Acute Psychiatric Unit, Cavan General Hospital

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ACUTE PSYCHIATRIC UNIT, CAVAN GENERAL HOSPITAL

Lisdarn, Cavan, H12N889

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2023 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Pauline Ackermann,
General Manager, Mental Health, CHO 1

Inspection Team:
Damien Lanigan, Lead Inspector
Aoife Gallaher
Barbara Murphy
Carol Brennan-Forsyth

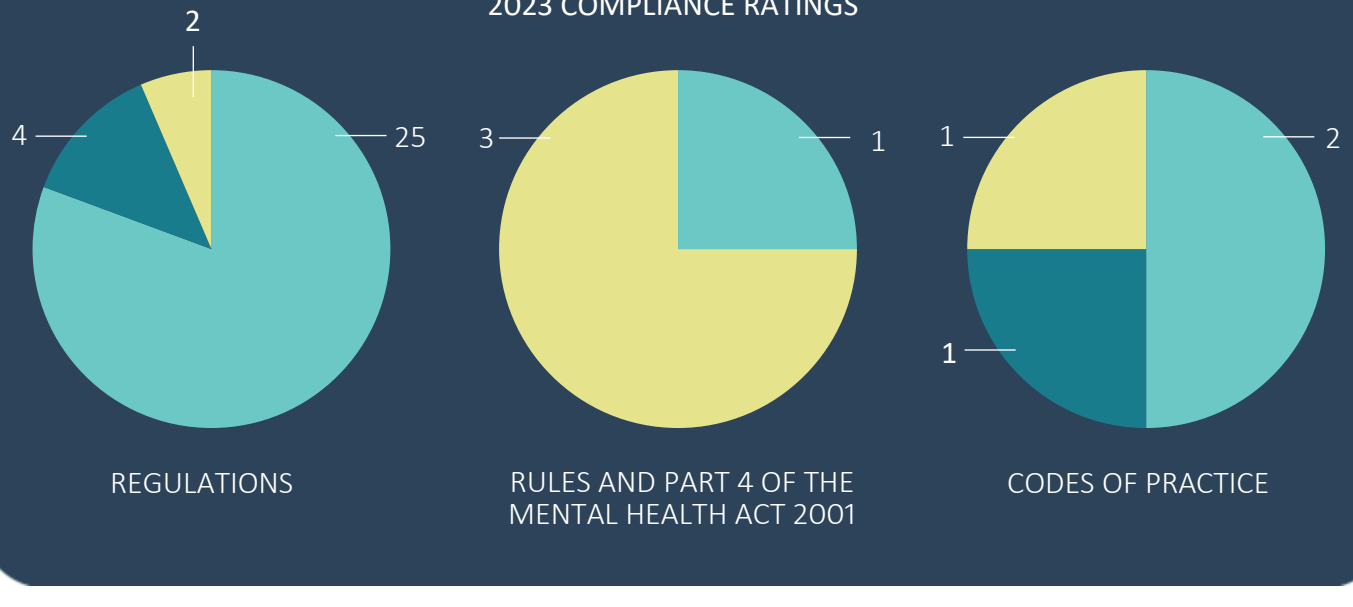
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
17 – 20 October 2023

Previous Inspection date:
16 – 19 August 2022

Inspection Type:
Announced Annual Inspection

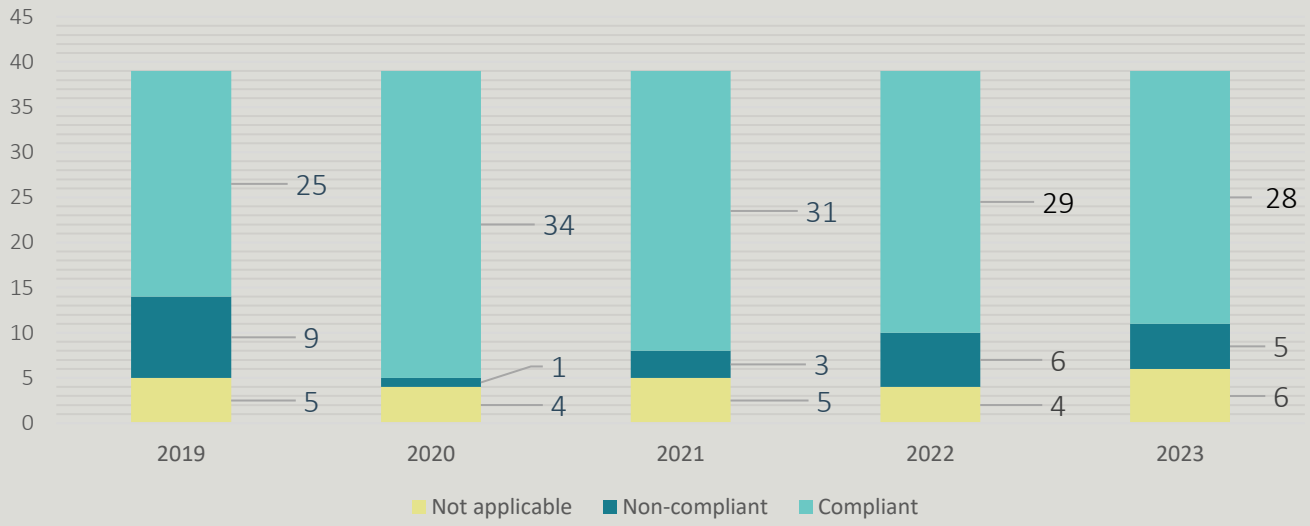
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

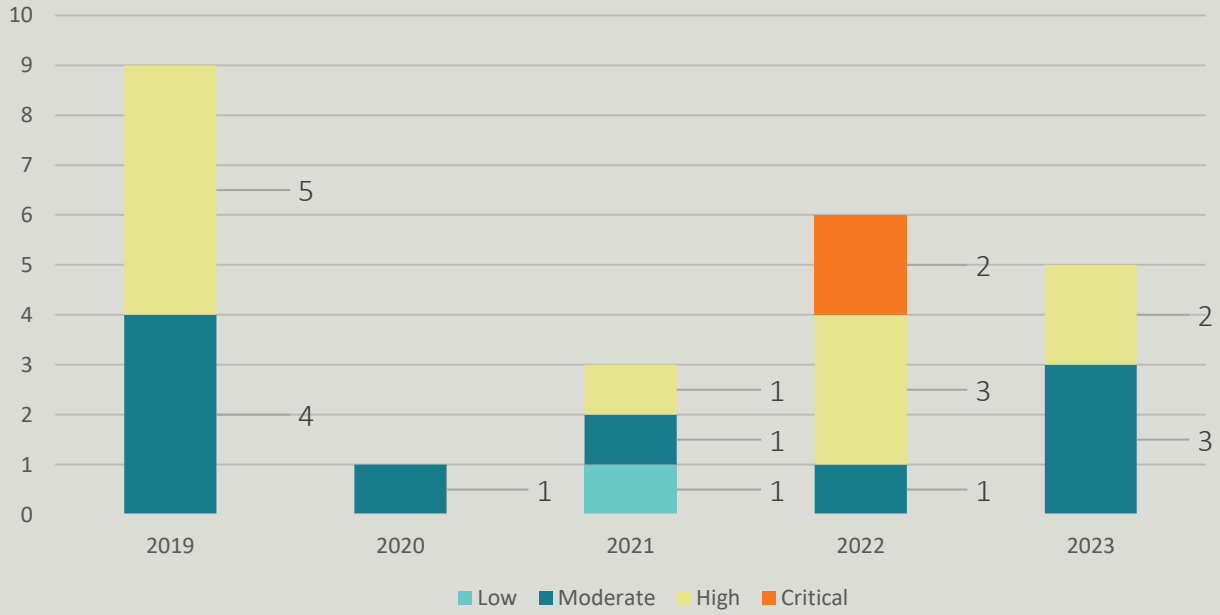
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

The Acute Psychiatric Unit (APU) was a 25-bed unit on the lower ground floor of Cavan General Hospital, and at the time of inspection 19 residents were accommodated. The adult community mental health sector teams referred residents for inpatient care, and inpatient care was managed by a dedicated inpatient treating team working in the approved centre.

The Psychiatry of Later Life (POLL) team also admitted to the approved centre and this team managed the care and treatment of these residents. The inpatient treating team consisted of a consultant psychiatrist, nursing staff, medical staff, an occupational therapist, a social worker and administration staff. There was also input from the Child and Adolescent Mental Health Service (CAMHS) team when necessary.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	74%	97%	91%	83%	85%

Conditions to registration

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

Conditions	Findings
Condition 1: *The registered proprietor must develop and implement a costed, funded, and timebound plan to ensure compliance with Regulation 22: Premises. The plan must detail how ligature risks will be addressed and minimised. The registered proprietor shall provide updates on the implementation and progress of the plan in the form and frequency prescribed by the Mental Health Commission.*	The approved centre was not in breach of Condition 1.

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*1/9/2022*	*To provide information on plans associated with critical risks identified with Regulation 22: Premises on inspection.*	*Approved centre was requested to provide plans in advance of the regulatory compliance meeting*
Regulatory compliance meeting	*12/9/2022*	*To provide plans to mitigate the critical risks identified with Regulation 22: Premises on inspection*	*Detailed explanation of the plans were outlined at the Regulatory Compliance Meeting. MHC continue to monitor the implementation of the corrective actions outlined during the meeting.*

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:

- ***Cleanliness***: The approved centre, including bedrooms, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Medication safety:*** The ordering, storing, 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:

- ***Cleanliness***: The approved centre was not clean on the outside area, buckets used for cigarette butts were dirty, and paving outside was dirty, and the exit to the garden was dirty with cigarette butts on the floor. Toilet bowls and sinks were stained.
- ***Ligature points:*** were not minimised to the lowest practical level, based on risk assessment.

- ***Mandatory training:*** Not all staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Access to essential information: Register of residents:*** Though the approved centre had a documented register of residents, it was not up-to-date: a diagnosis on admission was not recorded for three residents, and a diagnosis on discharge was not recorded for one resident.
- ***Maintenance: Hazards:*** There were hard and sharp edges in the garden area. There were unprotected rain gullies around the periphery of the garden where individuals could potentially slip and trip.

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.
- ***Individual care plans:*** Each resident had an individual care plan that met all stipulated requirements.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, social worker, occupational therapist, registered psychiatric nurse, a psychologist, and a dietitian. 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.
- ***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:

- **General health needs:** Residents' general health needs were not assessed regularly. In a sample of five six-monthly general health check records inspected of five different residents, none of the five six-monthly general health checks inspected had been fully completed. A selection of reasons include: there was no proof that resident's weight was checked and recorded for two residents, and there was no evidence in clinical files of blood results for two residents.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** Accommodation at the approved centre comprised of three four-bed en suite dormitories, one six-bed en suite dormitory and seven single en suite bedrooms.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed

discretion and respect for confidentiality when discussing the resident's condition or treatment needs.

- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Seclusion and Mechanical Restraint were not used in the approved centre. 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 physical restraint for that person. The approved centre was, however, not compliant with the Code of Practice on Physical Restraint for four different reasons.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***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***: The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend.
- ***Residents' feedback:*** No residents availed of the opportunity to meet with the inspection team during the inspection. Five questionnaires were completed by residents for inspectors. The residents were complimentary about the environment and the care they received. All five respondents indicated that they were always able to discuss worries or concerns with a member of staff. Two respondents indicated that they always felt safe in the approved centre and three respondents indicated sometimes in response to this question. *(Please refer to section 5.0 for detailed service-user feedback).*

However:

- ***Environment:*** Internal bedroom walls and windowsills required repairs and painting.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The Acute Psychiatric Unit Cavan was part of the Community Healthcare Organisation (CHO) Area 1, and it and the community services were under the governance of the Cavan/Monaghan Area Mental Health Management Team (AMHMT). Two core meetings: the Cavan/Monaghan AMHMT meeting, and the Quality and Patient Safety (QPS) Committee were central to the Cavan/Monaghan Mental Health Service governance processes. Both meetings took place monthly.
- ***Leadership:*** The QPS committee meeting met monthly and included representation from the heads of disciplines. The approved centre was governed locally by the local business meeting and a clinical governance committee which was formed this year in 2023, and both met monthly.
- ***Restrictive practices reduction:*** The approved centre had a reduction of restrictive practices strategy.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. The approved centre had a local risk register and applicable risks had a pathway for escalation to the QPS committee and the Cavan/Monaghan Area Mental Health Management Team meetings.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. Seven quality initiatives had been implemented since the last inspection, such as a weekly discharge planning group was introduced by the psychologist at the approved centre, which examined the experiences of being in an acute mental health unit and included preparation for discharge. *(Please refer to section 2.0 of this report for full list of quality initiatives).*
- ***Policies:*** The approved centre's policies were up-to-date.
- ***Staff training:*** Clinical supervision was provided for medical staff and the health and social care professional groups.
- ***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. Resident community meetings and 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:*** The approved centre had weekly access to advocacy services provided by the Peer Advocacy in Mental Health service. The advocacy contact details were displayed within the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an excellent average compliance rate of 89% over the last 4 years. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Safety: Risk:*** Ligature points were not minimised to the lowest practical level, based on risk assessment and not all staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Restrictive practices reduction:*** The approved centre was not compliant with the Code of Practice on Physical Restraint for four reasons in a sample of three physical restraint episodes inspected, one reason was: the multi-disciplinary review and oversight committee accountable to the registered proprietor nominee did not meet quarterly nor produce a report following each meeting of the review and oversight committee.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A car was purchased for shared use between a community facility and the Acute Psychiatric Unit which was used to support social and recreational activity for residents.
2. The Resident Information Booklet was reviewed and updated this year.
3. The Recovery College provided a weekly in-reach class which delivered an introduction to Wellness Recovery Action Plans and understanding Your Care Plan groups.
4. A weekly discharge planning group was introduced by the psychologist at the approved centre which examined the experiences of being in an acute mental health unit and included preparation for discharge.
5. The hospital shop now visits the approved centre daily.
6. A handout leaflet of local religious orders contact details was produced and made available to residents.
7. A Daily Safety Pause initiative was introduced since January of 2023. It focussed on safety awareness which helped the team be more proactive about the challenges faced in providing safe, high quality care for patients.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Acute Psychiatric Unit (APU) was located on the lower ground floor of Cavan General Hospital and provided 25 beds for mental health inpatient services which covered the population of Cavan and Monaghan. The approved centre benefited from its co-location with Cavan General Hospital in terms of access to general health care for residents.

The adult community mental health sector teams referred residents for inpatient care where they were managed by a dedicated inpatient treating team working in the approved centre. The Psychiatry of Later Life (POLL) team also admitted to the approved centre and this team managed the care and treatment of these residents. There was also input from the Child and Adolescent Mental Health Service (CAMHS) team when necessary.

The inpatient treating team consisted of a consultant psychiatrist (which was provided on an in-reach basis by consultants from the community), nursing staff, medical staff, an occupational therapist, a social worker, a psychologist, a pharmacist and administration staff. There was input from a music therapist, an art therapist and the Recovery college on a weekly sessional basis in the approved centre.

Accommodation at the approved centre comprised of three four-bed en suite dormitories, one six-bed en suite dormitory and seven single en suite bedrooms. There was a large spacious dining room, two sitting rooms, a music room, a family room, a quiet room, a well-equipped occupational therapy room and kitchen. There was a recreational room with exercise machines, foosball table and boxing bag for resident's use. The approved centre had access to a central garden within the approved centre. The garden had seating and raised planting beds and a central gazebo area.

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

Resident Profile	
Number of registered beds	***25***
Total number of residents	**19**
Number of detained patients	4
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of the Community Healthcare Organisation (CHO) Area 1 which comprised of a large geographical area, spanning five counties: Cavan, Donegal, Leitrim, Monaghan, and Sligo. The Acute Psychiatric Unit Cavan was under the governance of the Cavan/Monaghan Area Mental Health Management Team (AMHMT). Two core meetings: the Cavan/Monaghan AMHMT meeting, and the Quality and Patient Safety (QPS) Committee meeting were central to the Cavan/Monaghan Mental Health Service governance processes. Both meetings were scheduled monthly.

The Area Mental Health Management Team meeting was attended by the general manager, heads of disciplines, area lead for mental health engagement and administrative staff. Minutes of these meetings indicated that regular discussions took place regarding operational planning, human resources, finances, quality, safety and risk, regulatory compliance, local management teams, mental health engagement, staffing and performance monitoring.

The QPS committee meeting also met monthly and included representation from the heads of disciplines. Standing items on the agenda included quality improvement, auditing, risk management, infection control, incident reviews, the risk register, health and safety and policy review and comments /complaints. The approved centre had a local risk register. The risk register contained health and safety risks, clinical risks and corporate risks. The risk register was maintained and was reviewed at the approved centre's local clinical governance meeting. All incidents had been appropriately reported and the approved centre used the National Incident Management System (NIMS). The risk manager reviewed the incidents for patterns and trends. There were key personnel with responsibility for risk management working in the approved centre. The approved centre had a risk manager. The person with overall responsibility for risk was identified and known by staff.

Not all risks at the centre were minimised to the lowest practical level as ligature risks existed within the approved centre. There was however a ligature reduction committee meeting quarterly at the approved centre who were actively addressing how the centre would manage these risks. Ligature risks were identified on the centres ligature audit. Mitigation measures included an increase in the staffing levels at the centre and a revised observation policy which was based on individual risk assessment. Some works had taken place to address the ligature risks identified in the approved centre which included installation of anti-ligature tv units and window blinds.

The approved centre was governed locally by the local business meeting and a clinical governance committee which was formed this year, and both met monthly. Representation at these meetings came from nursing, medical and allied health professionals along with quality and patient safety, risk manager, nurse practice development and hospital administration. These meetings incorporated agenda items that included restrictive practice reduction management, health and safety, safeguarding, policies and protocols, quality safety and risk, risk register, Infection control, incident management, comments and complaints, auditing and mandatory training. Issues discussed at the meeting were escalated to the AMHMT meeting as appropriate.

An organisational chart clearly identified the structures of leadership and the lines of authority and accountability within the approved centre. Each of the disciplines provided the inspection team with information about their own governance structures. Each head of discipline outlined clear strategic goals for the service and the systems that were in place to monitor goal attainment. Clinical supervision was provided for medical staff and the health and social care professional groups. The approved centre had strong links with Cavan General Hospital, in terms of clinical support for infection control, medication provision and safety and access to medical consultancy.

Resident engagement in governance and quality improvement processes were facilitated throughout the service. Resident community meetings and suggestions boxes provided residents with the forum to voice requests, suggestions and concerns. The approved centre had access to advocacy services provided by the Peer Advocacy in Mental Health service (formerly the Irish Advocacy Network). Advocacy was provided weekly at the approved centre. The advocacy contact details were displayed within the approved centre.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 19: General Health	✗	Moderate	✓		✓		✓		✗	High
Regulation 22: Premises	✗	High	✓		✗	High	✗	Critical	✗	High
Regulation 26: Staffing	✗	High	✓		✓		✗	High	✗	Moderate
Regulation 28: Register of Residents	✓		✓		✓		✓		✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✓		✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
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 no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	There had been no child admission to the approved centre which was applicable to the code of practice.

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. No residents availed of the opportunity to meet with the inspection team during the inspection however five completed questionnaires were received from residents during the inspection.

Of the five completed questionnaires, four indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood, and one could not remember. Four respondents indicated they always received information on their diagnosis and one respondent indicated sometimes to this question. All five respondents indicated that they understood what their care plan was. Three indicated that they were always involved in setting goals for their individual care plans while two indicated sometimes to this question. All five of the respondents indicated that they knew their multi-disciplinary team members and knew their keyworkers. All five respondents indicated that they were always able to discuss worries or concerns with a member of staff. Four respondents felt there was enough activities in the approved centre while one did not. All respondents indicated that they were happy with how staff spoke with them. Four respondents felt they had space for privacy while one did not and all respondents felt their privacy and dignity was respected during their stay in the approved centre.

All respondents indicated that they could communicate freely with family, friends and the advocate. Two respondents indicated that they always felt safe in the approved centre and three respondents indicated sometimes in response to this question. All respondents indicated that they were always able to give feedback to staff, and to make a complaint when they were not satisfied with any part of their stay.
On a scale of 1-10, with 1 being poor and 10 being excellent for their overall experience of care and treatment at the approved centre. Three residents rated it 8 out of 10, one resident rated it 9 out of 10 and one resident rated it 10 out of 10.
Comments on the questionnaires included that the staff were very attentive and that they were happy with the treatment given at the approved centre.

5.2 Advocacy

The approved centre had an advocacy service and the advocate attended the approved centre. The advocate attends the centre once a week in person. The inspectors received a report from the Peer Advocacy in Mental Health representative. It included both positive feedback and feedback on how improvements could be made to the service. This included that:

- Residents were complimentary about the care received and said that staff were helpful with individual resident needs such as arranging family visits to the centre.
- That access to the psychologist on an individual basis was appreciated.
- That input from the social worker in the centre with regards to accommodation, home help and advice about benefits and entitlements was appreciated.
- Residents were delighted that staff facilitated leave and supported them to attend home, getting necessities and services arranged, going on day trips, arranging translation.
- That group work facilitated by the occupational therapist was enjoyable and groups such as baking and sleep hygiene and going for walks were beneficial.
- That the environment in the centre was good with comfortable spaces to sit quietly, exercise equipment and groups and that they liked the outdoor space and flowers.
- That residents would like more discussion about their medication when it comes to needing more or feeling that they should be on less medication and greater input into how they receive their medication.
- That there would be greater access to leave out of the centre.
- Residents expressed a want to go home and avail of community services.
- Residents would like if there was more time for staff to talk with them.
- Residents expressed a wish that there was greater access to the occupational therapist, the social worker and the psychologist. They would like to see an increase in these resources.
- Younger residents found that it was hard to pass the time in the centre and wanted more activities.
- Residents expressed a wish to have more discussion and input around their discharges to address concerns and fears they had about going home or moving to new accommodations.

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 Nominee
- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Clinical Nurse Manager 2 (x2)
- Clinical Nurse Manager 1
- Principal Psychologist Nominee
- Occupational Therapy Manager
- Principal Social Worker
- Clinical Pharmacist
- Assistant Director of Nursing
- Administrator for Mental Health Commission correspondence
- Nurse Practice Development Coordinator

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 idenegulation tifiable by staff when receiving medication, health care or other services.

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in May 2022. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Activities available included books, television, gym, board games, walks, quizzes, bingo, yoga, art, coffee morning groups and trips to the coffee shop/canteen.

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. Mass was held every Sunday in the hospital chapel. Religious ministers could be contacted to attend the approved centre where required.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Visiting times were appropriate and reasonable, and the justifications for any visiting restrictions were documented in the clinical file. The approved centre provided a visiting 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. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting room was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents had access to their own mobile phones and a portable phone was available on the ward. There was no internet access on the ward.

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, last reviewed in February 2022, and an Alcohol, Illicit Substances and Non-Prescribed Medications Policy, last reviewed in September 2021. Together, these policies included all requirements related to:

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

The clinical files of two residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. 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.

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

staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in September 2023.

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

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). Therapeutic services and programmes consisted of a weekly group co-facilitated by the occupational therapist (OT), social worker and psychologist. Each health and social care professional facilitated one group per week specific to the needs of the residents. A music therapist and an art therapist attended weekly as did an educator from the Recovery College who conducted Wellness Recovery Action Plan (WRAP) and care planning groups. A yoga instructor facilitated a group every weekend.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. The OT, social worker and psychologist provided individual sessions and assessments to residents.

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 September 2023. The clinical file of one resident who had been transferred from the approved centre 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. The transfer documentation included a letter of referral, a list of current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in November 2020. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Five clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessments documented a physical examination, family or personal history, smoking status, dental health, nutritional status, and medication review. However, there was no evidence to suggest that the resident's weight had been checked in two residents' assessments. In four of the clinical files, neither body mass-index nor waist circumference had been recorded. There was no evidence to suggest that the resident's blood pressure had been recorded in one of the clinical files.

For residents on anti-psychotic medication, there was an annual assessment of their prolactin and electrocardiogram (ECG) heart function. However, there was no evidence in three of the clinical files that a fasting glucose had been completed for the residents. Blood results had been stored electronically for three of the five residents; no results were available for the other two. There was no evidence in the clinical files of blood lipid results for two residents.

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 applicable national screening programmes that were available according to age and gender, including bowel screening.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that residents' general health needs were assessed regularly as none of the five six-monthly general health checks inspected had been fully completed, 19(1)(b).

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 November 2020.

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

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

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. Where residents shared a room, bed screening was provided to ensure that their privacy was not compromised. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information. 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. Appropriately sized communal rooms were provided: there were two sitting rooms, a quiet room, dining room, gym, occupational therapy (OT) kitchen, OT room, music room and family room. There was suitable and sufficient heating in day areas and bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Not all hazards were minimised in the approved centre. Hard and sharp edges were observed in the garden area. Around the periphery of the garden, there were unprotected rain gullies that presented a slip and trip hazard. There was warning signage displayed on the walls. Ligature points throughout the approved centre were not minimised to the lowest practicable level, based on risk assessment. Some works had taken place to address the ligature risks identified in the approved centres ligature audit which included the installation of anti-ligature tv units and window blinds.

The approved centre was not kept in a good state of repair externally and internally. Bedroom walls and windowsills in the four dorm bedrooms and four of the single bedrooms required repairs and painting. There were holes and marks and cracking in the walls and peeling paint in the bedroom areas. The toilet bowls and sinks were stained in some single and shared bedrooms. There were markings on the flooring throughout the centre.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Overall, the centre was clean, hygienic, and free from offensive odours. However, in the garden area, buckets used for cigarette butts were dirty, stained and dented and the paving around them was dirty. The exit to the garden area was dirty, with cigarette butts on the floor. 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. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were 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 registered proprietor did not ensure that the premises was clean as buckets used for cigarette butts were dirty, stained and dented and the paving around them was dirty and the exit to the garden area was dirty, with cigarette butts on the floor, 22(1)(a).**
b) **The registered proprietor did not ensure the premises were maintained in good decorative condition due to the following: floor covering in the bedroom areas and corridors of the approved centre required upgrading; toilet bowls and sinks were stained in some single and shared bedrooms and internal bedroom walls and windowsills required repairs and painting, 22(1)(a).**
c) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of the residents. Ligature points and were not minimised to the lowest practical level, based on risk assessment, 22(3).**
d) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of the residents, as hazards were not minimised. There were hard and sharp edges in the garden area. There were unprotected rain gullies around the periphery of the garden that constituted as slip and trip hazards, 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 March 2022, 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, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

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

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified.

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 Safety Statement which was last reviewed in June 2023.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in November 2020, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. Not all healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory areas.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (29)	29	100%	27	93%	29	100%	27	93%
Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%
Medical (2)	1	50%	1	50%	0	0%	2	100%

Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%

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

a) **The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all staff had completed their training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26(4).**
b) **The registered proprietor did not ensure that all staff members had completed training on the provisions of the Mental Health Act (and all regulations and rules made thereunder, commensurate with their role, 26(5).**

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 October 2021, and included the following:

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

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure 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, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating MODERATE

(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. However, the register was not up to date in respect of all residents, in that a diagnosis on admission was not recorded for three residents, and a diagnosis on discharge was not recorded for one resident.

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

a) **The registered proprietor did not ensure an up to date register was maintained in relation to every resident in the approved centre, 28(1).**
b) **The registered proprietor did not ensure the register of residents included all the information specified in Schedule 1 of the Mental Health Act 2001. The register of residents did not contain the following information: diagnosis on admission for three residents, diagnosis on discharge for one resident, 28(2).**

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary. The approved centre provided resources and facilities to access the Mental Health Tribunals remotely where required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

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 March 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 complaint's procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaint's 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, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in September 2021, and included the following:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate.

Structural risks, including ligature points, were removed or effectively mitigated. Ligature risks were identified on the centres ligature audit. Mitigation measures included an increase in the staffing levels at the centre, of one staff member per shift and a revised observation policy which was based on individual risk assessment. There was a ligature reduction committee at the centre who were actively addressing how the centre would manage these risks.

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

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

There was an up-to-date certificate of registration, with one condition to registration attached that was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 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 three patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment and that all three patients were unable to consent to receiving treatment.

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

- The names of the medications prescribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.
- Any supports provided to the patient in relation to the discussion and their decision-making.

- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in 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 persons 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 August 2023, and included all of 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. Mandatory training was delivered every 12 months at a minimum. A record of attendance at training was maintained.

Monitoring: The approved centre's multi-disciplinary review and oversight committee, responsible for reviewing all episodes of physical restraint in detail, did not meet on a quarterly basis, and did not produce a report following each meeting.

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

The orders for physical restraint lasted for a maximum 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 CP within 24 hours. The residents were informed of the reasons

for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical file as soon as was practicable.

Where it was the resident's wish in accordance with their individual care plan (ICP), the resident's representative was informed of the physical restraint as soon as was practicable. Where the resident's representative was not informed, there was a record explaining why this did not occur in the clinical file.

The Mental Health Commission was notified of the start and end time and date of each episode of physical restraint in the correct format and within three days of each episode. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy. The residents were continuously assessed throughout the uses of restraint to ensure their safety.

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 debrief included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. However, a record of all attendees who were present at the debrief was not documented in the clinical file for all three episodes.

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 forms. There was a copy of the clinical practice forms in the clinical files, and they were available to the Mental Health Commission on request.

Clinical Governance: 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 of the resident by a registered medical practitioner did not take place as soon as practicable and no later than two hours after the start of the episode of physical restraint, 3.4.**
b) **A record of all attendees who were present at the debrief was not recorded in the clinical file for three episodes of physical restraint, 5.6.**
c) **The multi-disciplinary review and oversight committee accountable to the registered proprietor nominee did not meet quarterly nor produce a report following each meeting of the review and oversight committee, 7.8(vi).**

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

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

Evidence of Implementation: ECT was administered in the theatre of the main General Hospital. There was an ECT suite with a private waiting area and an adequately equipped treatment room and recovery room. There was a facility for monitoring EEG on two channels. The ECT machines were regularly maintained and a record of maintenance was kept. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for management of cardiac arrest, anaphylaxis, and malignant hyperthermia, were prominently displayed. A named consultant psychiatrist (CP) had responsibility for ECT management, and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were always in the suite, one of whom was a designated ECT nurse.

The clinical file of one voluntary resident who had received ECT was examined. The CP assessed the resident's capacity to consent to receiving treatment, and this was documented in their clinical file. Appropriate information on ECT was given by the CP to enable the resident to make a decision and consent to receive ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side effects. Consent was obtained in writing for each ECT treatment session, including anaesthesia. Both a capacity assessment and a cognitive assessment were completed with the resident prior to commencement of the programme of ECT.

A pre-anaesthetic assessment was recorded in the clinical file. Any physical problems were noted, and the anaesthetist was informed. The assessment also included: a detailed medication history, the duration of fasting, relevant haematology and biochemistry investigations, and an ECG if required.

The programme of ECT was prescribed by the responsible CP and recorded in the clinical file. The prescription detailed the reason for using ECT, alternative therapies that were considered or proved ineffective, the discussion with the resident and, where appropriate, their next of kin, a current mental state examination, and the assessments completed before and after each ECT treatment. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine.

An ECT record was completed after each treatment and placed in the resident's clinical file. This record included: a session number, laterality, the prescribed and administered dose and the duration and quality of the seizure. It also contained the signature of the Registered Medical Practitioner administering ECT. The reasons for continuing or discontinuing ECT were recorded in the resident's file. A cognitive assessment was completed after each ECT programme, and a copy of this assessment was kept in the resident's clinical file.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in July 2021, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in June 2021, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

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

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. 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, or advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 19 General Health					
Reason ID : 10004986		**The registered proprietor did not ensure that residents' general health needs were assessed regularly as none of the five six-monthly general health checks inspected had been fully completed, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The 5 six monthly General health checks were fully completed.	Annual General Health Audit	Action Complete	08/04/2024	NCHD APU
Preventative Action	1. APU Clinical Director sent memo to all NCHD to instruct them to complete all parts of the general health check in the six monthly health checks. 2. APU Clinical Director will ensure recommendations from the Annual General Health audit are implemented.	1. Annual General Health Audit. 2. Annual General Health Audit.	1. Action Complete. 2 . No barriers to implementation. Has commenced and is ongoing.	08/04/2024	1. APU Clinical Director 2. APU Clinical Director

Regulation 22: Premises					
Reason ID : 10004978		**The registered proprietor did not ensure that the premises was clean as buckets used for cigarette butts were dirty, stained and dented and the paving aro17 m was dirty and the exit to the garden area was dirty, with cigarette butts on the floor, 22(1)(a).**			
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly					
Reason ID : 10004979		**The registered proprietor did not ensure the premises were maintained in good decorative condition due to the following: floor covering in the bedroom areas and corridors of the approved centre required upgrading; toilet bowls and sinks were stained in some single and shared bedrooms and internal bedroom walls and windowsills required repairs and painting, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1. Floor covering in bedrooms and corridor will be replaced when the ceiling and windows within the APU are being replaced. 2. Liaise with cleaning contractors to identify alternative cleaning products to remove stains on toilet bowls. 3. Internal bedroom walls and windowsills have been painted and repaired.	1.Regular MEG audit 2.Regular MEG audit 3.Regular MEG audit	1. Waiting for ceiling and window replacements.– dependant on external contractors 2. Legionella water treatment is causing the staining of the toilet bowls and the staining will re-occur as a result. 3 Action completed	28/02/2025	1 .Nominee Registered Proprietor 2. APU ADON
Preventative Action	Ongoing Maintenance schedule in place to check for damage.	Quarterly inspection by CNM2 and regular MEG audits	No barriers to implementation. Has commenced and is ongoing.	08/04/2024	APU CNM2

Reason ID : 10004980		The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of the residents. Ligature points and were not minimised to the lowest practical level, based on risk assessment, 22(3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The works to install a new ceiling and windows has commenced in 1 room within APU (family room). When this is complete we will assess the suitability of the new ceiling and windows for the rest of the APU.	Annual ligature audit	Reliant on external contractors	28/02/2025	Nominee Registered Proprietor
Preventative Action	APU ligature Reduction Group will continue to meet regularly to review audits and implement recommendations.	Annual ligature audit	No barriers to implementation. Has commenced and is ongoing.	08/04/2024	APU ADON
Reason ID : 10004981		**The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of the residents, as hazards were not minimised. There were hard and sharp edges in the garden area. There were unprotected rain gullies around the periphery of the garden that constituted as slip and trip hazards, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A solution to reduce the slip and trip hazard has been identified and a Contractor has been	Annual Level 1 Health and Safety Audit and quarterly Maintenance audit by CNM2.	Reliant on external contractors.	31/07/2024	Cavan Monaghan Mental Health Service (CMMHS) Business Manager.

	appointed. We are awaiting a start date for these works.				
Preventative Action	1. APU Governance Group to implement any recommendations from APU Health and Safety Audits and Maintenance audits. 2. Signage warning of hazard in place until work in courtyard is completed and all residents who are rated as high falls risk are accompanied within the courtyard.	1. Annual Level 1 Health and Safety Audit and quarterly Maintenance audit by CNM2. 2. Annual Level 1 Health and Safety Audit and quarterly Maintenance audit by CNM2.	1. No barriers to implementation. Has commenced and is ongoing. 2. No barriers to implementation. Action Complete.	08/04/2024	1. APU Clinical Director.

Regulation 26: Staffing					
Reason ID : 10004984		**The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all staff had completed their training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training in PMCB, BLS and Fire Training has been provided since the inspection for all staff in APU who have not completed this training or were due for update. Training opportunities will continue to be available for all APU staff.	Training audit quarterly	Availability of trainers and training venue. Ability to release staff for training while keeping a safe staffing level.	30/06/2024	All Heads of Discipline
Preventative Action	1 There is an ongoing training schedule aiming for 100% compliance by the end of Q2 2024. 2 APU ADON completes Staff Training Template quarterly and circulates this to all heads of Discipline and uploads to the CIS.	1. Training audit quarterly. 2. Training audit quarterly.	1. Availability of trainers and training venue. Ability to release staff for training while keeping a safe staffing level in APU 2 No barriers to implementation. 2 Has commenced and is ongoing	03/06/2024	1. All Heads of Discipline 2. APU ADON

Reason ID : 10004985		The registered proprietor did not ensure that all staff members had completed training on the provisions of the Mental Health Act (and all regulations and rules made thereunder, commensurate with their role, 26(5).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	100% of APU staff have completed this training	Training audit quarterly.	Action Complete.	08/04/2024	All Heads of Discipline
Preventative Action	1 All heads of discipline continually monitor staff training records and remind staff of their obligation to complete mandatory training as per CMMHS Mandatory Training Policy 2 APU ADON completes the MHC Mandatory Training Template quarterly and circulates to all heads of discipline and uploads to the CIS	1. Training audit quarterly 2. Training audit quarterly	1. No barriers to implementation. Has commenced and is ongoing 2. No barriers to implementation. Has commenced and is ongoing	08/04/2024	1. All Heads of Discipline 2. APU ADON

Regulation 28: Register of Residents					
Reason ID : 10004982		**The registered proprietor did not ensure an up to date register was maintained in relation to every resident in the approved centre, 28(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The register was up dated immediately upon the return of APU Administrative Staff member after return from unplanned leave.	APU Administrative staff could identify that the register was fully up to date upon completion of the update.	Action Complete.	08/04/2024	APU administrative staff
Preventative Action	Review of the register daily by APU administrative staff to ensure it is up to date.	Daily review of the Register of residents.	No barriers to implementation. Has commenced and is ongoing	08/04/2024	APU administrative staff.
Reason ID : 10004983		**The registered proprietor did not ensure the register of residents included all the information specified in Schedule 1 of the Mental Health Act 2001. The register of residents did not contain the following information: diagnosis on admission for three residents, diagnosis on discharge for one resident, 28(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Register of residents was updated to include all information specified in Schedule 1 of the Mental Health Act.	APU Administrative staff could identify that the register was fully up to date upon completion of the update.	Action Complete.	08/04/2024	APU Administrative Staff
Preventative Action	1. APU Clinical Director has sent Memo to all NCHDs to instruct them that all residents in the Approved Centre must have a	1. Daily review of the register of residents 2 Daily review of the register of residents	1 Action Complete. 2. No barriers to implementation. Has commenced and is ongoing	08/04/2024	1. APU Clinical Director 2. APU Administrative Staff

	diagnosis documented on admission and on discharge to APU. 2. Review of the register daily by APU administrative staff to ensure it is up to date.				

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10004987		**In one episode of physical restraint, a medical examination of the resident by a registered medical practitioner did not take place as soon as practicable and no later than two hours after the start of the episode of physical restraint, 3.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	No corrective action indicated.	N/A	N/A	08/04/2024	N/A
Preventative Action	Ongoing education of all staff involved in physical restraints on the requirements. Actions and recommendations from The Review and Oversight Committee are implemented. NCHDs attend APU PMCB training. Training video on physical restraint and the requirements of the physical restraint policy has been developed and is available on the CMMHS shared drive for all staff to view. Physical restraint policy is on the CMMHS Policy Portal and it is mandatory for all staff to read and understand the	Quarterly audit of all physical restraints.	No barriers to implementation Has commenced and is ongoing	08/04/2024	APU Clinical Director CMMHS PMCB instructors All Heads of Discipline

	contents of the policy.				
Reason ID : 10004988		**A record of all attendees who were present at the debrief was not recorded in the clinical file for three episodes of physical restraint, 5.6.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	No corrective action indicated.	N/A	N/A	08/04/2024	N/A
Preventative Action	Post restraint debrief form has been developed for use within CMMHS. The use of this form ensures that all attendees present at the debrief are recorded.	Quarterly audit of all physical restraints.	Action completed	01/01/2024	PMCB instructor
Reason ID : 10004989		**The multi-disciplinary review and oversight committee accountable to the registered proprietor nominee did not meet quarterly nor produce a report following each meeting of the review and oversight committee, 7.8(vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Review and Oversight Committee is now meeting quarterly and producing a report following each meeting.	Minutes of quarterly meeting and report subsequent to each meeting.	No barriers to implementation. Has commenced and is ongoing.	08/04/2024	APU Clinical Director
Preventative Action	Continue quarterly meetings of the Review and Oversight Committee and production of report following each meeting	Minutes of quarterly meeting and report subsequent to each meeting.	No barriers to implementation. Has commenced and is ongoing.	08/04/2024	APU 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.

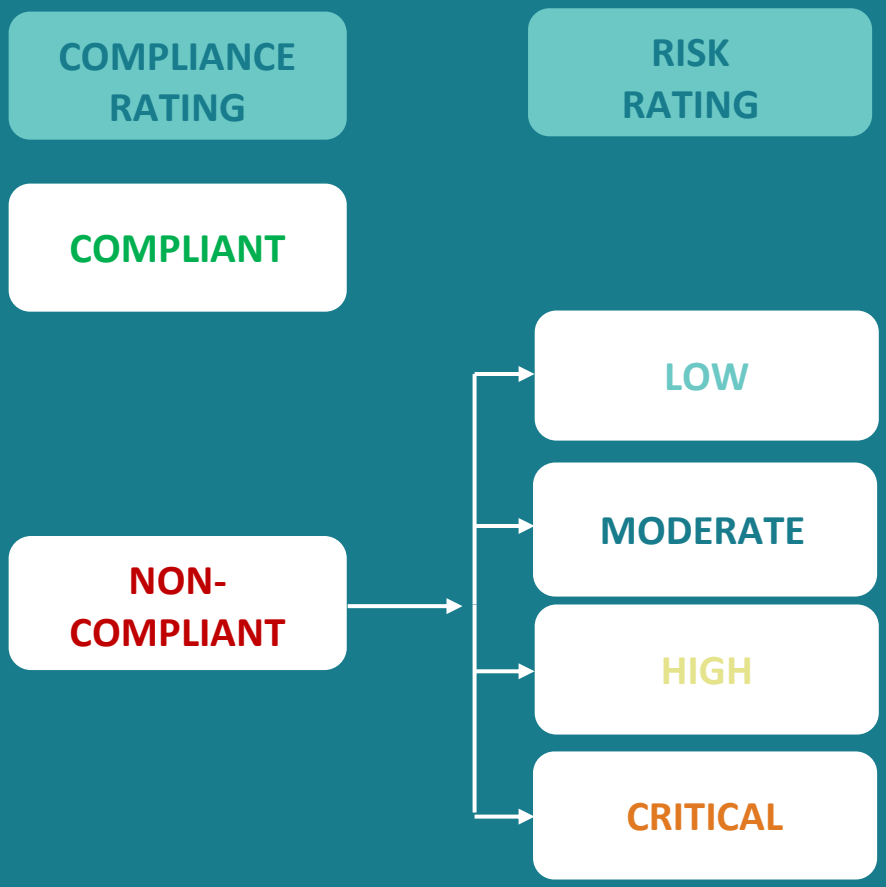
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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