MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

St Michael's Unit, Mercy University Hospital

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

ST MICHAEL'S UNIT, MERCY UNIVERSITY HOSPITAL

St Michael's Unit, Mercy University Hospital, Grenville Place, Cork

Date of Publication:
Thursday 01 April 2021

ID Number: AC0163

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life

Most Recent Registration Date:
1 March 2020

Conditions Attached:
Yes

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Kevin Morrison, General Manager, Mental Health Services, Cork Kerry Community Healthcare

Inspection Team:
Carol Brennan-Forsyth, Lead Inspector
Noeleen Byrne
Rajeev Ramasawmy

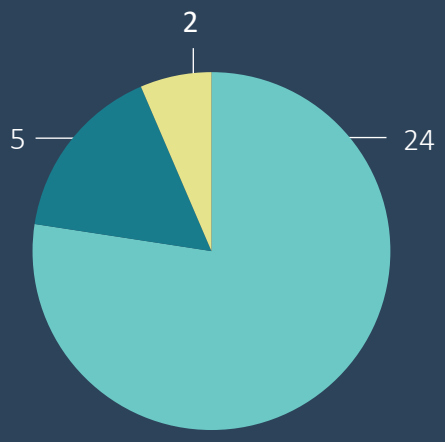
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
29 October – 02 November 2020

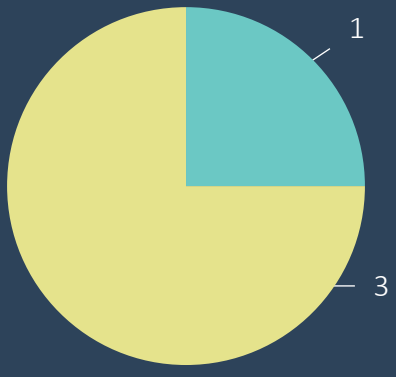
Previous Inspection Date:
24 – 27 September 2019

Inspection Type:
Announced Annual Inspection

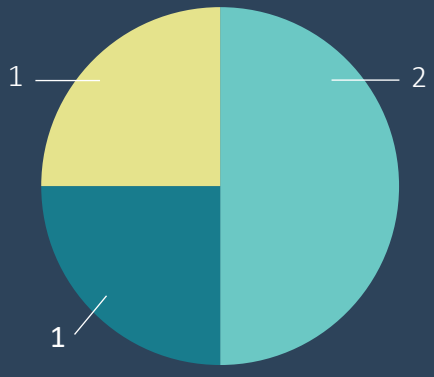
2020 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



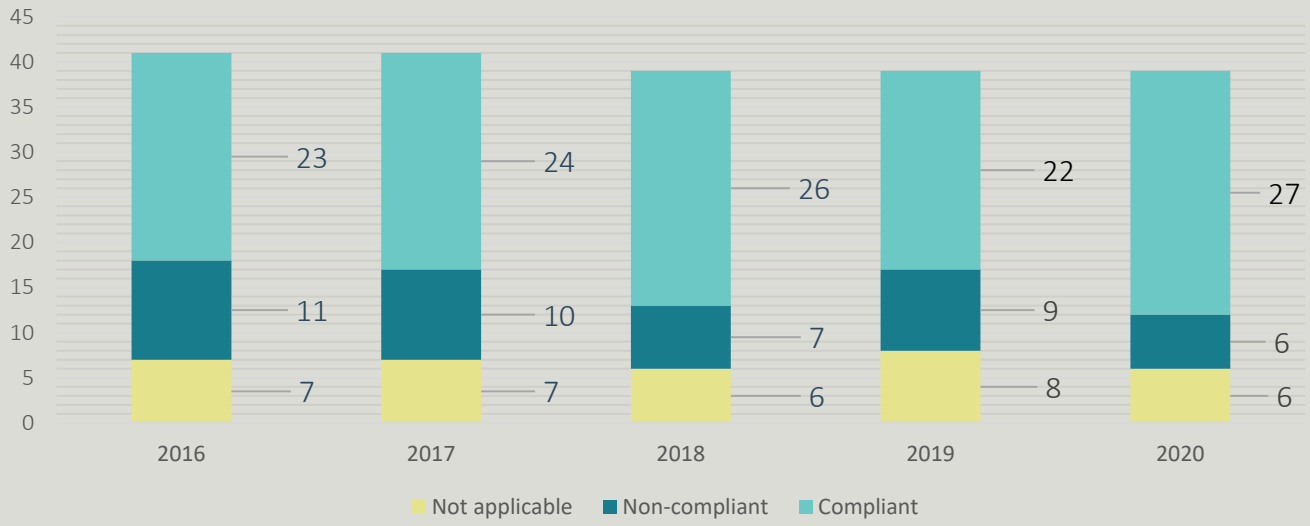
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2016 – 2020

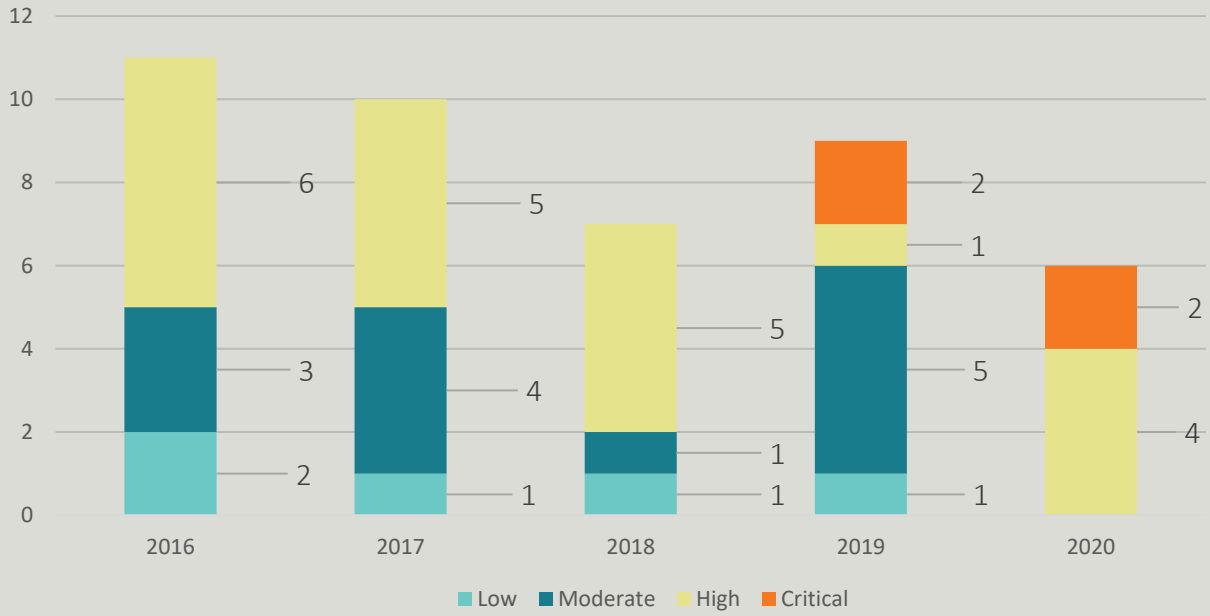
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



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 2016 – 2020



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with regulations, rules and codes of practice.

In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

St. Michael's Unit was situated in Cork city centre. The 50-bed acute approved centre was on the first floor of the Mercy University Hospital and was comprised of acute and sub-acute wards. The acute area contained 18 beds and the sub-acute area had 32 beds. Five Adult Mental Health teams and a Psychiatry of Later Life team admitted residents to the approved centre.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	68%	71%	79%	71%	82%
Regulations Rated Excellent	1	6	10	10	N/A

Conditions to registration

There was one condition 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.*

Finding on this inspection: The approved centre was in breach of Condition 1, as the approved centre was non-compliant with Regulation 21: Privacy and Regulation 22: Premises at the time of inspection. Both non-compliances were rated as a critical risk.

Safety in the approved centre

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- There was suitable and sufficient catering equipment in the approved centre, as well as proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Kitchen areas were clean.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- Hazards, including large open spaces, steps and stairs, slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces were all minimised in the approved centre.
- Medication was ordered, prescribed, stored, and administered in a safe manner.

However:

- Ligature points had not been minimised in the approved centre. This had not been included in the approved centre's risk register.

Appropriate care and treatment of residents

- Therapeutic services and programmes included: a social group; working towards discharge; community access; community meetings; craft group; exercise group; and cooking. The psychology department provided the following: anxiety management; being an inpatient; challenging negative thinking; communication skills; connecting with your emotions; coping with distress using self-soothing; improving sleep; and healing with compassion and mindfulness. Nurse therapy co-facilitated some of these groups and, in addition, ran a men's group and a news and views group.
- For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

However:

- Individual care plans (ICPs) were not satisfactory:
    - One of the five ICPs examined was not developed by the multi-disciplinary team (MDT).
    - Goals were not appropriate on one of five ICPs examined.
    - Four of the five ICPs were not reviewed by the MDT.
    - One of the five ICPs was not reviewed weekly.
- The six-monthly health assessment did not include family and personal history, body-mass index (BMI), waist circumference, and nutritional status in the three clinical files inspected. One general health assessment did not record the resident's blood pressure and in another the resident's weight had not been documented.

Respect for residents' privacy, dignity and autonomy

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident and, where residents shared a room, bed screening ensured that their privacy was not compromised.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was clean.
- There was a visiting room where residents could meet visitors in private.
- Physical restraint was compliant with the Code of Practice on the Use of Physical Restraint.

However:

- The approved centre was not adequately sized to provide an environment that respected the residents' privacy and dignity:
    - The two-bedded room was not of an adequate size so as to ensure resident privacy and dignity.
    - The sitting room in the sub-acute ward was very small and unable to accommodate the residents.
    - The resident's relaxation and recreation areas were very limited.
    - The conservatory was only accessible under supervision, which limited communal space for the residents.
- Residents did not have access to a garden or outdoor space.
- The approved centre was not free from offensive odours, as a strong smell of cigarette smoke was noted on both days of inspection.
- The approved centre did not have adequate and suitable furnishings for the number and mix of residents in the approved centre.

Responsiveness to residents' needs

- Recreational activities included knitting, embroidery, mindful colouring, air hockey, football, board games, crosswords, puzzle books, DVDs, books and walks. The approved centre also had a gym which was available to residents, chair yoga sessions were also provided. The approved centre provided access to recreational activities on weekdays and during the weekend.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.

Governance of the approved centre

- St. Michael's Unit, Mercy University Hospital was part of the North Lee Mental Health Services, which was part of the wider Cork Kerry Community Healthcare Organisation. St. Michaels Unit was governed by the North Lee Mental Health Services Senior Management Team. Sub-committees and working groups fed into the North Lee Senior Management Team, some of which included: a COVID-19 Outbreak Control Team, a Quality and Safety Committee; St. Michael's Unit Nurse Management Group; Policies Procedures Group, Incident Review Group, an Audit Committee; and an ICP Working Group.
- The Policies Procedures, Protocols and Guidelines (PPPGs) group provided a multi-disciplinary approach to policy development, review, approval, and dissemination.
- There was an audit cycle in place and audit results were monitored by the Audit Committee.
- St. Michael's Unit risk register was maintained by the Incident Review Group, which met every three months. Information in relation to the St. Michael's Unit risk register was escalated into the North Lee Mental Health Services Management Team and the Quality and Safety Committee when appropriate.
- North Lee serious incidents, trends, and analysis were also discussed by the North Lee Quality and Safety Committee.
- Not all disciplines had formal structures and processes in place for measuring staff performance and personal development. At the time of inspection, mandatory training for staff was on hold due to the COVID-19 pandemic.
- The approved centre had a COVID-19 contingency plan in place and the COVID-19 Outbreak Control Team met regularly to discuss procedures and risks to the unit.
- The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE's 'Comment, Compliment or Complaint' process, and resident community meetings.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre had introduced an Individual Care Plan (ICP) Working Group to improve interdisciplinary care planning processes.

2. The approved centre had recommenced promotion of a tobacco free campus.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Michael's Unit was situated beside the river Lee, in Cork city centre. The 50-bedded approved centre was on the first floor of the Mercy University Hospital and comprised of acute and sub-acute wards. The acute area contained 18 beds and the sub-acute area had 32 beds. St. Michael's Unit provided inpatient care to the following areas: City North East, City North West, Blarney/Macroom, Cobh, Glenville, and Middletown/Youghal. Five Adult Mental Health teams and a Psychiatry of Later Life team admitted residents to the approved centre.

Access in and out of the main building was controlled and monitored by a security guard, who was positioned at the main entrance to St Michael's Unit. Due to the city centre location of the approved centre, parking was very limited.

St Michael's Unit contained single bedrooms, double bedrooms, and dormitory rooms. One 2-bedded room within the sub-acute area was remarkably small and not of an adequate size to ensure residents' privacy and dignity. The approved centre's activities areas comprised of a dining room, an occupational therapy kitchen, an occupational art room, an activities room, a small gym, and a multi-purpose consultation room. On the sub-acute ward, there was a small sitting room which under normal circumstances could not accommodate many residents. At the time of inspection even fewer residents could access the sitting room due to the COVID-19 pandemic and social distancing guidelines. The approved centre had a conservatory attached which overlooked the river; however, due to on-going issues with smoking, the conservatory was locked and could only be accessed by the residents under supervision. The acute ward had a large, open lounge area with chairs and a TV. Hoists and other mobile towel rails were also stored in this area. The residents' relaxation and recreational areas were very limited and residents had no access to outdoor space. Due to this, the environment was restrictive in nature. The approved centre was found to be clean and generally well maintained.

Ligature points continued to be very evident throughout the approved centre, no work had been undertaken to minimise the risks associated with the ligature points since the last inspection. Ongoing plans to reconfigure St Michael's Unit were still under discussion.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**40**
Number of detained patients	6
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

St. Michael's Unit, Mercy University Hospital was part of the North Lee Mental Health Services. North Lee was a subsection of Cork Mental Health Services, which was part of the wider Cork Kerry Community Healthcare Organisation. St. Michaels Unit was governed by the North Lee Mental Health Services Senior Management Team. Numerous sub-committees and working groups fed into the North Lee Senior Management Team, some of which included; a COVID-19 Outbreak Control Team, a Quality and Safety Committee; St. Michaels Unit Nurse Management Group; Policies Procedures Group, Incident Review Group, an Audit Committee and an ICP Working Group.

The Policies Procedures, Protocols and Guidelines (PPPGs) group provided a multi-disciplinary approach to policy development, review, approval, and dissemination. There was an audit cycle in place and audit results were monitored by the Audit Committee. The Audit Committee fed into the North Lee Mental Health Services Quality and Safety Committee.

The approved centre's registered proprietor had overall responsibility for the risk management process. St. Michael's Unit risk register was maintained by the Incident Review Group which met every three months. Members of the Incident Review Group consisted of the Assistant Director of Nursing (ADON), Clinical Nurse Manager 3 and the Clinical Director. Information in relation to the St. Michael's Unit risk register fed into the North Lee Mental Health Services Management Team and the Quality and Safety Committee when appropriate. The approved centre's risk register fed into the wider risk register maintained by the Cork Mental Health Services Management Team. Incidents and trends were discussed at the three monthly Incident Review Group, escalated incidences were discussed at multi-disciplinary team meetings. North Lee serious incidents, trends, and analysis were also discussed by the North Lee Quality and Safety Committee. The most prominent risks identified by the service were in relation to the COVID-19 pandemic, mandatory training for staff, ligature points, maintenance of the approved centre, and residents' unauthorised smoking on the unit. These risks were documented on the risk register; however, it was evident that there had been limited effective reduction and improvement with the risk associated with ligature points since last inspection. Discussions had taken place regarding on-going plans to reconfigure the approved centre, as the building was not fit for purpose. The risk associated with the building had not been placed on the approved centre's risk register at the time of inspection.

Not all disciplines had formal structures and processes in place for measuring staff performance and personal development. The formal arrangements and availability of clinical supervision varied across disciplines. At the time of inspection mandatory training for staff was on hold due to the COVID-19 pandemic. Staff reported that there was a lack of occupational therapists (OTs) for the St Michael's Unit, there was one designated OT for 40 residents. There was OT in reach into the Unit to attend Individual Care Plan meetings and provide 1:1 services for residents. Two nurse therapists had been allocated to the approved centre to support the therapeutic programmes. Psychology and social work reported having an adequate compliment

of staff. Both disciplines provided in reach services to the approved centre. Due to the COVID-19 pandemic nursing staff from the community had been redeployed to the approved centre, agency staff had also been contracted to maintain staffing levels in times of need.

The approved centre had a COVID-19 contingency plan in place and the COVID-19 Outbreak Control Team met regularly to discuss procedures and risks to the unit. The Mercy Hospital had set up a COVID-19 Assessment Hub in the Accident and Emergency Department (A&E). A Mental Health Liaison Nurse was available to assist in the Accident and Emergency Department where necessary.

The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE's 'Comment, Compliment or Complaint' process and resident community meetings.

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 2016 and 2020 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2016		2017		2018		2019		2020	
Regulation 15: Individual Care Plan	✗	Moderate	✗	High	✓		✗	Moderate	✗	High
Regulation 19: General Health	✓		✓		✗	High	✗	Moderate	✗	High
Regulation 21: Privacy	✗	Moderate	✗	High	✗	High	✗	Critical	✗	Critical
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	Critical	✗	Critical
Regulation 32: Risk Management Procedures	✗	High	✓		✓		✗	Moderate	✗	High
Code of Practice Relating to the Admission of Children Under the Mental Health Act 2001		Not Applicable		Not Applicable	✓			Not Applicable	✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable
Rules Governing the Use of 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 on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

a) 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.
b) Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
c) The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

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

Eleven service user experience questionnaires were completed and returned to the inspection team, 2 residents were interviewed over the phone and one resident spoke with the inspectors on the walkabout. Feedback suggested that the residents understood their ICPs and most said they were involved in setting their own goals. One resident said he has never been invited to an MDT meeting. Most of the respondents said they were able to discuss worries or concerns with members of staff. Four residents mentioned that they would like to get more fresh air and exercise and would like access to an outdoor space. Resident's mentioned the lack of privacy sharing bedrooms with so many other people and the lack of quiet space in the bedrooms and in the communal areas.

The inspection team did not engage with the IAN at the time of inspection.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Area Administrator
- General Manager
- Principal Social Worker
- Occupational Therapist

Apologies:

- Acting Head of Service
- Principal Clinical Psychologist
- Occupational Therapy Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

There were a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Menus were reviewed regularly by the dietitian. Meals came from the main hospital's kitchen. Residents had at least two choices for meals. Water coolers were not in use at the time of inspection due to COVID-19 restrictions, though residents were offered water and cold drinks regularly throughout the day.

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

There was suitable and sufficient catering equipment in the approved centre, as well as 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. At the time of the inspection, no residents wore nightclothes during the day.

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 operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed on October 2018.

A resident's personal property and possessions were safeguarded in the property room when the approved centre assumed responsibility for them. Secure facilities were provided for the safe keeping of the resident's monies, valuables, personal property, and possessions, as necessary; there was a safe in each office of the acute and sub-acute wards. 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 separate 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 and 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. These included the following: knitting, embroidery, mindful colouring, air hockey, football, board games, crosswords, puzzle books, DVDs, books and walks. The approved centre also had a gym which was available to residents, chair yoga sessions were also provided. The approved centre provided access to recreational activities on weekdays and during the weekend.

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 was practicable.

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 operational policy and procedures relating to visits. The policy was last reviewed on October2020.

Visiting times were appropriate and reasonable; due to COVID-19 restrictions and in line with public health advice, visitors were not permitted in the approved centre, except on compassionate grounds. The approved centre had a designated room for visitors, 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 visitors 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 operational policy and procedures relating to communication. The policy was last reviewed on February 2018.

Residents had access to mail, fax, e-mail, internet, telephone, or any device for the sending and receiving of messages and goods unless risk-assessed with due regard to the residents' well-being, safety, and health. Residents had access to post and there was a cordless phone for residents' use. All residents could use their own mobile phone unless otherwise risk assessed. Residents had access to a computer in the resource room with staff supervision. An iPad been provided for the residents use during the COVID-19 pandemic. As there were no restrictions to websites on the internet, the iPad could be accessed by residents when in the therapies department.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

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 operational policy and procedures relating to the conducting of searches. The policy was last reviewed on February 2018. It included all requirements related to:

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

The clinical file of one resident was examined on inspection in relation to the search process. Risk was assessed prior to the search of the resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches and the request for consent and the received consent were documented for every search. The resident search policy and procedure was communicated to all residents and relevant staff were documented to have read and understood the policy on searches.

Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy, and gender; at least one of the staff members conducting the search was the same gender as the resident being searched. A written record of every search of a resident and every 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. 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 operational policy and procedures relating to the care of the dying. The policy was last reviewed on February 2018. No deaths had occurred in the approved centre since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. One of five ICPs was not developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. 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 goals of one of five ICPs inspected were not appropriate. ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. ICPs identified the resources required to provide the care and treatment identified. Not all ICPs were reviewed by the MDT in consultation with the resident. Four ICPs were not reviewed by the full MDT, while one ICP was not reviewed weekly.

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

a) **One of five ICPs was not developed by the MDT.**
b) **Goals were not appropriate on one of five ICPs.**
c) **Four of five ICPs were not reviewed by the MDT.**
d) **One in five ICPs was not reviewed weekly.**

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, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Occupational therapy groups and activities included: social group; working towards discharge; bingo; community access; community meetings; craft group; exercise group; cooking; baking; and, out and about. The psychology department provided the following: anxiety management; being an inpatient; challenging negative thinking; communication skills; connecting with your emotions; coping with distress using self-soothing; improving sleep; and, healing with compassion and mindfulness. Nurse therapy co-facilitated some of these groups, and ran a men's group, a games group, and a news and views group.

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 an operational policy and procedures relating to the transfer of residents. The policy last reviewed on March 2018.

The clinical file of one resident who had been transferred from the approved centre was examined during the inspection process. Full and complete written information for the resident was transferred when they moved from the approved centre to another facility. Information accompanied the resident upon transfer. The following information was issued, with copies retained, as part of transfer documentation: letter of referral, including list of current medication; resident transfer form; and, required medication for the resident during the transfer process.

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 written operational policy and procedures relating to medical emergencies. The policy was last reviewed on March 2020.

The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED), both of which were checked weekly. Records were available of any medical emergency within the approved centre and the care provided.

Three clinical files were examined in relation to the provision of general health services during the inspection process. General health interventions were in line with individual care plans (ICPs). Not all residents' general health needs were assessed within the required six month timeframe, as confirmed in the case of one clinical file reviewed. The six-monthly general health assessment documented physical examination, smoking status, and dental health. However, family and personal history, BMI, waist circumference, and nutritional status were not documented in the three clinical files inspected. One general health assessment did not record the resident's blood pressure and in another the resident's weight had not been documented.

Residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG) heart function test. Adequate arrangements were in place for access by residents to general health services and for the referral to other health services as required.

Residents could access national screening programmes that were available according to age and gender, including but not limited to the following: Breast Check; cervical screening; retina check for diabetics only; bowel screening; and medication review.

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

a) One resident did not have their health needs assessed within the required six month timeframe, 19.1.

b) One general health assessment did not include the residents blood pressure, 19.1(b).
c) Three of three general health assessments did not include family/personal history.
d) Three of three physical assessments did not document BMI and waist circumference 19.1 (b).
e) One of three physical assessments did not document the resident's weight, 19.1 (b).
f) Three out of three general health assessments did not include the residents nutritional status. 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 operational policy and procedures relating to the provision of information to residents. The policy was last reviewed on February 2018.

The required information was provided to residents and their representatives at admission, including the approved centre's information booklet that detailed its care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. It contained details of housekeeping arrangement, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements; relevant advocacy and voluntary agencies, and; residents' rights.

Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis unless, in the treating psychiatrist's view, provision of such information might be prejudicial to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to resident needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating CRITICAL

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

INSPECTION FINDINGS

Residents were called by their preferred name and the general demeanour of staff and the way in which they dressed and communicated with residents was respectful. Staff were discrete when discussing the resident's condition or treatment needs and sought the resident's permission before entering their room, as appropriate.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident. However, a room in the approved centre had two beds and two lockers, residing two residents; space in this room was very tight and privacy in this regard was acutely compromised. On the sub-acute ward, there was a small sitting room which under normal circumstances could not accommodate 32 residents. At the time of inspection even fewer residents could access the sitting room due to the COVID-19 pandemic and social distancing guidelines. This communal room was a thoroughfare to the green room (activity room). The approved centre had a conservatory overlooking the river which was locked at the time of inspection. Residents could only access it under supervision as some residents had been using it as a smoking area. The residents' relaxation and recreational areas were very limited and residents had no access to outdoor space. Due to this, the environment was restrictive in nature and impacted on the resident's privacy and dignity.

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; if so, the windows had opaque glass. Noticeboards did not display resident names or other identifiable information. Additionally, residents were facilitated to make private phone calls.

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

a) **The two-bedded room was not of an adequate size so as to ensure resident privacy and dignity.**
b) **The sitting room in the sub-acute ward was very small and unable to accommodate the residents.**
c) **The conservatory was only accessible under supervision which limited communal space for the residents.**
d) **The resident's relaxation and recreation areas were very limited which impacted on the resident's privacy and dignity.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating CRITICAL

(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 did not have access to personal space. One bedroom had two beds and two lockers, residing two residents; space in this room was very tight and privacy in this regard was acutely compromised. On the sub-acute ward, there was a small sitting room which under normal circumstances could not accommodate 32 residents. At the time of inspection even fewer residents could access the sitting room due to the COVID-19 pandemic and social distancing guidelines. This communal room was a thoroughfare to the green room (activity room). The approved centre had a conservatory which was locked at the time of inspection. Residents could only access it under supervision, as residents had been using it as a smoking area. This further reduced communal space. The acute ward had a large communal area which was also a thoroughfare, in addition this area was used to store hoists and mobile hand towel rails. As a consequence of this lack of space, not all private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. The residents' relaxation and recreational areas were very limited. Residents had no access to a garden or outdoor space, as the approved centre was located on the first floor with the main entrance leading onto the street. Discussions had taken place regarding on-going plans to reconfigure the approved centre, little had changed since the last inspection. The approved centre had three conditions pertaining to this regulation at the time of inspection.

Temperatures in the bedroom and day areas were appropriate and comfortable. Rooms in the approved centre were properly ventilated. The lighting in communal rooms suited the needs of residents and staff. It was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were not evident in all areas of the approved centre. Hazards were not minimised in the approved centre; several pieces of equipment were left in the corridor and communal area. Furthermore,

ligatures points were evident on windows and door handles, straps on bins, door mechanisms, and pipes on walls; no work had been conducted on these ligature points since the last inspection.

The approved centre had a general programme of maintenance, decorative maintenance and cleaning. Extra deep cleaning had taken place in response to the CODID-19 pandemic. Overall, the approved centre was clean and hygienic. A strong smell of cigarette smoke was noted in the female toilets on both days of inspection. Generally, the approved centre was well maintained although several stained roof tiles were noted during inspection. The approved centre did not have suitable furnishings to support residents' independence and comfort, as there were a limited amount of chairs in the communal areas.

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

a) **The physical structure of the approved centre was not developed and maintained having due regard for the number and mix of residents in the approved centre, 22 (3).**
b) **Residents did not have access to a garden or outdoor space, 22 (3).**
c) **Ligature points had not been minimised in the approved centre, 22 (3).**
d) **The approved centre was not free from offensive odours, as a strong smell of cigarette smoke was noted on both days of inspection, 22 (1)(a).**
e) **Several stained roof tiles were noted at the time of inspection, 22 (3).**
f) **The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22 (2).**

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 operational policy and procedures relating to the ordering, prescribing, storing and administration of medicines. The policy was last reviewed on July 2020. It contained all necessary processes, including:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident, and; a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

All entries in the MPARs were legible. When 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 on the label or packaging, or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as a refrigerator.

Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and operating procedures relating to health and safety. The policy was last reviewed on July 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to staffing. The policy was last reviewed on July 2020. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements.

The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times. This was documented. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) & 26(5) have been deferred until 2021.

The following is a table of clinical staff assigned to the approved centre.

Staff in Approved Centre		
Staff Grade	**Day**	**Night**
Assistant Director of Nursing	1 WTE (9-5)	0
Clinical Nurse Manager 3	1 WTE (9-5)	0
Consultant Psychiatrist	1	0
Non Hospital Consultant Doctor	1	0
Occupational Therapist	1	0
Nurse Therapist	2	0

Ward or Unit Breakdown			
Ward or Unit	**Staff Grade**	**Day**	**Night**
St Michael's Unit	Clinical Nurse Manager 2	1	1
	Registered Psychiatric Nurse	8	6

In-reach to Approved Centre*			
	Staff Grade	**Day**	**Night**
	Consultant Psychiatrist	6	On call
	Non Consultant Hospital Doctor	12	On call
	Occupational Therapist	6	0
	Social Worker	4	0
	Psychologist	6	0

Whole time equivalent (WTE)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the maintenance of records. The policy was last reviewed on February 2018.

Resident records were secure, up to date, in good order, and were physically stored together. All resident records were reflective of the residents' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Records were maintained in good order; for example, there were no loose pages. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures requiring a three-yearly review were reviewed appropriately.

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 provided assistance when the patient required assistance to attend or participate in the process, including remotely.

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 operational policy and procedures relating to the complaints process. The policy was last reviewed on February 2018 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was available to the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon thereafter. This information was available within the resident information booklet and noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Information displayed on noticeboards in the approved centre informed residents, their representatives, family, and next of kin of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. 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). Complainants were informed promptly of the outcome of a complaint investigation and details of the appeals process were made available to them, and this was documented.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had written operational policy and procedures relating to risk management. The policy was last reviewed on July 2019. The risk management policy addressed all policy related regulatory requirements, including:

- 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. The approved centre's risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Structural risks, including ligature points, were not removed or effectively mitigated; the situation regarding ligature points remained the same as last year's inspection findings. Discussions had taken place regarding on-going plans to manage the ligature risks and reconfigure the approved centre, as the building was not fit for purpose. No structural work had taken place in the approved centre since last inspection. The ligature risks had not been placed on the approved centre's risk register at the time of inspection. The approved centre has been non-compliant with this regulation

for three consecutive years and has a condition attached to their registration pertaining to the minimisation of ligature points.

Clinical risks, as well as health and safety risks were identified, assessed, treated, reported, and monitored. Health and safety risks were dealt with in accordance with relevant legislation. Corporate risks in the approved centre were identified, assessed, treated, reported and monitored by the approved centre; these risks were documented in the risk register. Individual risk assessments were completed prior to and during the following: physical restraint; at admission to identify individual risk factors, including general health risks, and risk of absconding or self-harm; resident transfer; resident discharge; and, in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes. Residents, along with their representatives if applicable, 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; all clinical incidents were reviewed by the MDT 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 in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting; information provided was anonymous at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies; the emergency plan incorporated evacuation procedures.

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

a) **Risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Ligature points had not been removed or effectively mitigated.**
b) **The risks associated with ligature points had not been documented in the approved centre's risk register.**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had a certificate of registration with three conditions to registration attached. The certificate was displayed prominently in the approved centre. At the time of inspection the approved centre was waiting for an up-to-date certificate from the Mental Health Commission.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 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 file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment and that the patient was unable to consent.

A Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient. It documented: 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. Form 17 also detailed the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the patient in relation to the discussion and their decision-making. The form also included 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.

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy relating to the use of physical restraint. The policy was last reviewed on September 2020. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

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. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

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

Evidence of Implementation: The clinical file of one resident who was physically restrained was reviewed on inspection. Physical restraint (PR) was used in rare, exceptional circumstances and was in the best interests of the resident, where the resident posed an immediate threat of serious harm to the self or others. PR was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered; PR was based on risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint. PR was initiated by a registered medical practitioner (RMP), a registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. There was a designated staff member responsible for leading in the physical restraint of a resident and for monitoring the head and airway of the resident.

The Consultant psychiatrist (CP) or duty consultant psychiatrist was notified as soon as was practicable; this was recorded in the clinical file. The RMP completed a medical examination of the resident (physical examination) no later than three hours after the episode of PR. PR lasted for a maximum of 30 minutes; the episode of PR was recorded in the clinical file. A Clinical practice form (CPF) was completed by the person who initiated and ordered the use of PR no later than three hours after the episode. The CPF was signed by the CP within 24 hours. The resident was informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of PR unless the information may be prejudicial to the resident's mental health, well-being, or emotional condition. The reason for not informing the resident was documented in the clinical file. As soon as practicable and with the resident's consent, or where the resident lacked capacity and could not consent, the resident's next of kin or representative was informed

of the use of PR and a record of this communication was placed in the clinical file. When the next of kin was not informed, a justification was documented in the clinical file.

Staff were aware of relevant considerations in the individual care plan (ICP) pertaining to the resident's requirements and needs in relation to the use of PR; this may include advance directives. Special consideration was given when restraining a resident who was known by staff involved in the PR to have experienced sexual or physical abuse. Where practicable, a same sex staff member was present at all times during the episode of PR. The resident was afforded the opportunity to discuss the episode with members of the MDT involved in their care as soon as was practicable. The completed CPF was placed in the resident's clinical file. The episode of PR was reviewed by members of the MDT and documented in the clinical file no later than two days after the episode.

The approved centre was compliant with this code of practice.

Admission of Children

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written operational policy and procedures relating to the admission of a child. The policy was last reviewed on July 2020. It addressed the following:

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

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

Evidence of Implementation: The clinical file of a child that had been admitted to the approved centre was examined on inspection. Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. Provisions were in place to ensure the safety of a child, to respond to a child's special needs as a young person in an adult setting, and to ensure the right of the child to have their views heard.

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

Children did not have access to age-appropriate advocacy services. There was no documented evidence that children had their rights explained to them and information provided about the ward and facilities in a form and language they could understand. Appropriate visiting arrangements for families were available, including for visiting children. The consent for treatment was obtained from one or both parents.

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

a) **Age-appropriate facilities and a programme of activities appropriate to age and ability was not provided, 2.5 (b).**
b) **The child did not have access to age-appropriate advocacy services, 2.5 (g).**

c) **It was not documented in the clinical that child had their rights explained and was provided with information about the ward and facilities in a form and language they can understand, 2.5 (h).**

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 2020, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in March 2018, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in October 2020, 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: A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed, which included presenting problem, past psychiatric history, and family history. Resident's family member, carer, or advocate were involved in the admission process, with resident consent.

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

Discharge: The discharge plan included the following: estimated date of discharge; documented communication with the relevant general practitioner and primary care team, along with the Community Mental Health Team (CMHT); a follow up plan; and, a reference to early warning signs of relapse and risks. The discharge meeting was attended by residents, key worker, relevant members of the MDT, and family, carer, or advocate, where appropriate and with the consent of the resident. The discharge assessment included psychiatric and psychological needs, a current mental state examination, and a comprehensive risk assessment and risk management plan. It also included social and housing needs and informational needs. Discharge was coordinated by a key worker, and a preliminary discharge summary was sent to the

general practitioner, primary care team, and CMHT within three days. A comprehensive discharge summary was issued within 14 days.

Discharge summaries 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. A family member, carer, or advocate was involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10001648		**One of five ICPs was not developed by the MDT. Goals were not appropriate on one of five ICPs. Four of five ICPs were not reviewed by the MDT. One in five ICPs was not reviewed weekly.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	ICP champions group has been set up with a representative from each CMHT. This team meets monthly. Their remit is to provide feedback to each CMHT regarding their effectiveness in meeting the MHC requirements; and they also provide feedback on any issues highlighted. - The Clinical Director sent an email to the lead for the ICP audit group and the HODs highlighting the issues raised in the MHC report so that all teams were clear regarding the specific issues/deficits to be addressed	Heads of Discipline ICP champions group Audit committee CMHTs	These actions are achievable and realistic	26/02/2021	CP audits will take place monthly to enable regular monitoring and results will be forwarded to the ICP leads so that any issues arising can be addressed efficiently/immediately -Audit results will be categorised by team and deficits will be escalated to the ICP champions' team so that the rep for the team will follow up. - ICPs will be added to the risk register for compliance monitoring and tracking. This will be discussed at monthly HOD meetings
Preventative Action	A visual display in the form of a bar chart)	1. All ICP`s will be fully completed	1. 1st March 2021 2. 8th May 2021 3 Next HOD	31/05/2021	Audit committee ICP champions group. HOD

	of the audit results per team will be produced for internal review by HOD, audit committee and ICP champions. -ICP champions group to give detailed feedback on ICPs to one CMHT per month on a rotational basis. It is anticipated that this feedback will be focused and specific. Copy of feedback summary to be shared with HOD and reviewed at HOD meetings. -Audit will be a recurring item on the agenda on all Heads of Discipline meetings and concerns can be highlighted early - Regular six monthly ICP training (provided by the NL Psychology Dept)will be incorporated into the Friday MDT academic schedule - One page summary of relevant audit(s)	measured by audits 2. Ongoing Feedback to local CMHT's and also overview to the HOD group. 3. Audit program added as a standing order to the North Lee HOD meeting.	meeting scheduled for 4th March 2021		All MDT across all sector teams

	that are completed on a particular week to be displayed at the start and end of Friday morning academic teaching sessions.				

Regulation 19: General Health					
Reason ID : 10001652		**One resident did not have their health needs assessed within the required six month timeframe, 19.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	new excel sheet has been developed with an extra column for 6 month physical health reviews. This will be monitored by the Delayed Discharge Committee who meet 6 weekly. Patients requiring 6 month physicals will be highlighted. The Consultant Psychiatrist representative of the Delayed Discharge Committee will then discuss /remind the sector consultant psychiatrist to complete this documentation. CD has emailed all sector consultants and highlighted the incomplete documentation as noted by the MHC.	Progress in relation to this matter will be monitored via a monthly audit which will be monitored by the audit committee Any concerns re incomplete documentation will be escalated to the CD /ADON and CNM3	These actions are achievable and realistic	01/03/2021	Consultants, NCHDs, Audit committee Delayed Discharge Committee CD/ADON/CNM3

Preventative Action	The Consultant Psychiatrist representative on the Delayed Discharge Committee will highlight to the sector consultant psychiatrists when these assessments are due -The excel sheet will be colour coded so that the delayed discharge team will be alerted 60 days before this is due, as a reminder. - One page summary of relevant audit(s) that are completed on a particular week to be displayed at the start and end of Friday morning academic teaching sessions. -The need to complete regulation 19 will be incorporated into the NCHD induction programme (which occurs every six months Jan and July yearly)	A monthly audit will be undertaken and monitored by the audit committee Any concerns re deficits in documentation will be escalated to the CD/ADON /CNM3. Addition to Training Material for NCHD Induction programs	These actions are achievable and realistic	01/03/2021	Delayed discharge group Audit Committee Consultant Psychiatrists NCHDs CD /ADON/CNM3

Reason ID : 10001653		One general health assessment did not include the residents blood pressure, 19.1(b). Three of three general health assessments did not include family/personal history. Three of three physical assessments did not document BMI and waist circumference 19.1 (b). One of three physical assessments did not document the resident's weight, 19.1 (b). Three out of three general health assessments did not include the residents nutritional status. 19.1 (b).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff will again be informed of the need for complete documentation CD has sent an email to all consultant psychiatrists highlighting the importance of completing all necessary documentation.	A monthly audit will be undertaken and monitored by the audit committee Any concerns re deficits in documentation will be escalated to the CD /ADON/CNM3	These actions are achievable and realistic Completed 11.2020	01/03/2021	Consultant psychiatrists Audit committee CD ADON CNM3
Preventative Action	On-going regular audits will identify any deficits in documentation -One page summary of relevant audit(s) that are completed on a particular week to be displayed at the start and end of Friday morning academic teaching sessions. - The need to complete regulation 19 will be incorporated into the	A monthly audit will be undertaken and monitored by the audit committee Any concerns re deficits in documentation will be escalated to the CD /ADON/CNM3 Addition to Training Material for NCHD Induction programs	1. Immediate (Have been added to Audit schedules) 2. Next rotation July 2021	31/07/2021	Audit committee Consultant Psychiatrists Audit committee CD ADON CNM3

	NCHD induction programme (which occurs every six months Jan /July yearly)				

Regulation 22: Premises					
Reason ID : 10001665		The approved centre was not free from offensive odours, as a strong smell of cigarette smoke was noted on both days of inspection, 22 (1)(a).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Tobacco Free Campus meetings in place on the units. Quit packs introduced to the unit by Health promotion officer, leaflets and posters also to create awareness. Presentations by Health Promotion Officer to Nursing staff and junior doctors to promote NRT. NRT material to be added to shared folders for Medical staff. Mercy Hospital in addition to St. Michael's is now a designated Tobacco Free Campus.	Template created to track and also allows escalation and de-escalation as required.	Meeting took place 11/01/2021 next meeting scheduled for 15/03/2021. 30/04/2021	30/04/2021	TFC group with support from HOD and all MDT members.
Preventative Action	Ongoing work with the TFC group to encourage the use of NRT for patients on the unit.	Ongoing TFC group needs to be kept energised to support patients.	Meetings Held quarterly	31/03/2021	TFC Group supported by HOD's and all MDT members.

Reason ID : 10001667		The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22 (2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New and additional furniture received by the unit. Additional furniture also placed in other off ward locations to assist patients.	27 additional furniture items delivered onto SMU and 15 additional specialist furniture pieces received in January 21.	COMPLETE	27/01/2021	CNM3, ADON and Area Administrator.
Preventative Action	Ongoing replacement and upgrading of furniture and soft furnishings on the unit.	Bi-Annual review of furniture to check for damage rips and tears.	Achievable	30/06/2021	cM3, ADON and other MDT members.

Regulation 32: Risk Management Procedures					
Reason ID : 10001669		**The risks associated with ligature points had not been documented in the approved centre's risk register.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	This will be added to the risk register and reviewed at HOD meeting on 4 March.	Monthly HOD meeting	achievable	04/03/2021	ADON to add to risk register/ HODs to review
Preventative Action	On-going monitoring of ligature audit and associated corrective measures by audit committee.	Risk registrar review as a standard item at HOD meeting (monthly) and QPS (quarterly)	Next HOD is 04/03/21 and next QPS is 08/04/2021.	08/04/2021	ADON to add to risk register/ HODs to review

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10001645		**Age-appropriate facilities and a programme of activities appropriate to age and ability was not provided, 2.5 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Existing policy to be revised by North Lee policy group. Specifically, this revision will include details of our process for consultation with the treating CAMHS team and their input on the development of age appropriate programmes of activity.	Policy in place	achievable	31/05/2021	North Lee Policy Group/HODs
Preventative Action	New admission checklist to be devised for admission of under 18's.	Checklist in place	achievable	31/03/2021	North Lee Policy Group/HODs
Reason ID : 10001646		**The child did not have access to age-appropriate advocacy services, 2.5 (g).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Existing policy to be revised by North Lee policy group to incorporate the above.	Policy in place	Achievable	31/05/2021	North Lee Policy Group/HODs
Preventative Action	New admission checklist to be devised for admission of under 18's and	policy in place	achievable	31/05/2021	North Lee Policy Group/HODs

	which will identify advocacy services				
Reason ID : 10001647		**It was not documented in the clinical that child had their rights explained and was provided with information about the ward and facilities in a form and language they can understand, 2.5 (h).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Existing policy to be revised by North Lee policy group to incorporate the above.	revised policy	achievable	31/05/2021	North Lee Policy Group/HODs
Preventative Action	New admission checklist to be devised for admission of under 18's.	revised policy	achievable	31/05/2021	North Lee Policy Group/HODs

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.

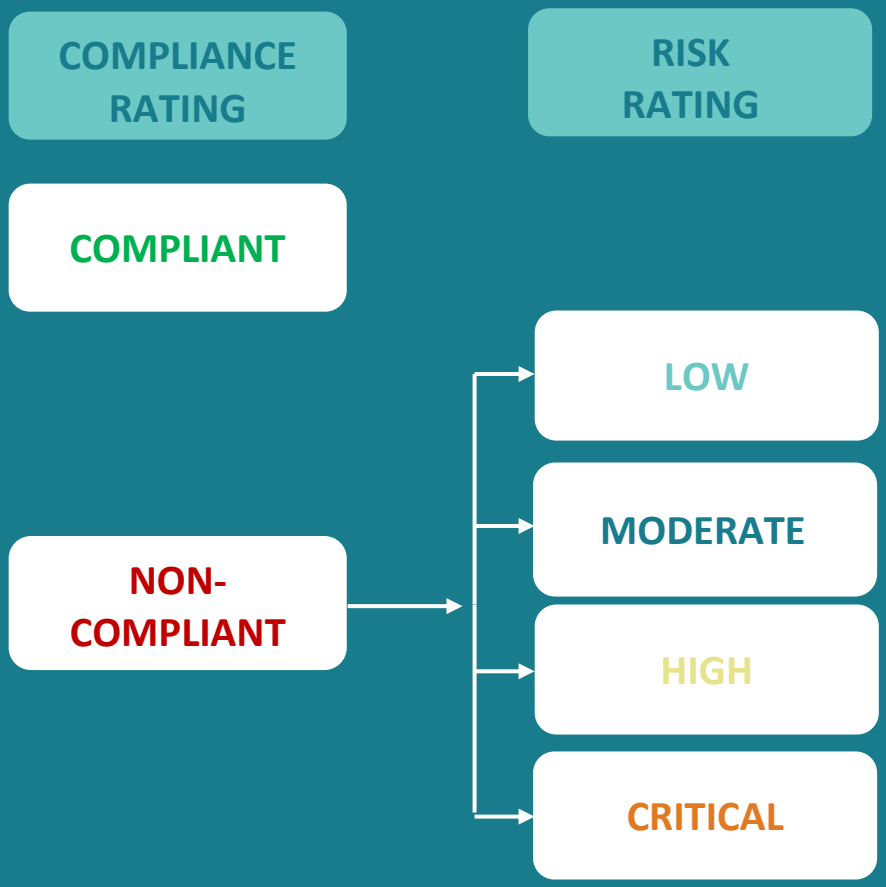
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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