023. Phase 1 of the works was completed in September, 2023. Phase 2 of the works commenced on 18th October, 2023 with the temporary closure of the Unit. The Centre will reopen on the 31st July, 2024. 2.Monthly planned preventative maintenance meetings and quality and safety walkthroughs by nurse management and maintenance	1.Refurbished premises. 2.Preventative and Corrective Maintenance Plan for the unit to capture and track maintenance tasks and projects.	Achievable	31/10/2024	1.HSE Estates, Contractor, General Manager 2.ADON & Maintenance Dept

	will commence when reopened.				

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10004854		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices and relating to the administration of medicines to residents, as a clear record of the date of discontinuation was not recorded for one medication on one resident's Medication Prescription and Administration Record, 23 (1). The registered proprietor did not ensure that the approved centre had appropriate and suitable practices and relating to the administration of medicines to residents, as two entries on one resident's Medication Prescription and Administration Record were not legible, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1.All Medication Prescription and Administration Records were reviewed following the inspection, and the identified non-compliances were corrected. 2.The Clinical Director has send a memo to all prescribers within the unit regarding prescribing best practices as per the unit policy and the Judgment support framework.	Reviews completed post inspection, corrective actions completed.	Completed	10/04/2024	1.Medical Staff 2.Clinical Director
Preventative Action	1.Medication memo will be re-resent to all prescribers prior reopening of the unit by the Clinical Director 2.Medication best	Regular audit, results will be monitored and actioned by the audit group. Induction plan for new NCHD's	Achievable	31/10/2024	1.Clinical Director 2.Medical Tutor 3.Audit Group Chair

	practices will be discussed at NCHD teaching sessions. 3.Medication module included in NCHD induction at rotation.				

Regulation 26: Staffing					
Reason ID : 10004856		**The registered proprietor did not ensure that all staff had access to training to enable them to provide care and treatment in accordance with best contemporary practice, as not all healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26 (4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training is a standing item on the local Area Management Team Meeting and is reviewed on a monthly basis. All HOD are asked to prioritise mandatory training for their staff members.	100% compliance on mandatory training	Achievable	31/12/2024	All HOD
Preventative Action	All staff will have fire training prior to the centre re-opening following its temporary closure. Training is a standing item on the local Area Management Team Meeting and is reviewed on a monthly basis. All HOD are asked to prioritise mandatory training for their staff.	100% compliance with mandatory training. Staff Training Plan/Matrix in place	Achievable	31/12/2024	All HOD

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10004816		Age-appropriate facilities were not provided to a child admission, 2.5(b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A comprehensive refurbishment program of works addressing communal space, ligature risk and to enhance the environment of the centre commenced in 2023, allowing for the inclusion of an Ensuite bedroom on the first floor, and an additional service user sitting room and quite room on the ground floor.	Refurbished premises	Achievable	31/07/2024	HSE Estates, Contractor and General Manager
Preventative Action	All minors requiring inpatient treatment in the service area are facilitated by the CAMHS inpatient unit. In the rare and exceptional circumstance that the admission of a child occurs in CMHCR. They will be facilitated in a single Ensuite room and	Refurbished premises. Policy in place to support exceptional circumstances	Achievable	31/07/2024	HSE Estates, Contractor and General Manager

	have access to dedicated space for their recreational, activity and educational needs for the duration of their admission.				

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.

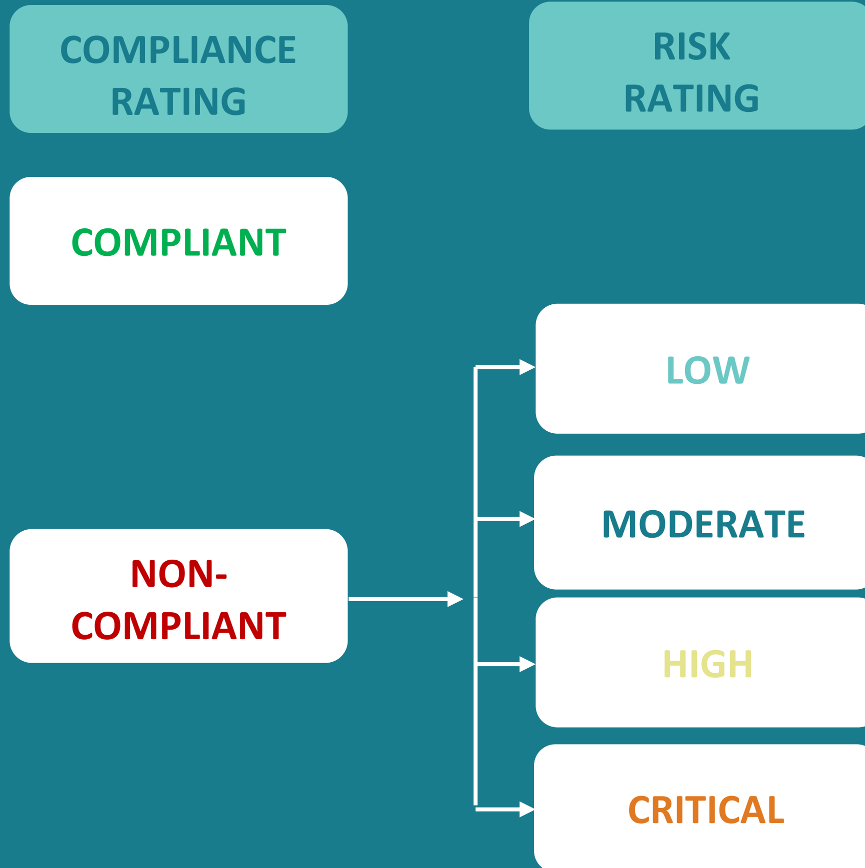
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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