# Mental Health Commission finds eight critical risk ratings in five approved mental health centres

Inspector finds 27 high risk ratings in five mental health centres

**Thursday 9 May 2019**: The Mental Health Commission (MHC) has today published five inspection reports, on centres in Clare, Cork, Sligo, Tipperary and Dublin, which identified eight critical risk ratings and 27 areas of high risk non-compliance.

Commenting on the reports Dr Susan Finnerty, Inspector of Mental Health Services, said, "There are critical risks identified by the inspection reports in each of the five approved centres. Safety is central to the provision of quality mental health services and finding eight critical risks and twenty seven high risk ratings is a matter of serious concern to the Commission. There has been repeated failure by some facilities to meet their legislative and care requirements."

**Units 2, 3, 4 and Unit 8 (Floor 2), St Stephen's Hospital is** located close to the village of Glanmire, outside the city of Cork. The approved centre was non-compliant on all of its conditions of registration – privacy, premises, staffing, and risk management procedures – for the third consecutive year, with three of these non-compliances rated as critical. There were four non-compliances with regulations rated as critical risk. Six compliances with regulations were rated as excellent.

The inadequacy of provision of care to residents in Unit 8 was of particular concern; lack of recreational activities, lack of access to national screening programmes, no outside space, lack of adequate physical health monitoring, poor individual care plans, one shower and one bath for 20 residents, and residents from the acute unit sleeping in Unit 8 when there was a bed shortage.

A ligature audit had been undertaken in only one of the four units in the approved centre. Risk management processes were uncoordinated and there was no single risk register for the entire approved centre. There was no evidence of a regular review and rating of risk applying to the centre. Medication management processes were satisfactory. Not all staff had up to date training in fire safety, Basic Life Support, prevention of violence and aggression, and child safety.

Resident observation levels as practiced were not sufficiently dynamic and were not consistent with approved centre observation policy. The practice of residents 'sleeping out' when there was a bed shortage in Unit 4, the admission unit, has continued, with 19 residents relocated between January and the end of April 2018. This practice had not been addressed as a risk issue. Individual care plans were of poor standard and did not evidence a recovery or person centred approach. This non-compliance was risk rated as critical.

Adequate arrangements were not in place for access by residents to Speech and Language Therapy based on residents' needs. Six-monthly physical health reviews did not include family and personal history, body mass index, weight, and waist circumference, smoking status, nutritional status (diet and physical activity, including sedentary lifestyle) and dental health, glucose regulation (fasting

glucose/HbA1c), and blood lipids were not included in the annual assessment of residents prescribed antipsychotic medication.

Availability of emergency clothing, should it be required, was not adequate. Not all bathrooms and bedrooms had suitable locks to safeguard the privacy of residents. In one unit, residents were able to see into the bedroom of other residents and this was an intrusion into the privacy of residents, as was the movement of residents to Unit 8 when a bed was required in Unit 4. There were not enough toilets and showers in Unit 8, as one shower and one bathroom was designated for 20 people. The standard of care and the environment in Unit 8 did not respect residents' privacy, dignity or autonomy. Residents could meet with visitors in private and were accommodated in making private phone calls.

There was no adjacent garden that provided easy access for residents of Unit 8. Chairs had cigarette burns on the arms and one chair was badly worn. Rooms were not well ventilated, and one unit was malodorous due to a smell coming from the bathrooms. Unit 3 had dirty floors and the bathrooms and toilets were malodorous and needed immediate attention.

The approved centre was not kept in a good state of repair, particularly Unit 3. Floor covering in Unit 8 was worn, and the flooring in the shower in Unit 4 needed replacing. There was no programme of general maintenance, decorative maintenance, decontamination, or repair of assistive equipment.

The Commission was alerted to serious concerns relating to premises, care planning and risk management. The Commission was concerned about the apparent disjointed governance in the approved centre as a whole. The Commission subsequently issued an Immediate Action Notice to address the concern and has been monitoring this issue on an ongoing basis.

The **Acute Psychiatric Unit, Tallaght Hospital** is a 52-bed approved centre. It consists of three units, Cedar (female admissions), Rowan (male admissions), and Aspen (high observation unit). The centre had one critical risk rating for premises and eight high risk ratings. There were three compliances with regulations that were rated as excellent. Compliance with regulations has remained low over a three year period: 51% compliance in 2016; 63% compliance in 2017 and 55% compliance on this inspection in 2018.

The approved centre was non-compliant with individual care plan, one of its conditions of registration on this inspection and for the previous two years.

Each resident had an individual care plan. However, in one case, there was a three-week delay in creating the resident's individual care plan; in two cases, the individual care plan was not developed by the multi-disciplinary team; in one case, there was a ten-week gap between individual care plan reviews when more frequent would have been more appropriate; and in six cases, resources were not documented appropriately.

Commenting on the reports, Dr Finnerty said, "The approved centres must provide individual care plans for residents. The care plan exists for each patient to assist with recovery and to facilitate the patient, the multi-disciplinary team, the family member or advocate, to work towards an agreed outcome and achievement of goals."

There was a cleaning schedule; however, the approved centre was not clean. The dining room doors had engrained food stains on them and the corridor floors were dirty. The cookers in the

occupational therapy kitchen had food stains baked in to the ovens and grills. The floor mats were not clean and had not been replaced in accordance with the service level agreement. One shower was malodorous and the walls were damp. Some bathrooms had poor ventilation; however, there was a programme to refurbish toilets and showers and one had been completed.

The approved centre was not in a good state of repair, as there were stained ceiling tiles, and wall covering was lifting off some walls. Chairs that had been used during painting were stained with paint and were in the consultant's room for residents and family members to sit on.

The approved centre was non-compliant with general health as the six-monthly general health assessment only included a physical examination. It did not assess family and personal history, body mass index (BMI), weight, and waist circumference, blood pressure, smoking and nutritional status, or a medication and dental review. Residents on antipsychotic medication also did not receive an annual assessment that considered glucose regulation, blood lipids, heart health via an electro-cardiogram exam, and prolactin levels.

The approved centre was non-compliant with the regulation on closed-circuit TV because CCTV cameras transmitted images for both seclusion rooms Cedar and Rowan to monitors in the nurse's station, and the monitors could be seen from the corridors by anyone passing. This was a violation of residents' right to privacy.

The centre was non-compliant and had a high risk rating on admission of children. Age-appropriate facilities and a programme of activities were not provided. Children did not have access to child advocacy services and in one case did not have access to en suite facilities, instead having to share a bathroom with adults. Appropriate accommodation was not therefore always provided.

The Commission was alerted to serious concerns in relation to cleanliness following the 2018 annual regulatory inspection. The Commission subsequently issued an Immediate Action Notice to address the concerns. The centre provided corrective and preventative plans and the Commission will seek an update in three months to ensure the plans are being implemented. Compliance in relation to individual care plan is monitored as part of the condition attached to registration. The centre is required to provide monthly reports to the Commission to demonstrate compliance.

**Sligo/Leitrim Mental Health In-patient Unit** is a 32-bed unit, on the outskirts of Sligo. At the time of the inspection there were 22 residents. The building dates from the 1930s, but plans are progressing for the development of a new acute unit on the campus of Sligo University Hospital with an opening target date of the first quarter 2021.

There has been a marked improvement in compliance with regulations since 2016, going from 51% in 2016, to 79% on this inspection in 2018. The centre had one critical risk rating of non-compliance in the area of risk management procedures and five high risk ratings. Twelve compliances were rated as excellent.

There was a concerning lack of risk management procedures in place, and this was rated by the inspectors as critical risk. There was no risk advisor at the time of the inspection and all staff were responsible for risk management. There was no clinical governance/business group in place in the approved centre, and there was no clear documentation of how risks were managed. The process to escalate risks to the service risk register was unclear. Residents who were assessed as high risk were only observed every two hours when they returned to the ward from the high dependency unit. This

was not in line with the observation policy that was sent to the Mental Health Commission following concerns being raised previously.

Residents who had assaulted staff were not managed in a manner that ensured the safety of residents and staff. Incident management forms indicated that there had been two fires in the approved centre since the last inspection. One was where a bin was set alight and the other a toilet roll was set on fire. Only seven nurses and no medical staff had up-to-date fire safety training. There was no emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies and/or evacuation.

The individual care plan was reviewed weekly but this review was often completed by medical and nursing staff and not the by the multi-disciplinary team. While residents had access to their individual care plans, not all care plans were reviewed in consultation with the resident. These deficiencies are unacceptable and demonstrate a lack of recovery and person-centred care.

Female residents who required seclusion were escorted to the seclusion room via the male admission ward, which was a gross invasion of privacy. All bedrooms on the female unit were without bedside lights or night-lights. Residents in shared dormitories could not control the lighting or turn on a bedside light if they wished to read in bed. New fitted wardrobes had no doors and were not conducive to resident dignity or privacy.

As part of a risk management programme, a seclusion and physical restraint group was established. One of the aims was to minimise behavioural hazards. There were 38 seclusion episodes since the last inspection and 37 episodes of physical restraint. The poor design of the premises was a factor in the high number of seclusions and restraints as there were no areas of outdoor space and no quiet room. The service highlighted that contracts had been signed for a new purpose built centre and undertook to manage the risks until this new approved centre was commissioned.

The Commission issued an Immediate Action Notice to address areas of non-compliance identified by the Inspector and has been monitoring this issue.

**Acute Psychiatric Unit, Ennis Hospital** is a 39-bed acute psychiatric admissions unit for the adult population of Clare and North Tipperary. At the time of inspection there were 25 residents in the centre. The approved centre had one critical risk rating for non-compliance with individual care plan and five high risk ratings for staffing, therapeutic services and programmes, maintenance of records, use of seclusion and use of physical restraint. The areas of staffing, maintenance of records and the use of seclusion have been non-compliant for three consecutive years. The centre had two conditions attached to its registration and was non-compliant with both conditions. Four compliances with regulation were rated excellent.

The standard of individual care plans was poor and was risk rated as critical. Goals identified were not adequate to address the resident's needs, the responsibility for implementing the care and treatment required was not always identified, and the resources required to provide the care and treatment were not identified. It was not clear that residents participated in the development of their care plans. There was no evidence that care plans were reviewed by the full multi-disciplinary team. Two multi-disciplinary meetings had been cancelled and as a result residents did not have a weekly review. It was not clear whether residents were offered a copy of their individual care plans. Resident feedback during the inspection suggested that not all were invited to attend multi-disciplinary meetings.

Not all care plans inspected identified residents' assessed needs and goals regarding therapeutic services and programmes. Residents were not assessed with regard to which therapeutic services and programmes would best suit their needs. However, programmes and services offered in the approved centre were evidence-based and wide-ranging.

The approved entre was not clean, even though there was a cleaning schedule in place. In addition, the approved centre was not in a good state of repair. The painted walls and doors were very badly marked and chipped. Painting had commenced during the inspection. In the care of the elderly unit, the lino in shared dormitories was torn; graffiti was evident on a wall in the high observation unit; a stain was evident on the ceiling of the seclusion room; the garden in the high observation unit required work; the occupational therapy kitchenette's oven and fridge were dirty, and the worktop was chipped; the blinds in the care of the elderly unit's dining room were broken; and one door hinge in the shared dormitory bedroom was badly chipped. Dried paint was evident on the floor in one single bedroom in the high observation unit. Inspectors found that not all faults observed in the approved centre were reported to the maintenance department.

The Commission was alerted to serious concerns relating to individual care planning. The Commission subsequently issued an Immediate Action Notice to address these concerns and has been monitoring this issue on an ongoing basis.

**Haywood Lodge, Co Tipperary,** a 40-bed single-storey building had one critical risk rating for therapeutic services and programmes and five high risk ratings for recreational activities, general health, premises, staffing, and use of physical restraint. There has been no improvement in compliance with regulations from 2016 to 2018, averaging at 68% compliance. No areas of compliance were rated as excellent.

The numbers and skill mix of staffing were insufficient to meet resident needs. The therapeutic services and programmes provided by the approved centre did not meet the assessed needs of the residents, as documented in their individual care plans. This non-compliance was rated as critical. No therapeutic programme was available to residents at the time of the inspection. The availability of occupational therapy and social work personnel was limited. A community occupational therapist only provided urgent seating assessments. The focus of the social work department was predominantly on assessment. The limited therapeutic services and lack of a therapeutic programme did not facilitate the restoration and maintenance of residents' optimal levels of physical and psychological functioning.

Residents did not receive on-going medical care to address medical issues unless their condition deteriorated. In addition, adequate arrangements were not in place for these residents to access general health services and for their referral to other health services as required.
Fourteen of the twenty residents under the care of the psychiatry of later life team did not have access to recreational activities. The other six residents were able to access art and beauty groups.

Information was not provided to each resident living with dementia in an understandable form and language. The East House lacked large visual cues such as graphics and images to assist residents living with dementia in establishing their location.

The approved centre was kept in a good state of repair but it was not clean, hygienic, and free from offensive odours. There was a malodorous smell in the East House during the first day of inspection.

A large, partially dried pool of urine and other stains were observed on the floor of one resident's en suite facility. This was subsequently addressed during the inspection.

The bathroom in the East House was cluttered with clothing and wheelchairs on the first day of the inspection. The property room was also cluttered with clothing from residents who were no longer in the approved centre. These two issues were rectified during the inspection. A designated cleaning room and laundry room was in place**.** The approved centre did not have a dedicated therapy or examination room.

Two leather chairs in the East House sitting room were worn and in need of repair and replacement. There were only two tables in the East House dining room for ambulant residents, and a third table was missing from the room.

Following the inspection the Commission had serious concerns regarding the provision of care and treatment to the approved centre's elderly residents. The Commission subsequently issued an immediate action notice to address these concerns and closely monitored the implementation of the service's action plan.

**ENDS**

**For the Editor**

**About the Mental Health Commission:**

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

**Approved Centres:**

A 'centre' is "a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder" (Mental Health Act 2001)

To operate an in-patient mental health service in Ireland, the service must be registered as an 'approved centre' with the Mental Health Commission. Each centre must re-register for approval every 3 years.

Upon registration, the service must comply with regulations made under the Mental Health Act 2001. Failure to comply with regulations may result in enforcement action including: corrective and preventative action plans, an immediate action notice, a regulatory compliance meeting, registration conditions, removal from the register (closure) and prosecution.

**MHC inspection process:**

There are 39 areas in the inspection process of approved mental health centres. Each approved centre is assessed against a suite of regulations, rules, and codes of practice.

Inspectors, over a three day period, use a combination of documentation review, observation and interview to assess compliance. The Inspection team

- speak with residents to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell them,
- review documents to see if appropriate records are kept, that they reflect practice, in line with the standards and are what people tell them.

Areas of inspection are deemed either compliant or non-compliant. Where areas are considered non-compliant, this is risk rated. Risk measurements are rated as low, moderate, high or critical.

Following the inspection, the Inspector prepares a report on the findings. A draft of the report is furnished to the registered proprietor of the approved centre, and includes provisional compliance ratings, risk ratings and quality assessments.

The registered proprietor is provided with an opportunity to review the draft and comment on any of the content or findings. The Inspector takes into account the comments by the registered proprietor and amends the report as appropriate.

Following this, the registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance addressing the specific non-compliances identified.

The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

**Enforcement and monitoring processes**
The Commission has a range of powers in relation to monitoring compliance of approved centres and where necessary, taking enforcement action.

The Commission will generally request a **corrective and preventative action** (CAPA) plan in the first instance and work with the service to address the concern. A CAPA plan must specifically address the non-compliance and put measures in place to prevent recurrence.

The Commission may issue an **Immediate Action Notice** where a concern needs to be addressed urgently.

The Commission can also direct services to attend a **Regulatory Compliance Meeting** at the Commission offices where they must provide evidence that they are implementing plans to address the concern. Where the Commission is not satisfied with plans provided, then the matter will be escalated.

The Commission may attach **conditions** to an approved centre's registration (similar to a penalty or endorsement on a driver licence). It is an offence to breach a condition of registration.
Where the Commission has ongoing and serious concerns about the care and treatment provided by an approved centre then it may **remove the service from the register**. This in effect means the closure of the approved centre.

Finally, there are a number of offences under the Act including offences relating to the failure or refusal to comply with the provision of the regulations. The Commission may decide to **prosecute** a service in relation to very serious and ongoing concerns.

## Inspection Reports

1. **Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital, Glanmire**
   https://www.mhcirl.ie/File/2018IRs/StStephensHosp_IR2018.pdf

The approved centre is located in four units within the grounds of St. Stephen's Hospital. The hospital is located close to the village of Glanmire, 5-6 kilometres outside the city of Cork. Three of the four units are located separately in the grounds, while Unit 8 is located on the second floor of the main hospital building. The approved centre provides both acute and continuing care to the population of the catchment area of North Cork.

The inadequacy of provision of care to residents in Unit 8 is of particular concern; lack of recreational activities, lack of access to national screening programmes, no outside space, lack of adequate physical health monitoring, poor individual care plans, one shower and one bath for 20 residents, and residents from the acute unit sleeping in Unit 8 when there was a bed shortage.

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

**Condition 1.** *To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.*

**Condition 2.** *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all health care professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

**Condition 3.** *To ensure a comprehensive risk management policy is implemented in the approved centre in adherence to Regulation 32(1) and (2), the approved centre shall submit a copy of their risk register to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Non-compliant areas on this inspection:

| Regulation/Rule/Act/Code | Compliance/Risk Rating 2016 | | Compliance/Risk Rating 2017 | | Compliance/Risk Rating 2018 | |
|---|---|---|---|---|---|---|
| **Regulation 7: Clothing** | X | Moderate | ✓ | | X | High |
| **Regulation 9: Recreational Activities** | X | High | ✓ | | X | High |
| **Regulation 14: Care of the Dying** | ✓ | | X | Low | X | Low |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Regulation 15: Individual Care Plan** | X | High | X | High | X | Critical |
| **Regulation 19: General Health** | ✓ | | X | High | X | Moderate |
| **Regulation 21: Privacy** | X | High | X | High | X | Critical |
| **Regulation 22: Premises** | X | High | X | High | X | Critical |
| **Regulation 26: Staffing** | X | High | X | High | X | High |
| **Regulation 27: Maintenance of Records** | X | Moderate | X | High | X | Moderate |
| **Regulation 28: Register of Residents** | ✓ | | ✓ | | X | Low |
| **Regulation 32: Risk Management Procedures** | X | Critical | X | High | X | Critical |
| **Code of Practice on the Use of Physical Restraint in Approved Centres** | X | High | ✓ | | X | High |
| **Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre** | X | Moderate | X | High | X | Low |

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.

Areas of compliance rated "excellent" on this inspection:

| Regulation |
|---|
| **Regulation 4: Identification of Residents** |
| **Regulation 8: Residents' Personal Property and Possessions** |
| **Regulation 13: Searches** |
| **Regulation 29: Operating Policies and Procedures** |
| **Regulation 30: Mental Health Tribunals** |
| **Regulation 31: Complaints Procedures** |

2. **Acute Psychiatric Unit, Tallaght Hospital**
   https://www.mhcirl.ie/File/2018IRs/APU_Tallaght_IR2018.pdf

The approved centre provides acute psychiatric care and is located on the ground floor of a building within the grounds of Tallaght Hospital, in southwest Dublin. It consists of three units, Cedar (female admissions), Rowan (male admissions), and Aspen (high observation unit). There are 52 beds in the approved centre, 23 in each of Rowan and Cedar Wards and six in Aspen Ward. Twelve residents were in hospital for more than six months.

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

**Condition 1:** *To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency prescribed by the Commission.*

**Condition 2:** *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Non-compliant areas on this inspection:

| Regulation/Rule/Act/Code | Compliance/Risk Rating 2016 | | Compliance/Risk Rating 2017 | | Compliance/Risk Rating 2018 | |
|---|---|---|---|---|---|---|
| Regulation 13: Searches | ✓ | | ✓ | | X | Low |
| Regulation 15: Individual Care Plan | X | High | X | High | X | Moderate |
| Regulation 19: General Health | X | Moderate | X | Moderate | X | High |
| Regulation 22: Premises | X | Moderate | X | High | X | Critical |
| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines | X | Moderate | X | Moderate | X | High |
| Regulation 25: Use of Closed Circuit Television | ✓ | | ✓ | | X | High |
| Regulation 26: Staffing | X | High | X | High | X | High |
| Regulation 27: Maintenance of Records | X | Moderate | X | Moderate | X | High |
| Regulation 29: Operating Policies and Procedures | ✓ | | ✓ | | X | Moderate |
| Regulation 32: Risk Management Procedures | X | Moderate | X | Moderate | X | High |
| Rules Governing the Use of Electro-Convulsive Therapy | ✓ | | ✓ | | X | Low |
| Rules Governing the Use of Seclusion | X | Low | X | High | X | High |
| Part 4 of the Mental Health Act 2001 - Consent to Treatment | X | High | X | High | X | Moderate |
| Code of Practice on the Use of Physical Restraint in Approved Centres | X | Moderate | X | Low | X | Moderate |
| Code of Practice Relating to the Admission of Children | X | Moderate | X | Moderate | X | High |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients | ✓ | | ✓ | | X | Low |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre** | **X** | Low | **X** | Moderate | **X** | Moderate |

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

Areas of compliance rated "excellent" on this inspection:

| Regulation |
|---|
| **Regulation 4: Identification of Residents** |
| **Regulation 10: Religion** |
| **Regulation 18: Transfer of Residents** |

### 3. Sligo Leitrim Mental Health In-patient Unit, Ballytivnan

https://www.mhcirl.ie/File/2018IRs/Sligo_LeitirmMHInPUnit_IR2018.pdf

The approved centre is a 32-bed unit, located on the Clarion Road, Ballytivnan, on the outskirts of Sligo town. It provides acute psychiatric care. The building dated from the 1930s and was situated on its own grounds, next to the former psychiatric hospital. Plans are progressing for the development of a new acute unit on the campus of Sligo University Hospital.

The approved centre is a two-story building; residents are accommodated on the ground floor with therapy rooms, a training room, and offices on the first floor. The unit is divided into female (14 beds) to the right of the entrance and male (14 beds) to the left of the entrance with a high-observation area off the male ward.

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

**Condition 1:** *To ensure adherence to Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update on the programme of maintenance to the Mental Health Commission in a form and frequency prescribed by the Commission.*

**Condition 2:** *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date with mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Non-compliant areas on this inspection:

| Regulation/Rule/Act/Code | Compliance/Risk Rating 2016 | | Compliance/Risk Rating 2017 | | Compliance/Risk Rating 2018 | |
|---|---|---|---|---|---|---|
| **Regulation 15: Individual Care Plan** | **X** | Moderate | **X** | High | **X** | High |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Regulation 19: General Health** | X | Moderate | ✓ | | X | High |
| **Regulation 21: Privacy** | X | Moderate | X | High | X | High |
| **Regulation 22: Premises** | X | High | X | High | X | High |
| **Regulation 26: Staffing** | X | Critical | X | High | X | High |
| **Regulation 32: Risk Management Procedures** | X | High | X | High | X | Critical |
| **Code of Practice on the Use of Physical Restraint in Approved Centres** | X | High | X | Moderate | X | Moderate |

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

Areas of compliance rated "excellent" on this inspection:

| Regulation |
|---|
| **Regulation 4: Identification of Residents** |
| **Regulation 5: Food and Nutrition** |
| **Regulation 6: Food Safety** |
| **Regulation 7: Clothing** |
| **Regulation 8: Residents' Personal Property and Possessions** |
| **Regulation 10: Religion** |
| **Regulation 14: Care of the Dying** |
| **Regulation 20: Provision of Information to Residents** |
| **Regulation 25: Use of Closed Circuit Television** |
| **Regulation 27: Maintenance of Records** |
| **Regulation 29: Operating Policies and Procedures** |
| **Regulation 30: Mental Health Tribunals** |

4. **Acute Psychiatric Unit, Ennis Hospital**
   https://www.mhcirl.ie/File/2018IRs/APU_Ennis_IR2018.pdf

The Acute Psychiatric Unit (APU) is located on the ground floor of Ennis Hospital. The 39-bed APU is the acute psychiatric admissions unit for the adult population of Clare and North Tipperary. There are eight consultant led teams admitting to the unit. Thirty-four beds are allocated to general adult admissions and five beds were designated to psychiatry of later life (POLL).

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

**Condition 1:** *To ensure adherence to Regulation 21: Privacy and Regulation 22: Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs, privacy and dignity of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.*

**Condition 2:** *To ensure adherence to Regulation 26 (4): Staffing the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up to date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*

Non-compliant areas on this inspection:

| Regulation/Rule/Act/Code | Compliance/Risk Rating 2016 | | Compliance/Risk Rating 2017 | | Compliance/Risk Rating 2018 | |
|---|---|---|---|---|---|---|
| **Regulation 15: Individual Care Plan** | ✓ | | ✓ | | X | Critical |
| **Regulation 16: Therapeutic Services and Programmes** | ✓ | | ✓ | | X | High |
| **Regulation 18: Transfer of Residents** | X | High | ✓ | | X | Low |
| **Regulation 19: General Health** | ✓ | | ✓ | | X | Moderate |
| **Regulation 21: Privacy** | X | High | ✓ | | X | Low |
| **Regulation 22: Premises** | X | High | X | Moderate | X | Moderate |
| **Regulation 26: Staffing** | X | Moderate | X | Moderate | X | High |
| **Regulation 27: Maintenance of Records** | X | Low | X | Moderate | X | High |
| **Rules Governing the Use of Seclusion** | X | Moderate | X | Moderate | X | High |
| **Code of Practice on the Use of Physical Restraint in Approved Centres** | ✓ | | X | High | X | High |
| **Code of Practice Relating to the Admission of Children** | X | Moderate | X | Moderate | X | Moderate |
| **Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre** | X | High | X | High | X | Moderate |

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

Areas of compliance rated "excellent" on this inspection:

| Regulation |
|---|
| **Regulation 4: Identification of Residents** |
| **Regulation 5: Food and Nutrition** |
| **Regulation 7: Clothing** |
| **Regulation 10: Religion** |

5. **Haywood Lodge**
   https://www.mhcirl.ie/File/2018IRs/Haywood_Lodge_IR2018.pdf

Haywood Lodge is a 40 bed single-storey building situated off the Haywood Road in Clonmel, County Tipperary. The approved centre consists of two units, which caters for Psychiatry of Later Life (East House), and Rehabilitation and Recovery (West House). Each unit has 20 spacious, en suite bedrooms, each facilitating direct access to a large enclosed garden.

There were no conditions to the approved centre's registration.

Non-compliant areas on this inspection:

| Regulation/Rule/Act/Code | Compliance/Risk Rating 2016 | | Compliance/Risk Rating 2017 | | Compliance/Risk Rating 2018 | |
|---|---|---|---|---|---|---|
| **Regulation 9: Recreational Activities** | ✓ | | ✓ | | X | High |
| **Regulation 16: Therapeutic Services and Programmes** | ✓ | | ✓ | | X | Critical |
| **Regulation 19: General Health** | X | Moderate | X | High | X | High |
| **Regulation 20: Provision of Information to Residents** | ✓ | | X | Low | X | Moderate |
| **Regulation 22: Premises** | ✓ | | X | Low | X | High |
| **Regulation 26: Staffing** | ✓ | | X | High | X | High |
| **Regulation 27: Maintenance of Records** | X | Moderate | ✓ | | X | Moderate |
| **Regulation 32: Risk Management** | X | High | X | Moderate | X | Moderate |
| **Rules Governing the Use of Mechanical Restraint** | X | High | ✓ | | X | Moderate |
| **Code of Practice on the Use of Physical Restraint** | ✓ | | ✓ | | X | High |
| **Code of Practice on Admission, Transfer and Discharge** | X | Moderate | X | High | X | Moderate |

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

No areas of compliance were rated excellent on this inspection.