Teach Aisling

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

TEACH AISLING

Westport Road, Castlebar, Co Mayo, F23R528

Date of Publication:
31 May 2024

ID Number: AC0172

2023 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
31 May 2022

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health Services

Inspection Team:
Barbara Murphy, Lead Inspector
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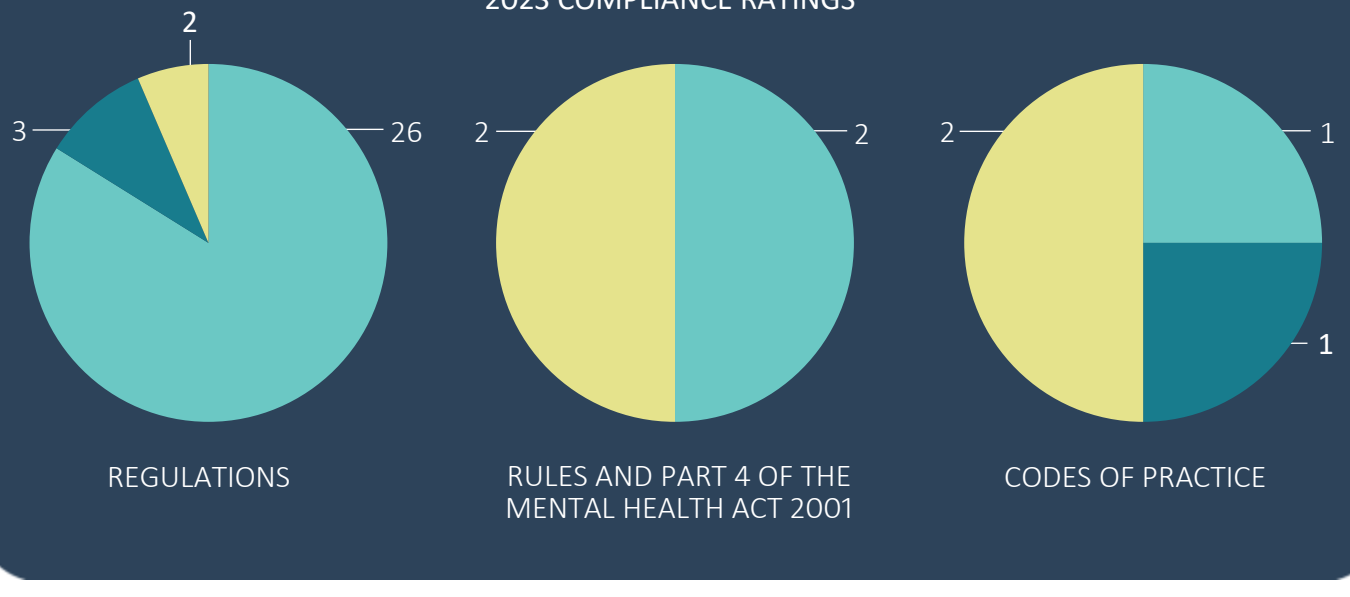
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
5 – 8 September 2023

Previous Inspection date:
15 – 18 February 2022

Inspection Type:
Announced Annual Inspection

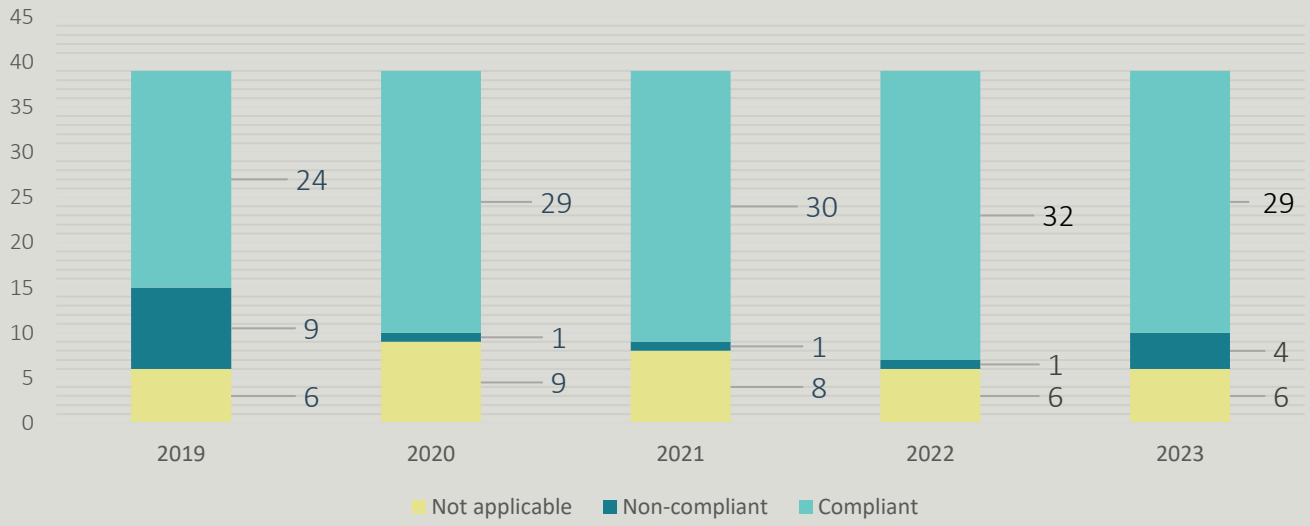
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

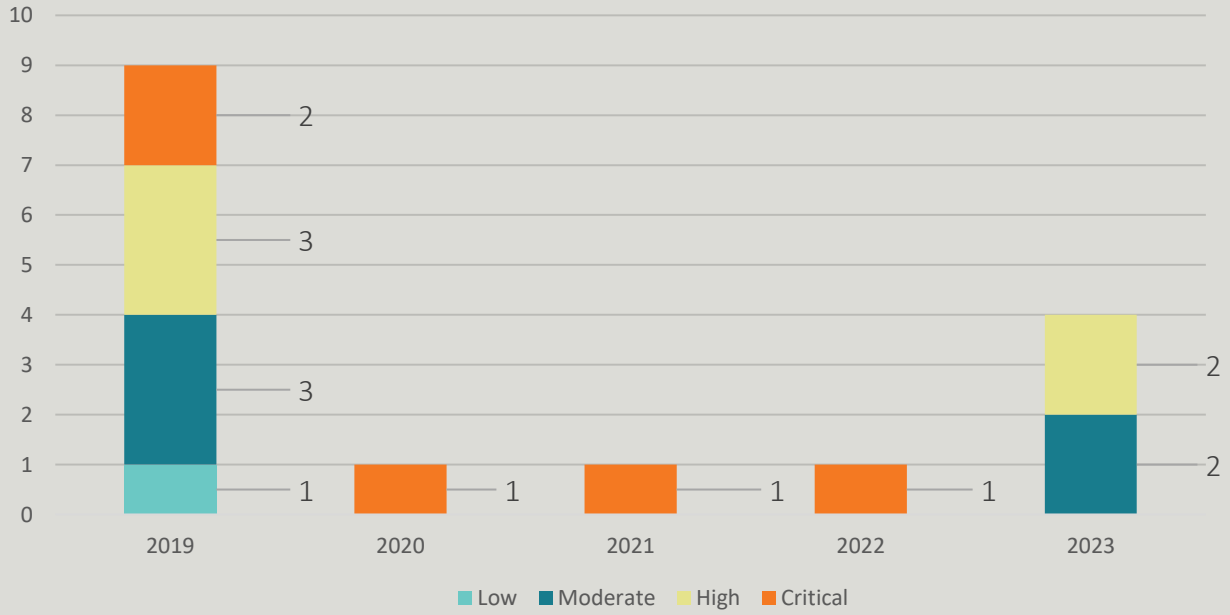
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Teach Aisling was located on the outskirts of Castlebar Co. Mayo. The approved centre was registered with the mental health commission as a long stay unit for people with enduring mental health and for mental health rehabilitation. Teach Aisling had developed as a specialised rehabilitation unit for residents and the staffing and therapeutic programmes reflected this. All of the residents were under the care of the Rehabilitation and Recovery specialist multi-disciplinary team. The approved centre was a purpose built, single storey building with single bedroom accommodation for eight residents.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	73%	97%	97%	97%	88%

Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency specified by the Commission.*	The approved centre was not in breach of Condition 1.
Condition 2: *To ensure adherence to Regulation 22: Premises, the approved centre shall develop and implement a*	The approved centre was not in breach of Condition 2.

costed, funded and time-bound plan which ensures that all residents of the approved centre are provided with appropriate accommodation which meets their needs. The approved centre shall provide a progress update on the development and implementation of this plan to the Mental Health Commission in a form and frequency specified by the Commission.	

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Number of registered nurses in the approved centre*:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** All staff were trained in the Mental Health Act 2001 and fire safety. Not all staff were trained in basic life support or management of aggression and violence. The approved centre provided evidence the training shortfalls occurred due to sick leave, injury leave, COVID-19 leave, maternity leave and the commencement of new members of staff. The approved centre had a comprehensive training schedule and a time bound plan to address the mandatory training needs of staff.
- ***Medication safety:*** The ordering, storing, prescription and administration 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:

- ***Ligature anchor points:*** Ligature points were not minimised to the lowest practicable level, based on individual risk assessment.

- ***Fire safety:*** Two sets of fire doors were damaged, which compromised fire safety and was not in accordance with the approved centre's risk management policy. The damaged fire doors were a health and safety risk which was not managed or mitigated by the approved centre.

Appropriate care and treatment of residents

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

- ***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.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) that documented the resident's needs; and goals that had been decided with the resident's input.
- ***Multi-disciplinary team working:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurses, a psychologist, a dietitian, a social worker, occupational therapist, art therapist, non-consultant hospital doctor, pharmacist and clinical nurse specialist in physical health. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line with residents' individual care plan, such as exercise, cooking, art therapy, and a spirituality group.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Individual care plans, rights-based care:*** In a sample of five ICPs inspected, in one ICP examined of a resident who had been physically restrained, the resident's ICP was not updated with the resident's preferences in the event where a restrictive intervention was required in the future, which means the ICP had not been updated as indicated by the resident's changing needs, condition, and circumstances.

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:*** Residents were accommodated in their own single, en suite bedrooms.
- ***Interactions between staff and residents:*** Staff in the approved centre respected 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.

- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. The approved centre did not use Mechanical Restraint.

  Use of restrictive practices: Physical Restraint: Physical restraint was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained by physical means, including information on attempts to reduce or eliminate the use of restraint for that person. It was not compliant with the Code of Practice on Physical Restraint for three different reasons in a sample of three physical restraint episodes inspected.

  Use of restrictive practices: Seclusion: The approved centre was compliant with the Rule on Seclusion.

Responsiveness to residents' needs

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

- ***Environment:*** The approved centre was adequately lit, heated and ventilated. There was suitable and sufficient heating in day areas and in bedrooms. Since the last inspection, painting had been completed and new flooring was installed in the activities room and some office spaces. The courtyard had been power-hosed and weeded.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Were appropriate and accessible to residents seven days a week.
- ***Residents' feedback:*** No residents availed themselves of the opportunity to speak with the inspection team. One resident questionnaire was completed which was complimentary of the approved centre's team, information provision, care planning, facilities and services provided in Teach Aisling. Care and treatment were rated at 10 out of 10 by the resident. Resident feedback from the advocacy report was extremely positive and an area of improvement was that residents would like to see the dietitian regarding managing health issues such as lowering cholesterol levels and to learn about portion sizes. ***(Please refer to section 5.0 for detailed service user feedback).***

However:

- ***Environment:*** The inside environment of Teach Aisling surrounding residents in the approved centre was not kept in a good state of repair everywhere, there were damaged wardrobes in a few bedrooms, lack of toilet paper dispenser installation, and water damage and stains were present on the corridor ceiling.

Governance, Leadership and Accountability

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

- ***Structure in place:*** Teach Aisling was governed under Mayo Mental Health Services (MMHS), which was part of the wider Community Healthcare West (CHW) network area for Galway, Mayo, and Roscommon. The Mayo Mental Health Services (MMHS) governance processes included the MMHS Area Management Team (AMT) meeting and the MMHS Quality and Patient Safety Committee (QPS) meeting.
- ***Leadership:*** There was evidence of supervision structures in place within each department. All heads of discipline were in continuous communication with staff members. Annual staff training analysis and plans were completed to identify and address training needs.
- ***Restrictive practices reduction:*** The approved centre had a reduction of restrictive practices strategy and was not compliant with the Code of Practice on Physical Restraint and was compliant with the Rule Governing Seclusion. Mechanical Restraint was not used in the approved centre.
- ***Risk:*** A multi-disciplinary operational group reviewed, monitored, and updated the approved centre's risk register. Risks were escalated from local to the area and CHW risk register as appropriate. Incident trends and analysis were discussed at the QPS meeting.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. The approved centre had implemented 8 quality initiatives since the last inspection, such as A Social Cognition and Interaction Training Group, which was co-facilitated by Occupational Therapy and psychology over 20 sessions. *(Please refer to section 2.0 for full list of quality initiatives).*
- ***Staff training:*** Not all staff were up-to-date in their training. The mandatory training progress record provided by the approved centre indicated shortfalls in Basic Life Support Training and Management of Violence and Aggression. There was evidence that these were unavoidable due to COVID-19, injury and sick leave and new staff members. There was a comprehensive plan and training schedule in place to address the deficits without delay.
- ***Complaints:*** There was a robust complaints process 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 were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** A representative from Peer Advocacy in Mental Health was available weekly to the residents of the approved centre. Their contact details were displayed in the approved centre. The service provided was a combination of in-person once a month and virtual or phone support to the residents.
- ***Regulatory compliance and engagement:*** The approved centre has had an excellent average compliance rate of 95% over the last 4 years. The compliance rate dropped by 9% since last year's inspection. The approved centre had two conditions attached to its registration at the time of the inspection in relation to Regulation 22: Premises, and it was not in breach of these conditions at the time of the inspection. It continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Risks:*** Ligature points were not minimised to the lowest practicable level, based on individual risk assessment. Two sets of fire doors were damaged, which compromised fire safety and was not in accordance with the approved centre's risk management policy. The damaged fire doors were a health and safety risk which was not managed or mitigated by the approved centre.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of a portable coffee dock to promote independence for residents to make hot drinks in a safe environment while enhancing social interactions within the approved centre.

2. Turlough Greenway Cycle; Residents were supported by the occupational therapist (OT) to cycle 10 km to promote physical health and wellbeing.

3. Teach Aisling Sports Day Event organised by OT and nursing staff to promote physical and psychological wellbeing and promote recovery through participation in a wide range of fun filled activities.

4. A Social Cognition and Interaction Training Group cofacilitated by OT and psychology with over 20 sessions.

5. Introduction of the Weekly Step Challenge by OT to promote physical health and wellbeing through fun, with spot prizes given.

6. Lakeshore Art Project; facilitated by Artist at Lough Lannagh and supported by OT and nursing. Residents painted views of Croagh Patrick and surroundings and resident's artwork is displayed in Teach Aisling.

7. Recycling project; to educate and promote a greener environment in Teach Aisling.

8. Creative song writing music group; residents wrote their own lyrics.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Teach Aisling was located on its own grounds off the Westport Road, on the outskirts of Castlebar. The approved centre was registered as a long stay unit for people with enduring mental health illness and for mental health rehabilitation. Teach Aisling had developed as a specialised rehabilitation unit for residents and the staffing and therapeutic programmes reflected this. The approved centre was a purpose-built, single storey building with accommodation for eight residents. The approved centre consisted of a central nursing station, communal sitting room, visitors room, dining room with kitchenette, laundry facility, activities room and pool room. These communal areas were linked by a large living area that was primarily used by one resident. There were occasions when the large living area was not accessible to the other residents. There were single en suite bedrooms which were decorated with residents' personal effects and furnished appropriate to each resident's needs. The bedrooms were along separate female and male corridors. There was an internal garden area that had new garden furniture. Residents of Teach Aisling were under the care of the Rehabilitation and Recovery specialist multi- disciplinary team. Two of the residents were actively preparing for independent community living. The suitable placement and care of one Teach Aisling resident had been under active discussion by senior clinical and business managers and were still ongoing, with an agreed final design in place and commencement of the tendering process.

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

Resident Profile	
Number of registered beds	***8***
Total number of residents	**8**
Number of detained patients	2
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	7
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Teach Aisling was governed under Mayo Mental Health Services (MMHS) which was part of the wider Community Healthcare West (CHW) network area for Mayo, Galway and Roscommon. Four approved centres resided within this catchment area. The Mayo Mental Health Services (MMHS) governance processes included the MMHS Area Management Team (AMT) meeting and the MMHS Quality and Patient Safety Committee (QPS) meeting. The area management team comprised of the Head of Service, Executive Clinical Director, Business Manager, Area Director of Nursing, Principal Psychologist, Occupational Therapy Manager, Principal Social Worker, Area Lead for Service User Engagement and Human Resources Manager.

The AMT convened monthly and provided oversight of the corporate and clinical functions of MMHS via sub-committees which reported to the AMT. These sub-committees included the Recovery College Operational Group, Infection Prevention and Control Group, the Health and Safety Group, the Drugs and Therapeutic Committee, the Judgement Support Framework group, Childrens First, the Community Living Implementation Group and the Therapeutic Services and Programmes multi-disciplinary group. Service budgets, policies for approval, skill mix of staff and performance management were also within the remit of the AMT. The Quality and Patient Safety (QPS) Committee meeting attendees were members of the senior team including the Quality and Patient Safety and Risk Advisor, some of these members also attended the AMT meeting which provided executive governance for Teach Aisling which convened monthly. The QPS meeting provided oversight of quality improvement through risk and incident management and disseminated recommendations and learning from adverse events/incidents.

A multi-disciplinary rehabilitation and recovery operational group comprised of the consultant, nurse managers, health and social care professionals and administration staff of the approved centre. The operational group met monthly and escalated unresolved local matters to the area management team. A Ligature Reduction Working group which comprised of business manager, consultant, maintenance manager, nurse managers and members of the multi-disciplinary was established in June 2023. The Terms of Reference was agreed and the first quarterly meeting scheduled for September 2023. Teach Aisling's MDT met weekly to discuss the service users care and treatment needs.

All clinical staff had received training on clinical risk management procedures appropriate to their role and function. There were key personnel with responsibility for risk management in the approved centre. The person with overall responsibility for risk was identified and known by staff. Responsibilities regarding risk were allocated at management level and the approved centre had access to the Quality and Patient Safety Advisor. The operational group reviewed, monitored, and updated the approved centre's risk register. Risks identified locally included the premises, risk of harm/injury due to ongoing challenging behaviour and ligatures.

There was an implemented programme of maintenance within the approved centre with updates provided to the Mental Health Commission. This was part of the requirements of condition one attached to the centre's registration in relation to Regulation 22: Premises. The ligature audit identified medium risk ligature points that had not been minimised to their lowest practicable level.

The approved centre had a local risk register and there was a process for escalation to the MMHS area risk register and the CHW risk register, if applicable. Risks identified in Teach Aisling, included the premises, risk of harm/injury due to ongoing challenging behaviour and ligature. The risk register rated risk of harm or injury to staff due to behaviours that challenge as high. This has been a persistent issue in Teach Aisling since entered onto the risk register in 2018. The premises was identified as unsuitable for one resident who required purpose-built accommodation on another site. There was a funded and time-bound plan in place within the approved centre with updates provided to the Mental Health Commission. This was part of the requirements of the second condition attached to the centre's registration in relation to Regulation 22; Premises.

Two episodes of seclusion of one resident were noted since the previous inspection. The approved centre did not have seclusion facilities and these episodes occurred in the living area, which was closed to other residents on these occasions.

There were risk management procedures and control measures in place; however, health and safety risks were not always adequately treated and managed. Fire doors in the corridor and the internal doors to the courtyard of the approved centre were not fully operational as they did not fully close when released by the electromagnetic door closer. The fire doors located in the large living area were locked with a key and the person in charge carried the door key. The rationale in place for this was for safety concerns of residents. These risks were not identified on the risk register. During the inspection, this issue were rectified once identified; all staff received a copy of the key. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and were reviewed to identify any trends or patterns occurring in the service. Analysis of incidents took place at the weekly multi-disciplinary meeting and serious incidents were reviewed at the monthly QPS meeting and feedback was given to staff of Teach Aisling through the relevant line managers.

Governance questionnaires were completed by each head of discipline and returned to the inspection team. Respondents provided a clear overview of the governance within their respective roles, issues of risk or specific concerns and outlined strategic goals for the service, and systems to monitor goal progression. A risk identified across all disciplines was the lack of office space in Teach Aisling for the health and social care professionals, who were all sharing the same office space and lack of accommodation in the community. A plan was in place to address the lack of space. The various committee's purposes, structures, responsibilities, and reporting relationships were well defined. A multi-disciplinary approach was fostered within governance structures and clinical care and the ethos of continuous quality improvement was visible. There was evidence of effective multi-disciplinary team work and comprehensive individualised care plans developed with residents and their representatives. The community living implementation group worked with Mayo Mental Health Services and local authorities to source accommodation and promote community integration for residents of the approved centre.

At the time of inspection, the approved centre was adequately staffed, and the numbers and skill mix of staffing were sufficient to meet resident needs. Members of the multi-disciplinary team included nursing, occupational therapy and psychology who were based in the approved centre. Social work and medical, pharmacy, dietetics and physical health nurse were accessible to residents in the approved centre on an in-reach basis. Speech and language therapy and physiotherapy were privately sourced and provided by approved and qualified health professionals.
In the area of mandatory training, not all staff were up to date in their training. The mandatory training progress record provided by the approved centre indicated shortfalls in Basic Life Support Training and Management of Violence and Aggression. There was evidence that these were unavoidable due to COVID-19, injury and sick leave and new staff members. There was a comprehensive plan and training schedule in place to address the deficits without delay.

There was evidence of supervision structures in place within each department. All heads of discipline were in continuous communication with staff members. The availability of clinical supervision varied across departments, ranging from formal to informal within their own disciplines and others facilitated by external providers. Not all disciplines had formal structures and processes in place for performance management

through appraisals. Annual staff training analysis and plans were completed to identify and address training needs.

Service user involvement in service delivery was facilitated by the availability of a suggestion box and at monthly resident meetings in the approved centre along with compliments and a complaints process to support service improvement.

The Area Lead for Mental Health Engagement attended the MMHS Area Management Team and the MMHS Quality and Patient Safety Committee meetings and linked in with the Peer Advocacy representative for Teach Aisling. The process of making complaints and the complaints officer contact details were displayed within the approved centre and in an information booklet. Minor complaints had been dealt with by the nominated complaints officer in the approved centre and were documented with clear actions and outcomes detailed in the complaints log. All formal complaints were reviewed at the Mayo Mental Health Services Complaints Committee meeting, with relevant actions identified if required. There had been no formal complaints were made since the last inspection. Residents were involved in the development and review of their individual care plans. Monthly resident community meetings took place in the approved centre, and this provided an opportunity for residents to raise concerns or make suggestions. A review of the meeting minutes indicated that activity planning and requests from residents were discussed.

A representative from Peer Advocacy in Mental Health was available weekly to the residents of the approved centre. Their contact details were displayed in the approved centre. The service provided was a combination of in person once a month and virtual or phone support to the residents.

Peer support workers visited the approved centre and engaged with and supported residents, both in groups and individually.

On 28 September 2022, the Mental Health Commission (MHC) published revised rules governing the use of seclusion and mechanical restraint, and a revised code of practice relating to the use of physical restraint in approved centres. The date of commencement for the code of practice and rules was the 1st of January 2023. At the time of inspection, the approved centre had used physical restraint and had integrated the revised code of practice. The Use of Physical Restraint Policy had been updated and Seclusion and Physical Restraint Reduction Policy was implemented, and an oversight committee was in place which had met quarterly. The Clinical nurse Manager III was the named senior manager with responsibility for the approved centre's reduction in restrictive practices. The approved centre had engaged in the use of positive behaviour support for residents involved in restrictive practices, however in one of the episodes of physical restraint, the person's individual care plan was not updated to reflect the outcome of the debrief.

The approved centre was proactive in managing issues concerning COVID-19. Community Health West implemented a COVID-19 governance structure through the COVID-19 crisis management team. MMHS introduced a policy on the prevention and management of the Transmission of COVID-19, which was reviewed and updated in January 2022 in line with national best practice guidelines from the Health Protection Surveillance Centre. This included, but not limited to, roles and responsibilities of staff, management of suspected or confirmed cases, face to face and remote consultations, visits and outbreak

protocols. There was an infection prevention and control clinical nurse available to Teach Aisling for advice and guidance.

3.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2019 and 2023 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 15: Individual Care Plan	✓		✓		✓		✓		✗	Moderate
Regulation 22: Premises	✗	High	✓		✗	Critical	✗	Critical	✗	High
Regulation 32: Risk Management Procedures	✗	High	✓		✓		✓		✗	High
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	Low	✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, 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 Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

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:

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

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

The residents were given the opportunity to speak with the inspection team and to complete feedback questionnaires. No residents availed themselves of the opportunity to speak with the team.

One resident questionnaire was completed which was complimentary of the approved centre's team, information provision, care planning, facilities and services provided in Teach Aisling.

The questionnaire indicated that:

- the resident knew who their multi- disciplinary team members were, they were 'always' involved in setting their goals for the individual care plans,
- they understood their care plan, and knew who their key worker was.
- they were happy with how staff spoke to them, and they were always given information about their diagnosis/care/treatment/medication in a way they understood.
- their privacy and dignity was respected, there were enough activities, they felt safe, could discuss worries/concerns and felt able to give feedback.

Care and treatment were rated at 10 out of 10 by the resident.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors did receive a report from the Peer Advocacy in Mental Health representative. Residents reported they appreciated the outdoor space in Teach Aisling including the courtyard area, especially in the good weather. Residents reported that they enjoyed spending time with the Occupational Therapist and engaging in the many OT activities. Residents reported there was a wide range of groups that were beneficial to their health and wellbeing, examples given included exercise groups, psychology group, spirituality group, football and walking groups. Residents enjoyed social outings, attending events, going to the swimming pool, lake, shopping and gym. Residents reported they enjoyed visits and outings with their peer support workers. Residents reported they appreciated the internal of the approved centre being repainted, liked the new wall colourings and the artwork/pictures displayed throughout Teach Aisling. Residents reported they received good care and treatment from all staff. Residents reported it was lovely when a remembrance service were held in the approved centre for a former resident who had passed away.

There were some areas in need of approvements that were identified by the residents. Some residents reported they would like to move on and have their own accommodation. Some residents reported that it was quiet in the approved centre and that they would like to go out more on their own. It was reported that residents would like to see the dietitian regarding managing health issues such as lowering cholesterol levels and learn about portion sizes.

6.0 Feedback Meeting

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

- Registered Proprietor
- Executive Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Managers 3 x 2
- Compliance Advisor
- Dietitian Manager
- Principal Psychologist
- Principal Social Worker
- Occupational Therapist Manager
- Occupational Therapist
- Business Manager
- Area Lead of Mental Health Engagement
- Consultant Psychiatrist
- Maintenance Manger

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. Menus were rotated on a monthly basis, and the dietitian was involved in menu selection. 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. Speech and language therapy assessments were undertaken and recorded 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 off-site and delivered to Teach Aisling. 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 their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in May 2023. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents had access to a pool table and a treadmill, as well as arts, crafts, and mindful colouring. Recreational activities included art, music, walks, and outings.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. A communion service was facilitated weekly, along with an art and spirituality session facilitated by an artist. Mass was held in the approved centre every three months. Residents could attend religious services in the community or watch mass on TV, and the priest was available to visit 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 2021.

Visiting times were appropriate and reasonable. There were no visiting restrictions in place at the time of the inspection. The approved centre provided a clean and bright room 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. The visiting room was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents could their own mobile phones or devices, and access was also provided to a portable phone and electronic tablet. Wi-fi (of variable quality) was available to the residents.

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

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in March 2022, 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 file of one resident was examined on inspection in relation to the search process. Risk was assessed prior to the search, as appropriate to the type of search being undertaken. General written consent was sought for routine environmental searches. 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.

A minimum of two clinical staff were in attendance at all times during the search. Due regard was shown to the resident’s dignity, privacy, and gender. 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 June 2021.

No end of life had been provided in the approved centre since the last inspection. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

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 reviewed by the MDT in consultation with the resident every one-to-three months. The ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances and goals.

However, in one ICP inspected, care and treatment in relation to physical restraint were not noted in the ICP. The ICP was not updated with the resident's preferences in the event where a restrictive intervention was required in the future; as such, the ICP had not been updated as indicated by the resident's changing needs, condition, and circumstances.

The approved centre was non-compliant with this regulation because in one individual care plan, the care and treatment was not updated as indicated by the resident's changing needs, condition and circumstances.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). There were two occupational therapists (OTs) in the approved centre who undertook a range of group work and one-to-one sessions. Groups included a morning "wake and stretch" group (including exercise and relaxation), a cooking skills group, a social cognition/interaction training group (which had been co-facilitated with the psychologist), a "tea and check" group (which involved reflection and goal-setting), and a spirituality group. An art therapist attended the approved centre once a week and undertook individual sessions with residents.

Community-based groups were facilitated for the purpose of promoting social integration: these included the "kickstart group", in which residents were encouraged to either play football or support from the sidelines; and a gym group, where residents attended the local gym either to exercise or engage in social activity. Various social outings were also facilitated to support social integration, including bowling and cycling on the greenway. The psychologist conducted individual sessions with the residents as well as co-facilitating groups with the OTs. The social worker attended the approved centre on an in-reach basis, and met one-to-one with residents.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

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 May 2023. The clinical file of one resident who had been transferred from the approved centre in an emergency situation was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. Communications between the approved centre and the receiving facility were documented and followed up with a written referral.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

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

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

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in September 2021.

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

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

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Access to interpretation and translation was available if 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 were 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. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space: each resident had an en suite single room. Appropriately sized communal rooms were provided: there were two communal spaces and a courtyard. There was suitable and sufficient heating in day areas and bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points, however, were not minimised to the lowest practicable level, based on risk assessment.

Since the last inspection, painting had been completed and new flooring added to the activities room. The courtyard had been power-hosed and weeded. However, the approved centre was not kept in a good state of repair internally. Damaged wardrobes were noted in several bedrooms. Fire doors on the corridor and internal doors to the courtyard were damaged and not closing properly. The corridor ceiling had water stains. There was a lack of toilet paper dispenser installation.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs, and furnished 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 internally, as damage to wardrobes, lack of toilet paper dispenser installation, and water damage to the corridor ceiling were evident, 22(1)(a).**
b) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and well-being of residents, staff and visitors: two sets of fire doors were damaged, which compromised fire safety, 22(3).**
c) **Ligature points were not minimised to the lowest practicable level, based on risk assessment, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in June 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 detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

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

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.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written health and safety policy (last reviewed in May 2023), and a Safety Statement (last reviewed in July 2023).

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

The approved centre had one multi-disciplinary admitting team, which included psychiatry, nursing, occupational therapy, social work and psychology. 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 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 staff were trained in basic life support or management of aggression and violence. The approved centre provided evidence the training shortfalls occurred due to sick leave, injury leave, COVID-19 leave, maternity leave and the commencement of new members of staff. The approved centre had a comprehensive training schedule and a time bound plan to address the mandatory training needs of staff.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (27)	23	85%	27	100%	21	78%	27	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%

Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%
Other MTA (2)	1	50 %	2	100%	2	100%	2	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in July 2022, 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 unauthorised access. Documentation of food safety and health and safety 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 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 if requested.

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 September 2021, 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. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented. No formal complaints had been made since the last inspection.

The registered proprietor ensured that the quality of service, care, and treatment was not adversely affected by reason of the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy on risk management (last reviewed in October 2022), a Safety Statement (last reviewed in July 2023), and an absence without authorised leave policy (last reviewed in January 2022). These policies and procedures included the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- 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.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Three sets of doors which were used as fire doors in the approved centre were not fully functional at the time of inspection. On one set, the door closer hinge was broken, and the doors would not fully close when released by the electromagnetic door closer. The second door did not close fully when released by the electromagnetic door closer, got stuck, making it difficult to open and close.

Fire doors located in the large living area were locked and the person in charge of the shift was the only person with access to the key. During the inspection, a copy of the key was given to all staff in the approved centre after the issue was highlighted.

Clinical risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate.
Health and safety risks were not identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Fire risks associated with defective fire doors were not assessed and identified on the approved centre's risk register, with the result that the risk had not been mitigated or managed. However, during the inspection, a risk assessment was completed, and the approved centre's risk register was updated to include the fire risks.

Structural risks, including ligature points, were removed or effectively mitigated. Corporate risks were identified, assessed, treated, reported and monitored by the approved centre, and documented in the risk register as appropriate.

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during resident seclusion, physical restraint, resident transfer, and resident discharge. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided 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 non-compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that all health and safety risks were appropriately identified, assessed, treated, reported and monitored in the approved centre in accordance with the risk management policy, as the fire risk associated with the defective fire doors were not assessed and identified on the local risk register as a risk. As a result, there were no methods to manage or mitigate the risk, 32(1).**

b) **The registered proprietor did not ensure that all health and safety risks were adequately identified, assessed, treated, reported and monitored in accordance with the risk management policy as the fire doors in the large living area could not be open when released, as the doors were locked with the key, 32(1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with two conditions to registration attached. The certificate was displayed prominently in the foyer at the entrance of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was last reviewed in last reviewed in January 2023. It included all the policy requirements for the rules governing the use of seclusion.

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

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

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

Monitoring: A multi-disciplinary review and oversight committee had been established to analyse every episode of seclusion in detail and was meeting on a quarterly basis. However, the review and oversight committee did not identify any areas for improvement, or identify the actions to be carried out, the persons responsible and the timeframes for completion of the actions.

Evidence of Implementation: The area used for seclusion was furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's

privacy was respected. There were no ligature points. The room allowed for staff to clearly observe the resident in the area being used as a seclusion facility. The room had externally controlled heating and air conditioning which enabled those observing the resident to monitor the room temperature. Seclusion facilities were not used as bedrooms, nor bedrooms used as seclusion facilities.

Orders for Seclusion: Three episodes of seclusion, all involving the same resident, were reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in the resident's best interests, when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including a risk assessment, and after all other interventions to manage the resident's unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner (RMP) and/or registered nurse (RN). A consultant psychiatrist (CP) was notified as soon as practicable of the use of seclusion. The seclusion orders did not last longer than eight hours. The resident was informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless this was detrimental to the resident. Where the resident was not informed of this, the reason was documented in the clinical file.

Cultural awareness and gender sensitivity was demonstrated. The resident's clothing respected their right to dignity, bodily integrity, and privacy.

A registered nurse undertook direct observation for the first hour following the initiation of the seclusion episode. A written record of the resident's well-being was made by a nurse every 15 minutes, including the level of distress and behaviour displayed by the resident. One of the seclusion episodes lasted for 20 minutes only; in the other two episodes, a nursing review took place every two hours (following risk assessment), and a medical review of the resident was undertaken no later than four hours after the commencement of the episode.

The resident was informed of the ending of each episode of seclusion, and the reason for ending seclusion was recorded in the clinical file. All uses of seclusion were clearly recorded in the clinical file and on the seclusion register. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of each episode. A copy of the seclusion register was placed in the clinical file. The episodes were reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment for each patient; one was deemed to have capacity to consent, and the other was unable to consent.

In respect of the patient who had capacity to consent, there was a written record of consent which detailed the following:

- The name of the medications prescribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of a discussion with the patients, including on the nature and purpose of the medications, the effects of medications such as the risk and benefits, and any views expressed by the patient.

- Any supports provided to the patient in relation to the discussion and their decision-making.

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

- The names of the medications proscribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in January 2023, and included all the policy-related criteria for this code of practice.

Policies and procedures regarding staff training included the following:

- Who will receive training based on the identified needs of residents who are restrained and staff.
- The identification of appropriately qualified person(s) to give the training.
- The mandatory nature of training for those involved in physical restraint.
- The areas to be addressed within the training programme.

The approved centre had a written policy on the reduction of physical restraint. The policy was last reviewed in February 2023, and included all the policy-related criteria for this code of practice.

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

Monitoring: The approved centre had a multi-disciplinary review and oversight committee which met quarterly to analyse every episode of physical restraint in detail, and determine if there was compliance with the code of practice and with the approved centre's own policies and procedures for each episode reviewed. However, the review and oversight committee did not identify and document an area for improvement. A medical review had not occurred within two hours after of the start of one physical restraint episode; this was not highlighted within the minutes or on the report provided for that time frame as an area for improvement.

Evidence of Implementation: Three separate episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there were no other less restrictive methods available to manage the residents' presentation. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical flies. In two of the episodes, a physical examination of the resident was completed no later than two hours after the start of the episode. However, for one episode, the medical examination did not take place within two hours.

The orders for physical restraint did not exceed a duration of 10 minutes. The clinical practice forms were 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 consultant psychiatrist within 24 hours.

The residents were informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical file as soon as was practicable. The Mental Health Commission was notified of the start time and date, and the end time and date, of each episode of physical restraint in the correct format and within three days of each episode.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the person's ICP pertaining to the person's specific requirements or needs in relation to the use of physical restraint. There was documented evidence that the principles of trauma-informed care were used where applicable. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy.

The residents were continuously assessed throughout the uses of restraint to insure their safety, and there was documented evidence that:

- The resident's head and neck were protected and supported where necessary.
- The resident's airway and breathing was not compromised.
- Effective communication was maintained with the resident, and the resident's physical and psychological health was monitored for as long as clinically necessary after using physical restraint.

Ending of Physical Restraint: The physical restraint in each instance was ended by the person who had led it. The time, date, and reason for ending the physical restraint was recorded in the clinical file on the date that each episode ended.

The residents were given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. This occurred within two working days of each episode of physical restraint, unless it was the preference of the resident who was restrained to have the debrief outside of this timeframe. The decision of the resident not to participate in the debrief, if that was their wish, was respected. A record of this was maintained and recorded in the resident's clinical file.

For the resident who agreed to participate, the debrief included a discussion regarding the resident's preferences in the event where a restrictive intervention was needed in the future (for example, preferences in relation to which restrictive intervention they would not like to be used). However, the resident's individual care plan was not updated to reflect the outcome of the debrief; in particular, the resident's preferences in relation to restrictive interventions going forward.

There was a record of all attendees who were present at the debrief and this was included in the clinical file. Appropriate emotional support was provided to the person following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

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

Clinical Governance: The episodes of physical restraint were reviewed by members of the multi-disciplinary team within five working days from the date of each episode. The review included the following:

- The identification of the trigger events which contributed to the restraint episode.
- A review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support.
- The identification of alternative de-escalation strategies to be used in future.
- The duration of the restraint episode and whether this was for the shortest possible duration.
- Consideration of the outcomes of the person-centred debrief, if available.
- An assessment of the factors in the physical environment that may have contributed to the use of restraint.

The multi-disciplinary team recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

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

a) **In one episode of physical restraint, a medical examination was not completed within two hours after the start of the restraint, 3.4.**
b) **Following an in-person debrief for an episode of physical restraint, the resident's individual care plan was not updated to reflect the outcome of the debrief, in particular the resident's preferences should a restrictive intervention be used in the future, 5.5.**
c) **The multi-disciplinary review and oversight committee did not identify and document an area for improvement: a medical review had not occurred within two hours of the start of one physical restraint episode, and this was not highlighted within the minutes or on the report provided for that time frame as an area for improvement, 7.8(iii).**

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

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. 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. 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.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10004865		**In one individual care plan, the care and treatment was not updated as indicated by the resident's changing needs, condition and circumstances.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified Individual Care Plan was reviewed and updated to reflect appropriate goals, care and treatment for the persons changing needs, conditions and circumstance.	Quarterly audits of regulation 15.	Yes	30/09/2023	Area Director of Nursing, Executive Clinical Director, Occupational Therapy Manager, Principal Social Worker & Principal Psychology Manager.
Preventative Action	An MDT working group has been established to review and develop a Recovery Individual Care Plan document for the Approved Centre. A review of the literature has been completed and a draft document is being developed for consultation and will be piloted. Continue to complete quarterly care plan audits. Most recent audit	Quarterly audits of Regulation 15.	Yes	30/06/2024	Area Director of Nursing, Executive Clinical Director, Occupational Therapy Manager, Principal Social Worker & Principal Psychology Manager.

	completed on 27th Dec 2023.				
Regulation 22: Premises					
Reason ID : 10004860		**The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and well-being of residents, staff and visitors: two sets of fire doors were damaged, which compromised fire safety, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All fire doors were assessed and fixed at the time of inspection by maintenance department. A Fire Safety Register has been implemented which includes weekly checks of extinguishers, means of escape, fire action notices, fire alarm systems, electrical & hazard control. Fire doors monitored as part of the HSE Fire Safety Guidelines - Fire Safety Register has also been commenced.	Weekly checks by person in charge. Completion of Fire Safety Register.	Achievable	30/09/2023	Area Director of Nursing, Business Manager, Maintenance Manager.
Preventative Action	A Fire Safety Management Plan is in place within the Approved Centre. Six monthly inspection of Fire Doors completed by	Weekly checklist completed as part of the Fire Safety Register. Annual maintenance audit with 3 monthly reviews and updates	Achievable	19/07/2024	Area Director of Nursing, Business Manager, Maintenance Manager.

	maintenance department. Next one due on the 4th April 2024. Fire Protection equipment, fire evacuation and training, testing/ service arrangement for firefighting equipment & emergency lighting, fire detectors/alarm systems and unit equipment checks, are all addressed within the Fire Safety Register. Any fire doors identified as requiring attention are reported immediately to maintenance department.	involving Nurse management, Infection Prevention and Control (IPC) Nurse, Maintenance Manager and Business Manager.			
Reason ID : 10004861		**Ligature points 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	Following completion of ligature audit all identified ligature anchor points were risk rated and action plans developed. A number of identified ligatures have been reduced,	Annual Ligature audit completed as per the HSE Mental Health Services: Ligature Risk-Reduction Policy and Audit Tool. Quarterly reviews and updates by Ligature Reduction Group.	Yes	31/07/2024	Business Manager, Nurse Management & Maintenance Manager.

	for example: reduced ligature wardrobes and reduced ligature lockers installed in all bedrooms, ligature reduction curtains in all resident areas. The Ligature Reduction Group review and update the ligature reduction plan 3 monthly or more frequently if required.				
Preventative Action	Annual ligature audit as per National Ligature Risk Reduction Policy and Ligature Risk Reduction Audit Tool with quarterly reviews utilised to reduce ligatures to the lowest practicable level. Most recent ligature reduction group meeting held on 13th Feb 2024 and plan updated.	Annual Ligature Audits with quarterly reviews and updates.	Yes	31/07/2024	Business Manager, Nurse Management & Maintenance Manager.
Reason ID : 10004862		**The approved centre was not kept in a good state internally, as damage to wardrobes, lack of toilet paper dispenser installation, and water damage to the corridor ceiling were evident, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	All Wardrobes replaced with reduced ligature wardrobes in all residents bedrooms. Reduced ligature lockers also installed in all bedrooms All broken or damaged toilet paper dispensers have been replaced. The service has identified a UK company that specialise in reduced ligature fixtures and fittings. They met with the service (March 2024) and displayed their products. They can supply magnetic plates to mount toilet paper dispensers. A sample is to be trialled in one area to ensure it meets the necessary standards and requirements. Water damage to corridor ceiling reported to maintenance department.	Annual Premises audit with 3 monthly reviews and updates involving Nurse management, Infection Prevention and Control (IPC) Nurse, Maintenance Manager and Business Manager.	Yes	30/06/2024	Business Manager, Nurse Management & Maintenance Manager

	Painting Contractor has been contacted and awaiting for commencement date.				
Preventative Action	Cleaning schedule in place and overseen by Infection Prevention Control Nurse and the Contract Cleaners Supervisor. Regular walk around by nurse managers. Any identified maintenance issues reported to Maintenance department. Continue to review and update Premises audit involving key stakeholders. Reviewed and updated audit findings 3 monthly.	Annual Premises audit with 3 monthly reviews and updates with Nurse management, IPC, Maintenance Manager and Business Manager.	Yes	30/06/2024	Business Manager, Nurse Management & Maintenance Manager.

Regulation 32: Risk Management Procedures					
Reason ID : 10004863		**The registered proprietor did not ensure that all health and safety risks were appropriately identified, assessed, treated, reported and monitored in the approved centre in accordance with the risk management policy, as the fire risk associated with the defective fire doors were not assessed and identified on the local risk register as a risk. As a result, there were no methods to manage or mitigate the risk, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	At the time of inspection the risk was identified, assessed and reported to maintenance department and was awaiting agreement at the Rehab Team monthly Business/Operations meeting to be escalated to the local risk register, as per local policy. The process requires that risks are brought to the Rehab Team Business/Operation Meeting to be agreed and escalated to the local risk register. The risk was brought to the next business/operation meeting on the 08/09/2023, agreed	Monthly reviews of risk register at the Rehab Team Business/ Operation Meeting.	Yes	08/09/2023	Area Director of Nursing, Business Manager, Maintenance Manager & QPS Advisor.

	and escalated to the Mayo Mental Health Service risk register.				
Preventative Action	A Fire Safety Management Plan is in place within the Approved Centre which includes the following: Fire Protection equipment, fire evacuation and training, testing/service arrangement for firefighting equipment & emergency lighting, fire detectors/alarm systems and unit equipment checks. Weekly checks are completed by person in charge.	Audit of Reg 22: Annual Premises audit with 3 monthly reviews and updates involving Nurse management, Infection Prevention and Control (IPC) Nurse, Maintenance Manager and Business Manager. 6 monthly fire door checks. Weekly checklist completed as part of the Fire Safety Register	Achievable	19/07/2023	Area Director of Nursing, Business Manager, Maintenance Manager.
Reason ID : 10004864		**The registered proprietor did not ensure that all health and safety risks were adequately identified, assessed, treated, reported and monitored in accordance with the risk management policy as the fire doors in the large living area could not be open when released, as the doors were locked with the key, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified issue was immediately resolved at the time of inspection and evidence provide during the inspection process. All staff members are supplied with a	Weekly checklist completed as part of the Fire Safety Register	Yes	05/09/2023	Area Director of Nursing, Business Manager, Maintenance Manager.

	key to the door in question.				
Preventative Action	A Fire Safety Management Plan is in place within the Approved Centre which includes the following: Means of escape, fire protection equipment, fire evacuation and training, testing/service arrangement for firefighting equipment & emergency lighting, fire detectors/alarm systems and unit equipment checks.	Audit of Reg 22: Premises 6 monthly fire door checks	Yes	12/07/2023	Area Director of Nursing, Business Manager, Maintenance Manager.

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10004866		**The multi-disciplinary review and oversight committee did not identify and document an area for improvement: a medical review had not occurred within two hours of the start of one physical restraint episode, and this was not highlighted within the minutes or on the report provided for that time frame as an area for improvement, 7.8(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Mayo Mental Health Services Multidisciplinary Review and Oversight Committee has been established. The group meet quarterly to provide an oversight and review function for restrictive practices within the Approved Centres. The multi-disciplinary review and oversight committee have been made aware of the non-compliance and will pay more attention documenting any non-compliance in minutes of the meetings.	Minutes of Mayo Mental Health Services Multidisciplinary Review and Oversight Committee	Yes	30/09/2023	Executive Clinical Director, Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker, Area Lead for Mental Health Engagement and Recovery, QPS Advisor & Principal Psychology Manager.
Preventative Action	All committee members to review minutes and if any omission to contact chair and include details in the draft minutes for approval at the next meeting.	Minutes of Mayo Mental Health Services Multidisciplinary Review and Oversight Committee.	Yes	30/09/2023	Executive Clinical Director, Area Director of Nursing, Occupational Therapy Manager, Principal Social Worker, Area Lead for Mental Health Engagement and Recovery, QPS Advisor & Principal Psychology Manager.

	The Committee must document any areas for improvement with regard to reducing restrictive practices. The Committee must identify the actions required for these improvements, the persons responsible for the actions and the timeframe for completion of these actions as required.				
Reason ID : 10004867		**Following an in-person debrief for an episode of physical restraint, the resident's individual care plan was not updated to reflect the outcome of the debrief, in particular the resident's preferences should a restrictive intervention be used in the future, 5.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A person centred de-brief was afforded to the identified person within the timeframes specified in the updated Code of Practice on the Use of Physical Restraint. The person did not express a preference should a restrictive intervention be used in the future. The person's Individual Care Plan was updated to reflect that a preference was not indicated by the person. The person's	Reviews of Restraint Care plan booklet at next MDT meeting. Quarterly audits of physical restraints in the Approved Centre	Yes	30/09/2023	Area Director of Nursing, Executive Clinical Director, Occupational Therapy Manager, Principal Social Worker & Principal Psychology Manager.

	Individual Care Plan also referenced the positive behaviour support plan that was in place to support the person to avoid episodes of behaviours of concern.				
Preventative Action	All episodes of physical restraint are reviewed and discussed at the next multi-disciplinary team meeting. Quarterly audits are completed against the updated Code of Practice on the Use of Physical Restraint. Action developed if required and findings circulated to all key stakeholders. Quarterly Individual Care plan audits are also completed to ensure the care plan is updated to reflect the persons changing needs, conditions and circumstance.	Quarterly audits of physical restraints in the Approved Centre	Yes	30/09/2023	Area Director of Nursing, Executive Clinical Director, Occupational Therapy Manager, Principal Social Worker & Principal Psychology Manager.
Reason ID : 10004868		**In one episode of physical restraint, a medical examination was not completed within two hours after the start of the restraint, 3.4**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All medical examinations must	Reviews of Physical Restraint Care plan	Yes	30/09/2024	Executive Clinical Director.

	occur within 2 hours after the start of an episode of physical restraint. This has been reiterated to all Consultant Psychiatrists and all Non Consultant Hospital Doctors.	booklet at next MDT meeting. Quarterly audits of physical restraints in the Approved Centre			
Preventative Action	All episodes of physical restraint are reviewed and discussed at the next multi-disciplinary team meeting. Quarterly audits are completed and action developed if required. Findings circulated to all key stakeholders.	Quarterly audits of physical restraints in the Approved Centre	Yes	30/09/2024	Executive Clinical Director.

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.

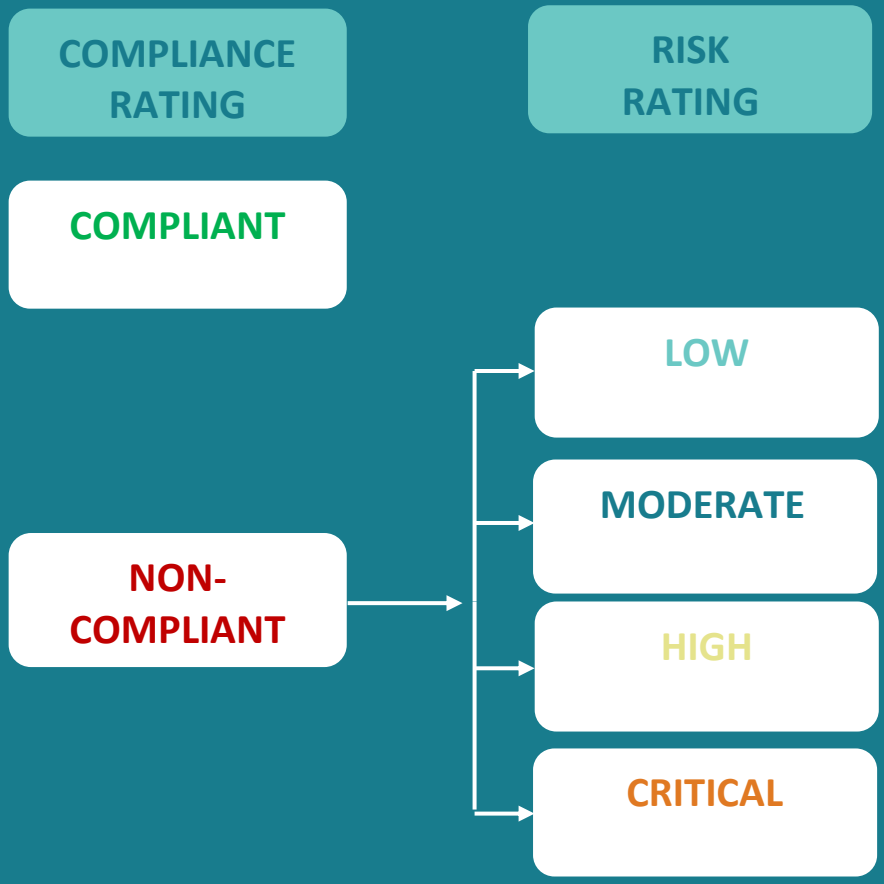
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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