Department of Psychiatry, Connolly Hospital

Annual Inspection Report 2021

Promoting Quality Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, CONNOLLY HOSPITAL

Blanchardstown, Dublin 15

Date of Publication:
Thursday 06 January 2022

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2021 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
7 December 2018

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Anne Marie Donohue, General Manager
Mental Health Services, CHO DNCC

Inspection Team:
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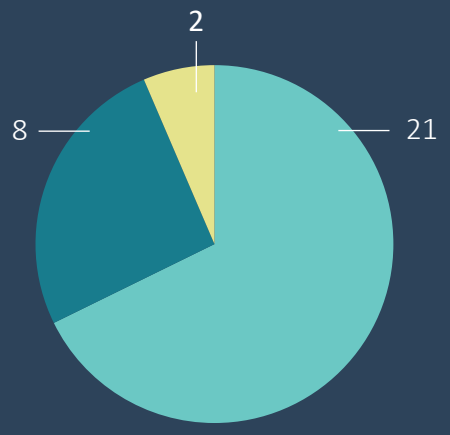
Inspection Date:
13 – 16 July 2021

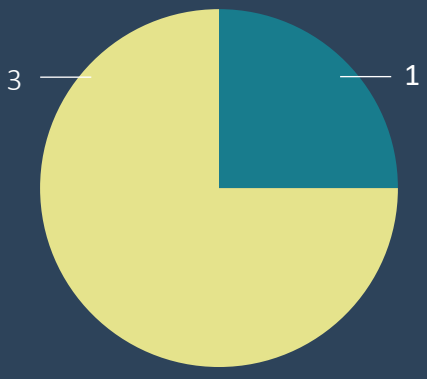
Previous Inspection date:
25 – 28 February 2020

Inspection Type:
Announced Annual Inspection

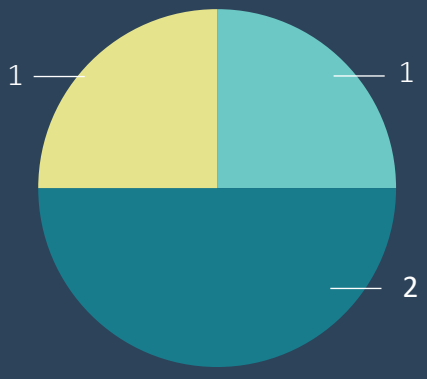
2021 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



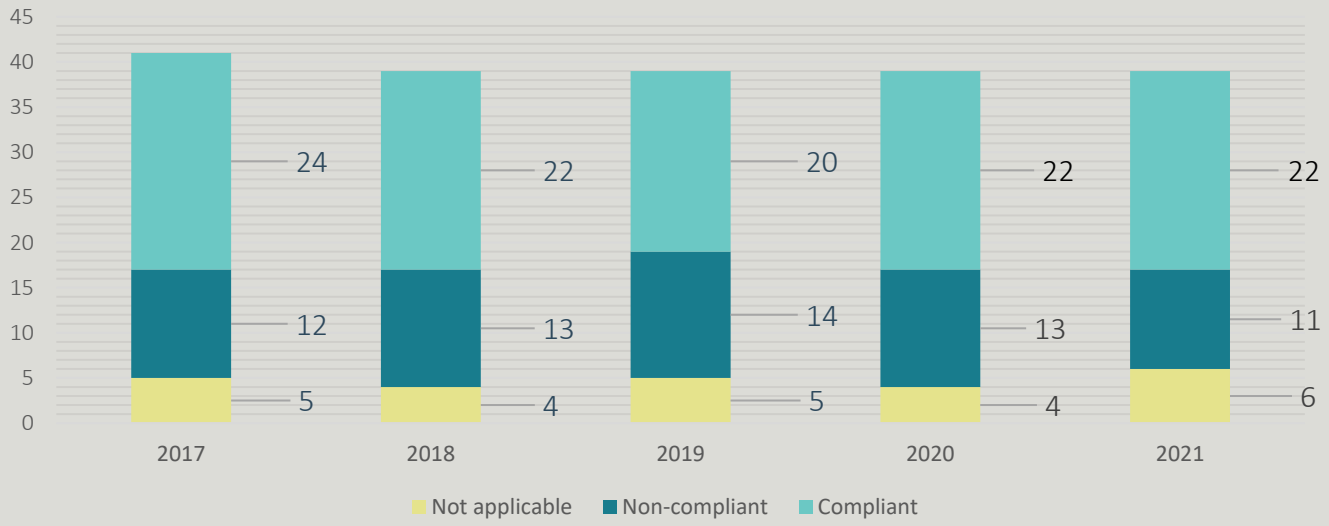
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2017 – 2021

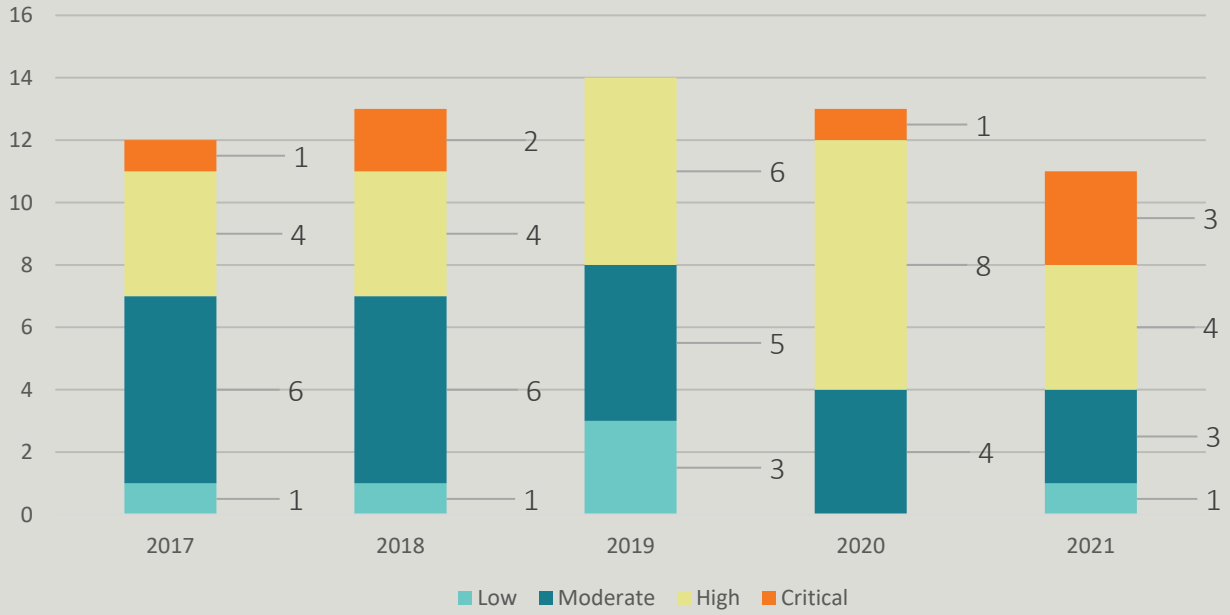
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2017 – 2021



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 2017 – 2021



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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

The Department of Psychiatry (DOP) was located on the lower ground floor of Connolly Hospital in Blanchardstown. The approved centre provided acute in-patient accommodation for the Dublin North City area from Cabra to Mulhuddart. A total of seven consultant led teams based in four catchment areas in Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. Two rehabilitation teams and a team dealing with the homeless population also admitted to the centre.

The approved centre had made no progress on overall compliance over the past five years.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	67%	63%	59%	63%	67%
Regulations Rated Excellent	7	4	6	5	N/A

The average rate of compliance across all approved centres in 2020 was 87%.

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to*	Not all healthcare staff were trained in the Mental Health Act 2001. Members of the medical team

ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission	had not completed the HSE online training in the Mental Health Act (2001).
The approved centre was in breach of Condition 1 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.	
Condition 2: *To ensure adherence to Regulation 15: Individual Care Plan, the approved centre shall audit their individual care plans on a monthly basis. The approved centre shall provide a report on the results of the audits to the Mental Health Commission in a form and frequency specified by the Commission.*	The approved centre provided monthly audits to the Mental Health Commission.
The approved centre was not in breach of Condition 2 and the approved centre was compliant with Regulation 15: Individual Care Plans at the time of inspection.	

Escalation and enforcement actions since previous inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	March 2020	Immediate Action Notice re Fire Safety 10000148	Response received 20 March 2020

Escalation and enforcement actions since this inspection

In response to the three critical risks found in relation to Regulation 19: General Health; Regulation 26: Staffing; Regulation 32: Risk Management and breach of Condition 1, the Commission took enforcement action of immediate action notices and regulatory compliance meeting. Enforcement actions are ongoing.

Safety in the approved centre

We found that there were significant safety concerns 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.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.

- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- 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.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.

However:

- A leaf side door to a fire door on a bedroom sub fire compartment on Pine Ward was missing. This was first reported for repair in February 2021; however, this had not taken place by July 2021 despite repeated requests. This could impact on the DOP's evacuation process should an evacuation be required. This was not escalated as a risk on the risk register.
- There was no evidence any fire drills had taken place which was also highlighted by the inspection team in 2020. There was no person with a clear role and responsibility for fire safety and ensuring fire drills were completed.
- All ligature points were not minimised to the lowest practicable level based on risk assessment.
- Not all healthcare staff were trained in the Mental Health Act 2001. Members of the medical team had not completed the HSE online training in the Mental Health Act (2001). This regulation was non-compliant for the previous five years.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities, but did not monitor residents physical health.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- One to one therapeutic sessions were provided by the occupational therapist where necessary. The psychologist facilitated a program each Friday, and a qualified exercise instructor ran exercise programs. Programmes included art therapy, music therapy, horticulture, yoga, fitness classes, recovery through occupational planning sessions, and looking forward sessions – covering weekend and discharge planning. Adequate in reach services were provided by social work.

However:

- Three residents had not received a documented six-monthly general health check. This meant that none of the three residents received a physical examination, a check of family or personal history, blood pressure, smoking status, dental health, nutritional status, and body mass-index, weight, and waist circumference within six months. This non-compliance was rated as a critical risk.
- Discharge summaries were not completed for one resident who had been discharged.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre did not always provide services in a way that respected residents' privacy, dignity and autonomy.

- All bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to a resident
- Residents were facilitated to make private phone calls.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However:

- At the time of the inspection, residents were required to make a request to staff if they wanted to open or close windows, as the window mechanism did not allow residents to open windows themselves.
- Not all personal belongings in the Pine Ward property room were labelled, which meant it was not possible to identify the property owner.
- Not all personal and valuable belongings on Ash Ward had been returned to residents who had been discharged from the approved centre.
- The residents' personal information board in the nursing station on Ash Ward was viewable from the office main door and window, as these had clear glass and because the doors of the noticeboard were left open. Residents full names were viewable.
- The approved centre was not maintained in a good structural and decorative condition. Floorings were marked, several walls had chipped paint, some toilets were heavily stained, and some bedrooms within the approved centre were either missing or had broken blinds.
- The rooms within the approved centre's premises were not adequately ventilated.
- Communal rooms were not appropriately sized to meet the needs of the residents.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of residents.

- Recreational activities included mindful colouring, drawing, word wheels, jigsaws, music, television, and DVDs. 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.
- There was sufficient private space, as well as areas for socialisation.

Governance of the approved centre

We found that there were areas of poor governance structures and processes.

- The Dublin North City Mental Health Services (DNC MHS) Management Team were responsible for overall governance and operation of the Approved Centre with the exception of Estates/Fire Maintenance which is provided for by Connolly Hospital.
- A programme of clinical audit was undertaken in the approved centre.
- Individual care planning was reviewed at each compliance committee meeting. The DOP audited individual care plans monthly as per their condition. Members of the multi-disciplinary team (MDT) were responsible for completing the audits with two MDT members being accountable each month. Staff attended workshops and a culture of accountability was promoted. The approved centre was compliant with Regulation 15: Individual Care Planning on this inspection.

However:

- It was apparent to the inspection team during the onsite visit that this management system led to uncertainty and confusion regarding completion of maintenance projects and the priority or urgency of work required. Risks, such as fire risks due to a damaged fire door, were not escalated to the risk register. The concerns regarding the fire door were only made aware to the Service Manager Dublin North City Mental Health Services at the time of inspection.
- Fire doors in the bedrooms on Pine Ward had closers which assisted the door to independently close. However, these were not present on doors in Ash Ward. The inspection team were unable to get a definitive answer as to why both units' fire door management operated differently.
- The Health and Safety Statement recorded the fire and safety officer within CHO9 as the person responsible for fire safety within the Department of Psychiatry (DOP). However, the inspection team were informed this role was an advisory one to the DOP.
- Despite a multi-disciplinary compliance committee that met every 6-8 weeks to discuss compliance within the approved centre, there was no improvement in overall compliance.

- Effort was evident to ensure that healthcare professionals working in the approved centre were up-to-date with mandatory training and some disciplines had achieved 100% with mandatory training. However, members of the medical team had not all completed the mandatory training on the Mental Health Act 2001.

COVID-19 response

- In response to the COVID-19 pandemic, DNC MHS implemented a COVID-19 governance structure through the COVID-19 crisis management team. The DOP introduced addendums to policies relating to COVID-19. COVID-19 infection control measures and guidelines were adhered to and prominent signage was visible throughout the DOP.
- All admissions were admitted onto Ash Ward and the garden which was shared by both wards had designated times for each ward to manage infection control.
- All residents who wished to avail of the vaccine in the DOP had been vaccinated at the time of inspection.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The courtyard for both units was complete which had new garden furniture and raised planters.

2. A room on Ash Ward was remodelled to facilitate a consultation room.

3. The Department of Psychiatry became a tobacco free campus from June 2021. All individuals using the service who smoke were offered Nicotine Replacement Therapy (NRT) on admission.

4. The introduction of identification stamps for each discipline with contemporaneous notes commenced from March 2021.

5. The Occupational Therapy Department had been renovated.

6. A new Individual Care Plan document was issued in May 2021 for circulation within the Department of Psychiatry.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry (DOP) was located on the lower ground floor of Connolly Hospital in Blanchardstown. A new entrance was in use to the DOP from the ground floor which had direct access to the DOP on the lower ground floor. The approved centre provided acute in-patient accommodation for the Dublin North City area from Cabra to Mulhuddart. The approved centre was part of the Dublin North City and County Healthcare Organisation (previously CHO 9). A total of seven consultant led teams based in four catchment areas in Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. Two rehabilitation teams and a team dealing with the homeless population also admitted to the centre.

The DOP consisted of a long reception corridor with adjacent offices, a tribunal room, and a family visiting room. Resident accommodation was on two wards, Ash and Pine, located off the reception corridor. The unit Occupational Therapy Department was located on a separate corridor off the main reception area. Both Ash and Pine Wards had accommodation for 21 residents. A High Dependency Unit (HDU) with accommodation for up to five residents, incorporating a seclusion room, was attached to Ash ward. Resident accommodation mirrored on both Ash and Pine wards consisted of a mix of single rooms (two), double rooms (three), four-bedded rooms (two), and a five-bedded room. There was a large, paved courtyard where renovations were completed since the previous inspection. The courtyard which was used by both units consisted of raised flower beds and colourful garden furniture. The Communal areas on both Ash and Pine Wards were small and inadequate to accommodate all the residents when the approved centre was at full capacity as noted in the previous inspection. A new multi-purpose room which was the entry point to the courtyard on Ash Ward had a new TV installed in Feb 2021; however, this was not operational.

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**36**
Number of detained patients	13
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The Dublin North City Mental Health Services (DNC MHS) Management Team were responsible for overall governance and operation of the Approved Centre with the exception of Estates/Fire Maintenance which is provided for by Connolly Hospital. There was a conjoint Steering Group represented by Connolly Hospital and the DNC MHS Management Team and an Estates/Maintenance workstream to ensure focus and oversight to this agenda.
Regular monthly NDC MHS management meetings occurred, and a variety of issues pertinent to the approved centre such as finance, recruitment and retention of staff, staff training, service development and COVID-19 were discussed. A separate Quality and Safety Committee met monthly to consider issues relating to risk management, policy development, and incident review and serious reportable events which contributed information to the NDC MHS meeting alongside a number of sub committees such as drugs and therapeutics, health and safety, and safeguarding of vulnerable persons.

Operational risks include admission of children to the Department of Psychiatry (DOP) due to Child and Adolescent Mental Health Service (CAMHS) bed deficits and secondly delays with face to face training due to the COVID-19 Pandemic.

The local management DNC MHS were responsible for the overall management and governance of the approved centre with the exception of the Estates/Maintenance which is provided by Connolly Hospital. It was apparent to the inspection team during the onsite visit that this management system led to uncertainty and confusion regarding completion of maintenance projects and the priority or urgency of work required. Connolly Hospital were responsible for some projects and NCD MHS accounted for some of the costs in their budget. 100,000 euro was approved in 2020 for minor works and 600,000 euro was approved from the National Mental Health Capital Fund in 2021 towards remedying the windows which raised concerns during last year's inspection due to challenges in opening and closing the windows. This project was yet to commence as further planning was required. At the time of the inspection, residents were still required to make a request to staff if they wanted to open or close windows, as the window mechanism did not allow residents to open windows themselves. The inspection team were informed this was delayed by the COVID-19 pandemic.

The maintenance department of CHB were responsible for the testing of fire alarms which were recorded and the maintenance of fire doors. During the walk about on the first day of inspection, it was noted a missing leaf side door to a fire door on a bedroom sub fire compartment on Pine ward was missing. This was first reported in February 2021 for repair; however, this had not taken place by July 2021 despite reoccurring requests. This could have impacted on the DOP's evacuation process should an evacuation be required, which was not escalated as a risk on the risk register.

The inspection team were informed of a steering group represented by Connolly Hospital and Dublin North City Management Team which was established following the MHC inspection in February 2020 to review issues found in the previous inspection report. However, the concerns regarding the fire door were only made aware to the Service Manager Dublin North City Mental Health Services at the time of inspection.

Both Ash and Pine ward were mirrored wards with regard to floor plans and fire compartments and sub compartments. However, on the walk about both units differed in the management of fire doors. Fire doors in the bedrooms on Pine ward had closers which assisted the door to independently close However, these were not present on doors in Ash ward. The inspection team were unable to get a definitive answer as to why both units fire door management operated differently. There was no evidence any fire drills had taken place which was also highlighted by the inspection team in 2020. It was reported to the inspection team that it was not the responsibility of CHB maintenance team. The Health and Safety Statement recorded the fire and safety officer within CHO9 as the person responsible for fire safety within the DOP. However, the inspection team were informed this role was an advisory one to the DOP.

The inspection team were provided with a variety of committee minutes relating to various aspects of governance. These included minutes of the hospital Executive Management Team and the Quality and Safety Executive Committee. Issues frequently discussed included recruitment of staff, staff training and compliance. There were a number of vacant posts amongst the non-consultant hospital doctors (NCHD's). The on-call rota was reduced from 1-18 to 1- 8 due to difficulties in securing cover. One psychologist, two occupational therapists and an occupational therapy assistant provided therapeutic services and programmes in the approved centre. One 0.5 whole time equivalent (WTE) Psychology post was vacant at the time of inspection. The Nursing department had appointed a vacant Clinical Nurse Manager II post through recruitment which was due to commence the week after inspection.

Social workers provided services using the in-reach model, where eight social workers from the community mental health teams, inclusive of the rehab team, met the assessed needs of residents in the approved centre. At the time of inspection, the position of area lead for mental health engagement was vacant. Formerly, this person was a member of the NDC MHS management team and would have attended Management Team and the Quality and Patient Safety Committee meetings. There was no service user representative on these committees. A representative from the Irish Advocacy Network (IAN) visited the approved centre weekly.

Each head of discipline completed governance questionnaires. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. A programme of clinical audit was undertaken in the approved centre. In addition to the various governance forums outlined, other systems were in place to support quality improvement and included a multi-disciplinary compliance and policy committee that met every 6-8 weeks to discuss compliance within the approved centre, which was overseen by the Dublin North City Quality & Patient Safety (QPS) Committee. This committee was established to ensure the Department of Psychiatry was compliant with Regulations, Rules, Codes of Practice. There were two conditions attached by the Mental Health Commission (MHC) to the approved centres registration, relating to Regulation 15: Individual Care Plan (ICP) and Regulation 26: Staffing, Mandatory Training.

The CHO Dublin North City and County Mental Health (CHODNCC) Services established a quarterly MHC Compliance Network event chaired by the Registered Proprietor nominee/General Manager of 5 HSE approved centres in the CHODNCC geographical area. There is representation by all clinical disciplines. Regulation 15 was the agenda of focus at the CHODNCC MHC Compliance Network event which the DOP participated in to ensure compliance with ICPs.

Individual care planning was reviewed at each compliance committee. The DOP audited ICPs monthly as per their condition. Members of the MDT were responsible for completing the audits with two MDT members being accountable each month. Staff attended workshops and a culture of accountability was promoted. There was a CHO Dublin North City and County Service Improvement Recovery & Reform ICP Workstream which the DOP engaged in. The DOP was previously non-compliant high on ICPs for the previous five inspections.

Effort was evident to ensure that healthcare professionals working in the approved centre were up-to-date with mandatory training and some disciplines had achieved 100% with mandatory training. However, members of the medical team had not all completed the mandatory training on the Mental health Act 2001 at the time of inspection. This impacted directly with the DOP's condition on mandatory training. Essential online learning was available via HSE land which was impacted slightly by the HSE cyber security attack. However, a temporary learning system was set up to provide interim access to limited amount of essential online learning from 7th June 2021. Documented minutes evidence regular updates were prompted to complete this on-line training. Mandatory training was also a standing agenda item on the North Dublin City Management meeting, the compliance committee and the consultant group meeting.

In response to the COVID-19 pandemic, DNC MHS implemented a COVID-19 governance structure through the COVID-19 crisis management team. The DOP introduced addendums to policies relating to COVID-19. COVID-19 infection control measures and guidelines were adhered to and prominent signage was visible throughout the DOP. All admissions were admitted onto Ash ward and the garden which was shared by both wards had designated times for each ward to manage infection control. All residents who wished to avail of the vaccine in the DOP had been vaccinated at the time of inspection.

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 2017 and 2021 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2017		2018		2019		2020		2021	
Regulation 8: Residents Personal Property and Possessions	✓		✓		✓		✓		✗	High
Regulation 19: General Health	✓		✗	High	✗	High	✗	High	✗	Critical
Regulation 21: Privacy	✓		✗	Moderate	✗	High	✗	Moderate	✗	Moderate
Regulation 22: Premises	✗	Moderate	✗	High	✗	Low	✗	High	✗	High
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High	✗	Moderate	✗	High	✓		✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	Moderate	✗	High	✗	Critical
Regulation 28: Register of Residents	✓		✗	Low	✓		✓		✗	Low
Regulation 32: Risk Management Procedures	✓		✓		✓		✗	High	✗	Critical
Rules Governing the Use of Seclusion	✗	Moderate	✗	Critical	✗	Low	✗	Moderate	✗	Moderate
Code of Practice Relating to the Admission of Children	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	High
Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre	✗	Low	✗	Moderate	✗	Moderate	✗	High	✗	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 no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable. As no involuntary patient had received ECT since the last inspection, this rule was not applicable.

Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- 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.

The inspection team spoke with one individual and received six questionnaires from individuals using the service. Five of six individuals highlighted they understood what their individual care plan (ICP) was. Three individuals reported they were always involved in setting goals for their ICP, two reported they were sometimes involved, and one individual expressed they did not wish to be involved. Four individuals knew their mental health care team in the Department of Psychiatry (DOP) and knew their keyworker. One individual reported they did not know their care team or key worker.

One person reported they were always able to discuss worries or concerns with staff as soon as they needed to. Three people agreed they were able to do this sometimes and one person reported this was never the case for this individual.

Two people expressed there were enough activities; however, four people did not agree that the DOP had enough activities. 50% of the questionnaires reported they were happy with how the staff talked to them and four of the six people agreed they had space for privacy. 50% of the six people, however, felt their privacy and dignity was not respected. Five of the six individuals highlighted they were able to communicate freely with friends/family or advocates.

Two people reported they always felt safe in the approved centre; this was agreed by three people but only sometimes whilst one person reported they never felt safe. Four people reported they were always able to give staff feedback and know how to make a complaint when the person was not satisfied with their stay in

the DOP. One person expressed this was in their experience only sometimes whilst one individual reported they did not know how to make a complaint.

Each person's questionnaire rated the service based on their overall experience of their care and treatment on a scale of 1-10 with 1 being poor and 10 being excellent. Two people rated the service 1, two people rated the service 7 and two people rated the service 8.

One person commented "The staff are excellent but I was not aware of the non-smoking policy until I got here. It has made my recovery very difficult, I feel that I should not be forced not to smoke, its very stressful". Another individual commented they also felt the no smoking policy was harsh for people who use the service and smoke.

One person spoke with the inspection team. They were very complimentary of the staff describing staff as approachable. They reported their mental health care team to be good also. Two issues the individual highlighted was the lack of activity and not being able to smoke as they reported in their experience, it was causing distress to a lot of people.

5.2 Advocacy

The approved centre had an advocacy service.
The Inspectors did not receive a report from the IAN representative.

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
- General Manager/Registered Proprietor Nominee
- Clinical Director
- Clinical Nurse Manager III
- Service Manager
- Principal Social Worker
- Occupational Therapist Manager
- Principal Psychology Manager
- Mental Health Act Administrator

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

Each resident was readily identifiable by staff when receiving medication, health care, and other services. At least two appropriate resident identifiers were used – including resident stickers with resident name, medical record number, date of birth, and address. The identifiers, detailed in each resident's clinical file, were checked when staff administered medications, undertook medical investigations, and provided 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 choices within the approved centre. Food was properly prepared and comprised of servings from different food groups as per the Food Pyramid. Residents received at least two choices for meals. Residents had sufficient supplies of safe, accessible, and fresh drinking water at all times. The needs of residents identified as having special nutritional and dietary requirements were assessed, addressed and documented in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

There was appropriate and adequate catering equipment, crockery, and cutlery to suit the needs of residents. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements. A daily log was taken of food and fridge temperatures.

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 did not wear nightclothes during the day, unless otherwise specified in their individual care plan. Residents were provided with emergency personal clothing that was appropriate and considered their preferences, dignity, bodily integrity, and religious and cultural practices. The emergency clothing was kept in the clinical nurse manager's office and checked by nursing staff.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2020. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP). Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

The approved centre had secure facilities for the safe-keeping of residents' valuables, monies, personal property and possessions. Residents had wardrobes and bedside lockers for storage. Overflow property was kept in a separate locked property rooms on both Ash and Pine Wards. The approved centre had safes.

A resident's personal property and possessions were not safeguarded when the approved centre assumed responsibility for them. Not all personal belongings in the Pine Ward property room were labelled, which meant it was not possible to identify the property owner. Not all residents personal and valuable belongings on Ash Ward had been returned to residents who had been discharged from the approved centre.

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

a) **Not all personal belongings in the Pine Ward property room were labelled, which meant it was not possible to identify the property owner.**

b) Not all residents personal and valuable belongings on Ash Ward had been returned to residents who had been discharged from the approved centre.

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 a range of recreational activities appropriate to the resident group profile during the week and at the weekend. This included mindful colouring, drawing, word wheels, jigsaws, music, television, and digital versatile discs (DVDs).

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. Residents had access to the hospital chaplain by request. Church services were shown through live stream television.

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

There was a written policy and procedures in relation to visits. The policy was last reviewed in September 2020. Due to COVID-19 precautions visits could only take place on compassionate grounds at appropriate and reasonable visiting times. There was a designated visitor room available where private visits could take place, 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 these visits. The visiting rooms were suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to resident communication. The policy was last reviewed in October 2020. Residents on Ash and Pine Wards had access to their personal mobile phones, and other electronic communication devices, in addition to postal mail.

The Department of Psychiatry did not have Wi-Fi but connected devices through mobile hot spots. There was no computer on any of the wards but there was a computer in the occupational therapy department and residents were accompanied there by staff to use the computer facility when required. Residents in the High Dependency Unit (HDU) did not have access to personal mobile phones, laptops or electronic tablets and this was documented in the approved centre's communication policy. Residents in HDU had access to the ward based portable phone. The inspection team were informed there were electronic tablets and iPads in the approved centre should residents of the HDU wish to communicate with family and friends.

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 to 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 in relation to the implementation of resident searches. The policy was last reviewed in July 2020. The policy addressed all of the requirements of the regulation, including the following:

- 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 and the process for carrying out searches in the absence of consent.
- The process for dealing with illicit substances uncovered during a search.

The resident search policy and procedure was communicated to all residents. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff. General written consent was sought for routine environmental searches, and a written record was kept of all environmental searches. The clinical file of one resident who was searched was inspected. The resident's consent was sought and documented, prior to the search taking place. Risk had been assessed prior to the search of the resident. The resident was informed by the person implementing the search of what was happening during a search and why. There was a minimum of two clinical staff in attendance at all times when the search was being conducted. The search was implemented with due regard to the resident's dignity and privacy. One of the staff members who conducted one of the searches was of the same gender as the resident being searched.

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 in relation to caring for residents who are dying. The policy was last reviewed in January 2019. As no resident had died in the approved centre premises since the last inspection compliance for this regulation was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Five ICPs were inspected. All ICPs were a composite set of documentation, with allocated space and sections for goals, treatment, care, resources required, and reviews. ICPs were stored within the clinical file, were identifiable and were not interrupted. ICPs were not integrated with progress notes.

All ICPs for resident admissions were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The MDT consisted of professionals from occupational therapy, social work, psychology, nursing and medical staff. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

All ICPs identified appropriate goals for the resident. All ICPs identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. All ICP's did identified the resources required to provide the care and treatment.

A multi-disciplinary team reviewed and updated individual care plans each week, in consultation with the resident in all five ICPs. The ICPs were updated following review, as indicated by the residents' changing needs, condition, circumstances and goals. This was documented.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the needs of the residents, as documented in the residents' individual care plans (ICPs). The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

The approved centre had a dedicated senior occupational therapist, one staff grade occupational therapist, and an assistant occupational therapist. Residents had access to a newly renovated Occupational Therapy Department which contained an art room, a group room, an occupational therapy kitchen, and a '*My Space'* room – a non-clinical homely room. Residents also had access to a therapeutic garden to grow plants, vegetables and herbs.

The approved centre had a flexible Therapeutic Program Timetable, which was based on the needs of the residents. One to one therapeutic sessions were provided by the occupational therapist where necessary. The psychologist facilitated a program each Friday and a qualified exercise instructor ran exercise programs. Programmes included art therapy, music therapy, horticulture, yoga, fitness classes, recovery through occupational planning sessions, and looking forward sessions – covering weekend and discharge planning. For residents who are unable to attend the Occupational Therapy Department, one- to-one sessions were provided in ward areas. Adequate in reach services were provided by social work.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in place in relation to the transfer of residents. The policy was last reviewed in March 2021. The clinical file of one resident who had been transferred from the approved centre in an emergency was examined. Communications between the approved centre and the receiving facility were documented and followed up with a written referral. Full, complete and relevant written information about the resident was transferred to the receiving hospital, which included the resident's clinical file.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating CRITICAL

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy and a policy for responding to medical emergencies. The medical emergencies policy was last reviewed in November 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans.

Residents' general health needs were not monitored and assessed as indicated by the residents' specific needs but not less than every six months. Three clinical files of resident who had been in the approved centre for more than six months were inspected. All three residents had received a medication review; but none of the three residents had received a documented six-monthly general health check. This meant that none of the three residents received a physical examination, a check of family or personal history, blood pressure, smoking status, dental health, nutritional status, and body mass-index, weight, and waist circumference within six months.

One resident was on antipsychotic medication and this resident had received an annual assessment of glucose regulation, blood lipids, prolactin levels, and an electrocardiogram heart function test. Adequate arrangements were in place for residents to access general health services and for their referral to other health services, such as a dietitian and a diabetic nurse as required.

The approved centre was non-compliant with this regulation because the Registered Proprietor did not ensure that all resident's general health needs were assessed regularly and no later than every six months in relation to three residents, 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 policy and procedures in relation to the provision of information to residents. The policy was last reviewed in July 2020.

Residents were provided with a resident information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on their diagnosis. Medication information sheets as well as verbal information were provided in a format appropriate to residents' 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 **MODERATE**

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

INSPECTION FINDINGS

The general behaviour of staff and the manner in which staff interacted with residents indicated respect. Staff were discreet when discussing the resident's condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity. Where a resident shared a room, bed screening ensured that their privacy was not compromised.

At the time of the inspection, the residents personal information board in the nursing station on Ash ward was viewable from the office main door and window as these had clear glass and because the doors of the noticeboard were left open. Residents full names were viewable. The noticeboard doors were promptly closed by staff once their attention had been brought to the matter at the time of the inspection.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that resident's privacy and dignity was respected at all times as the noticeboard on Ash Ward containing full names of residents was viewable from the office door and window, 21.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was adequately lit and heated. It was clean, hygienic and free from offensive odours. There was a sufficient number of toilets and showers for residents in the approved centre. Current national infection control guidelines were followed. Appropriate signage and sensory aids were provided to help residents in finding their way around the approved centre.

Rooms within the approved centre were not adequately ventilated. The windows within those rooms were locked or bolted and it was not possible for residents or staff to open the windows. Hazards were not minimised throughout the approved centre. A bin cover was broken, and a long protruding metal piece was visible in the bin. A different bin had an elastic band around it. A television was found in the assisted toilet area of the High Dependency Unit (HDU) with ants in the same toilet area.

Ligature points were not minimised to the lowest practicable level based on a risk assessment which were identified in a ligature audit.

While there was a documented programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment, the approved centre was kept in a poor state of repair externally and internally. On inspection, there were several severely marked floorings, chipped paint on a number of walls, and heavily stained toilets throughout the approved centre. Walls were marked where dispensers had been removed.

A number of the bedrooms in the approved centre were either missing blinds or had broken blinds, which did not adequately support resident independence and comfort. Sufficient outdoor and bedroom spaces

were provided for residents to move about. Due to COVID-19 precautions the garden was shared between Ash and Pine Wards at different times for daily 5-hour blocks of time given to each ward.

The size of the communal rooms on Ash and Pine ward were inappropriate to cater for the needs of 21 residents at full capacity on each ward.

The approved centre had a designated sluice room and a designated cleaning room. Assisted devices and equipment were provided to address resident needs.

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

a) **The approved centre was not maintained in a good structural and decorative condition. Floorings were marked, several walls had chipped paint, and some toilets were heavily stained, 22 (1, a).**
b) **The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre. Some bedrooms within the approved centre were either missing or had broken blinds, 22 (2).**
c) **The rooms within the approved centre's premises were not adequately ventilated. The windows within rooms of the approved centre were locked or bolted and it was not possible to open the windows, 22 (b).**
d) **All ligature points where not minimised to the lowest practicable level based on risk assessment.**
e) **Communal rooms on Ash and Pine Ward were inadequately sized to accommodate the needs of its residents, 22(3).**

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

NON-COMPLIANT

Risk Rating **MODERATE**

(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 in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in October 2020.

Each resident had a Medication Prescription and Administration Record (MPAR), and five of these were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases. One MPAR did not document a record of the date of discontinuation for nine medications.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently, where there was a significant change in the resident's care or condition, and this was 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 press unless it required refrigeration. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was non-compliant with this regulation because one medication, prescription, and administration record did not document a record of the date of discontinuation for nine medications, 23, 1.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy, and procedures relating to the health and safety of residents, staff and visitors. The health and safety policy was last reviewed in November 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating CRITICAL

(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 staffing policy and procedures in relation to the recruitment, selection and Garda vetting requirements. The policy was last reviewed in April 2021. An appropriately qualified staff member was on duty at all times, and this was documented. The numbers and skill mix of staffing were sufficient to meet resident needs.

The approved centre had seven multi-disciplinary teams. This included psychiatry, nursing, occupational therapy, social work and psychology. The approved centre also had a clinical pharmacy service.

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 the COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) outside of the Mental health Act training, have been deferred until 2022.

Not all healthcare staff were trained in the Mental Health Act 2001. Members of the medical team had not completed the HSE online training in the Mental Health Act 2001. The COVID-19 pandemic did not impact access to this training and mandatory training was a standing agenda item on the compliance committee and the Dublin North City Mental Health Management meetings. This regulation was non-compliant for the previous five years. The following table shows the number of staff trained in the Mental Health Act 2001 and the percentage of staff trained in each discipline.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (61)	61	100%
Medical (23)	8	35%
Occupational Therapist (3)	3	100%

Social Worker (7)	7	100%
Psychologist (1)	1	100%

The approved centre was non-compliant with this regulation because not all staff had completed mandatory training on the Mental Health Act 2001, 26 (4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had two written operational policies and procedures in relation to the creation of, access to, retention of and destruction of records. The policies were each last reviewed in January 2021. All residents' records were secure, up to date, in good order, with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements.

Resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained to a logical sequence. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use. Documentation relating to 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

NON-COMPLIANT

Risk Rating LOW

(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 electronic register of all residents admitted to the approved centre. It was available to the Mental Health Commission on inspection. The register was not up-to-date because it did not contain the complete information specified in Schedule 1 to the Mental Health Act 2001. Specifically, the discharge date was not recorded on the register for 17 residents, and the diagnosis on discharge was not recorded for 25 residents.

The approved centre was non- compliant with this regulation because:

a) **The register of residents was not up to date, 28 (1).**
b) **The register did not contain the complete information specified in Schedule 1 to the Mental Health Act 2001. The discharge date was not recorded on the register for 17 residents, and the diagnosis on discharge was not recorded for 25 residents, 28 (1).**

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 fifteen operating policies and procedures required by the regulations were reviewed within the required three-year time frame.

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 facilities with adequate resources to support the Mental Health Tribunals process. Staff accompanied and assisted patients to attend a Mental Health Tribunal as required. Resources and facilities were provided by the approved centre to support patients accessing Mental Health Tribunals 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 in relation to the management of complaints. The policy was last reviewed in May 2021. The policy covered the process for the management of 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 who was based in the approved centre who was responsible for dealing with all complaints in the approved centre. The complaints procedure including how to contact the complaints manager was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. 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.

All oral and written complaints were handled promptly, appropriately and sensitively. Minor complaints and formal complaints were documented 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.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

(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

There were three written policies in relation to risk management and incident management processes. The risk management policy was last reviewed in October 2020. The policies combined did not include all of the policy related regulation requirements. The policies did not include:

- The process for identification, assessment, treatment, reporting, and monitoring of organisational risks, and structural risks-including ligature points and capacity risks relating to the number of residents in the approved centre.
- The person with overall responsibility for risk management or the responsibilities of the registered proprietor.

The person with responsibility for risk, the risk advisor, was identified and known by all staff. Responsibilities were not allocated at management level and throughout the approved centre to ensure their effective implementation. There was no person with a clear role and responsibility for fire safety and ensuring fire drills were completed. No fire drills had taken place.

Not all aspects of the risk management policy were implemented throughout the approved centre. Risk management current procedures did not actively reduce identified risks to the lowest level of risk, as was reasonably practicable. Health and safety risks in relation to residents being able to safely evacuate in the event of a fire were not remedied. A leaf fire door leading to bedrooms 6-7 on Pine Ward was missing in the approved centre for six months because it was damaged and removed as a result. At the time of the inspection the fire door was still not replaced with a new door.

This was not escalated as a health and safety risk that could potentially negatively impact the evacuation process of residents in the event of a fire. The missing fire door in bedrooms 6-7 on Pine Ward was a health and safety risk and it was not identified, assessed, treated, reported, or monitored on the risk register in line with relevant legislation. At the time of the inspection the missing fire door had not been escalated for consideration to be placed onto the risk register. Closers on fire doors in the bedrooms were present on Pine Ward to allow the fire doors to independently close, but these closers were not present on Ash Ward and leaf doors were left ajar throughout both wards.

Multi-disciplinary teams (MDT) were involved in the development, implementation, and review of individual risk management processes. Corporate and clinical risks were identified, assessed, reported, treated, monitored, and recorded in the risk register. Individual risk assessments were completed prior to physical restraint episodes, seclusion, and at resident admission, transfer and discharge. These assessments were completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated and recorded in a standardised format. All clinical incidents were reviewed by the multi-disciplinary team (MDT), and a record was maintained of clinical reviews and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

a) **The risk management and incident management policies did not include the person with overall responsibility for risk management or the responsibilities of the registered proprietor, 32 (1).**
b) **The risk management policy did not include the process for identification, assessment, treatment, reporting, and monitoring of organisational risks, and structural risks-including ligature points and capacity risks relating to the number of residents in the approved centre, 32 (1).**
c) **The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk due to a fire leaf bedroom door being damaged and removed on Pine Ward and not replaced. This was not escalated as a health and safety risk that could potentially impact the safe evacuation of residents in the event of a fire. This risk was not identified, assessed, treated, reported, or monitored on the risk register, 32(1).**
d) **There was no person with a clear role and responsibility for fire safety and ensuring fire drills were completed. No fire drills had taken place, 32 (1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre was adequately insured against accidents and injury to residents. The approved centre's insurance certificate and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, with all conditions relating to the certificate of registration attached to it, which was displayed prominently.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: There was a written policy and procedures in relation to the use of seclusion, and the policy was reviewed annually. The policy addressed who may implement seclusion, the provision of information to the resident, and ways of reducing rates of seclusion use.

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

Monitoring: An annual report on the use of seclusion had been completed.

Evidence of Implementation: Residents in seclusion had access to adequate toilet and washing facilities. The seclusion room was designed with furniture and fittings which did not endanger resident safety. The seclusion room was not used as a bedroom. Seclusion was initiated by a registered nurse or registered medical practitioner. The consultant psychiatrist was notified within the appropriate time frame and this was recorded in the clinical file.

One seclusion episode contained within the resident's clinical file was inspected. In this episode, seclusion was only implemented in the resident's best interests, in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others. The use of seclusion was based on a risk assessment of the resident. Cultural awareness and gender sensitivity were demonstrated.

The resident was informed of the reasons, duration, and circumstances leading to discontinuation of seclusion. The resident was under direct observation by a registered nurse for the first hour and continuous observation thereafter. The resident was informed of the ending of seclusion.

A written record of the resident's level of distress and behaviour was made by the nurse every 15 minutes. The resident received a medical review by the registered medical practitioner every four hours.

This episode of seclusion was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion.

This episode of seclusion was recorded in the resident's clinical file and this use of seclusion was recorded in the seclusion register. The seclusion register was signed by a responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours. A copy of the seclusion register was in place within the resident's clinical file and available to inspectors.

The approved centre was non-compliant with this rule for the following reason:

a) This episode of seclusion was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion, 10.3.

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in July 2020. The policy covered:

- 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: Written record that all staff involved in physical restraint had read and understood the policy.

Evidence of Implementation: The clinical file of one resident who had been physically restrained was inspected. Physical restraint was only used in rare and exceptional circumstances when the resident posed an immediate threat of serious harm to themselves or others. The use of physical restraint was based on a risk assessment of the resident. Staff had first considered all other interventions to manage the resident's unsafe behaviour.

Cultural awareness and gender sensitivity were demonstrated in this episode of physical restraint. The resident's next of kin were informed about the physical restraint. The resident was informed of the reasons for, duration of, and circumstances leading to discontinuation of physical restraint. Physical restraint was initiated by a registered medical practitioner (RMP), and a designated staff member was 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 the duty consultant psychiatrist was notified of the use of physical restraint as soon as was practicable. A registered medical practitioner completed a medical examination of the resident within three hours after the start of the episode of physical restraint.

The order for physical restraint lasted for a maximum of 30 minutes and was recorded in the clinical file. A clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint no later than three hours after the episode and was placed in the resident's clinical file. The clinical practice form was signed by the consultant psychiatrist within 24 hours of the episode. The resident was afforded the opportunity to discuss the episode with members of the multi-disciplinary team (MDT) involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after 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: Policies and protocols were in place in relation to the admission of a child. The approved centre had a policy requiring each child to be individually risk assessed. A policy and procedures were in place regarding family liaison, parental consent, and confidentiality. Procedures were in place for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in the Children First guidelines.

Evidence of Implementation: The inspection team reviewed one clinical file in relation to one child admitted to the approved centre by court order since the last inspection. The approved centre was an adult facility, therefore 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 the children and to respond to the children's needs.

Age-appropriate advocacy services were not accessible to children. Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre in relation to child protection issues, staff having contact with the child had undergone Garda vetting. Copies of the Child Care Act 1991 Children Act 2001, and Children First guidelines were available to relevant staff.

Appropriate accommodation was designated and included segregation according to age and gender, sleeping arrangements, and bathroom areas. Staff were gender sensitive.

The child had their rights explained and information about the approved centre and facilities provided in a form and language that they could understand. The clinical file did not record this child's understanding of the explanation given because the child presented as very unwell throughout the admission.

Appropriate visiting arrangements for families, including children, were not applicable to this situation as there was no next of kin or family documented. The Mental Health Commission was notified of all children admitted to approved centres for adults within 72 hours using the appropriate notification form.

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 were not provided for child admissions, 2.5 (b).**
b) **Children did not have access to age-appropriate advocacy services, 2.5 (g).**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

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 a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in November 2020, the transfer policy was last reviewed in March 2021, and the discharge policy was last reviewed in May 2021. All policies combined included all of the policy related criteria of the code of practice.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the transfer policy, but audits had not been completed on the implementation of and adherence to the admission and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. An admission assessment had been completed.

The resident's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, social and housing circumstances, work situation, education, and dietary requirements. The resident received a full physical examination.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, a current mental state examination, informational needs, social and housing needs, and a comprehensive risk assessment and risk management plan. Family members were involved in the discharge process.

There was no opportunity to hold a discharge meeting with appropriate multi-disciplinary team input into discharge planning because the resident requested self-discharge early, which was 16 days before the

estimated date. A documented preliminary discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within three days because it did not exist. A documented comprehensive discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within fourteen days because it did not exist. A timely follow-up appointment was documented.

The approved centre was non-compliant with this code of practice because:

a) **A documented preliminary discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within three days because it did not exist, 38.3.**
b) **A documented comprehensive discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within fourteen days because it did not exist, 38.3 (b).**

Appendix 1: Corrective and Preventative Action Plan

Regulation 8: Residents' Personal Property and Possessions					
Reason ID : 10002256		**Not all personal belongings in the Pine Ward property room were labelled, which meant it was not possible to identify the property owner.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All residents personal property and possessions are safeguarded and labelled within the property room of the approved centre	Monthly Audit of property conducted as part of routine audits. This area will be subject to review on the Monthly Quality and Safety walk around led by Nursing and will be documented	Achievable and Realistic	02/11/2021	Nursing Management Team
Preventative Action	In accordance with the DOP policy and procedure, all property to be labelled to ensure is possible to identify the property owner. All staff involved in the management of residents' personal property and possessions will be	Monthly Audit of property conducted as part of routine audits and updated to the Department of Psychiatry Policy and Compliance Committee. Review on Monthly Quality and Safety walk around and documented.	Achievable and Realistic.	02/11/2021	Nursing Management Team

	orientated and familiarised with the DOP policy and procedure.				
Reason ID : 10002257		**Not all residents personal and valuable belongings on Ash Ward had been returned to residents who had been discharged from the approved centre.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All residents personal and valuable belongings within all wards of the Department of Psychiatry has been labelled and returned to patients as per policy.	Monthly Audit of property conducted as part of routine audits. Review on Monthly Quality and Safety walk around and documented	Achievable and Realistic.	02/11/2021	Nursing Management Team
Preventative Action	All staff involved in the management of residents personal and valuable belongings to be orientated and familiarised with the policy on property on annual basis and at induction.	Monthly Audit of property conducted as part of routine audits and updated to the Department of Psychiatry Policy and Compliance Committee. Review on Monthly Quality and Safety walk around and documented	Achievable and Realistic.	02/11/2021	Nursing Management Team

Regulation 19: General Health					
Reason ID : 10002272		**The Registered Proprietor did not ensure that all resident's general health needs were assessed regularly and no later than every six months in relation to three residents,19 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All residents had general health assessment completed after the MHC Inspection and will be general health needs will be assessed regularly and no later than every six months. The Mental Health Act Administrator will review and provide administrative update the Clinical Director and Responsibility Consultant Psychiatrist regarding residents due general health assessments.	General Health assessment log to be maintained and included in audit of charts by medical staff	Achievable and Realistic.	02/11/2021	Clinical Director; Responsible Consultant Psychiatrists and Mental Health Act Administrator
Preventative Action	Mental Health Act Administrator to keep an administrative record	Physical Health assessment log to be maintained and included in audit of	Achievable and Realistic.	02/11/2021	Clinical Director; Responsible Consultant Psychiatrists and Mental Health Act Administrator

	of patients due for six monthly general health assessment and provide update to the Clinical Director. Updated report to the Department of Psychiatry Policy and Compliance Committee meeting.	charts by medical staff. Reviewed as part of Quarterly Safety and Quality walk round and will be documented. Updated report for review by the DOP Policy and Compliance Committee meeting			

Regulation 21: Privacy					
Reason ID : 10002266		**The registered proprietor did not ensure that resident's privacy and dignity was respected at all times as the noticeboard on Ash Ward containing full names of residents was viewable from the office door and window, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff working in the Department of Psychiatry are aware of their GDPR obligations to uphold the privacy of residents in the approved centre. Since the MHC inspection the Windows to the "Nurses Station" have been updated with semi-transparent material and the notice boards are no longer being visible from the door and window.	Reviewed in monthly and Quarterly Quality and Safety walk round & updated to the DOP Compliance and Policy Committee	Achieved	02/11/2021	DNC Service Manager, Nurse Management, Department of Psychiatry Policy and Compliance Committee members
Preventative Action	Ongoing review of privacy of residents personal data as part of Monthly and Quarterly Quality and	Assessed at the monthly and quarterly quality and safety walk	Achievable and Realistic.	02/11/2021	DOP Compliance and Policy Committee members

	Safety Walk rounds with updated report to the DOP Policy and Compliance Committee	arounds and documented			

Regulation 22: Premises					
Reason ID : 10002258		**The approved centre was not maintained in a good structural and decorative condition. Floorings were marked, several walls had chipped paint, and some toilets were heavily stained, 22 (1, a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CHODNCC Chief Assistant Technical Services Officer confirmed that the approved centre is maintained in good structural condition. Ongoing funding continues to be approved for the annual decorative maintenance, Painting and refurbishing of the approved center. This programme of work is underway and will be completed by December 2021. Staff in the Department have met with Connolly Hospital Technical Services and have identified the cause of staining	Monthly and Quarterly Quality and Safety Walk rounds and documented	Achievable and Realistic	31/12/2021	Service Manager Dublin North City Mental Health Services, Technical Services Manager, Connolly Hospital and HSE CHODNCC Chief Assistant Technical Services Officer

	of the toilet is a by-product of Connolly Hospital's wider infection and prevention control regimen for legionella is feature of good maintenance and not attributed to any deficit in the Approved Centre's cleaning programme.				
Preventative Action	There is approved annual funding for decorative maintenance and refurbishments of the Department of Psychiatry. A Programme of painting, flooring and other refurbishments will be completed by December 2021. The Dublin North City Service Manager meets with Nurse Management on a monthly basis to review minor works required and	Monthly and Quarterly Quality and Safety Walk round.	Achievable and Realistic	31/12/2021	Service Manager Dublin North City, Connolly Hospital Technical Services, CHODNCC Chief Assistant Technical Services Officer, ECD, CD, HQSSI, Estates/Maintenance

	escalates funding requirement for same. A Quarterly Executive Quality and Safety Walk round by the ECD, ADON, Head of Quality and Service Improvement, Estates Lead will supplement the Monthly walk round and will be documented,. The CHODNCC Head of QSSI has developed updated draft checklist that will be updated as we progress to support the QSWRs scheduled for 15th November 2021				
Reason ID : 10002259		**The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre. Some bedrooms within the approved centre were either missing or had broken blinds, 22 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In response to COVID 19 guidance, suitable furnishings have had to be adapted to	Monthly and Quarterly Quality and Safety Walk	Achievable and Realistic	31/12/2021	DNC MH Service Manager, Nurse Management, DNC MH Management Team

	ensure social distancing in communal areas and consultancy received from the CHODNCC Infection Prevention Control Team in this regard. The Dublin North City Service Manager has a process in place for replacement of missing and broken blinds and is ongoing. All blinds have been replaced in the approved centre and new furniture has also been ordered.	Rounds will be documented			
Preventative Action	Monthly Quality and Safety Walk checklists have been developed to assist nurse management with prompts for the identification of refurbishment matters. The Service Manager Dublin North City meets with Nurse	Monthly Quality and Safety Walk round updates provided to the Service Manager, Dublin North City and DNC Management Team and supplemented by the Quarterly Executive Quality	Achievable and Realistic	31/12/2021	Service Manager, DNCMHS, Nurse Management, Dublin North City Management Team

	Management on monthly basis.	and Safety Walk rounds			
Reason ID : 10002260		**The rooms within the approved centre's premises were not adequately ventilated. The windows within rooms of the approved centre were locked or bolted and it was not possible to open the windows, 22 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Funding has been secured and a design team has been appointed for tender for alternative windows for the Department. Ventilation of Unit will be incorporated into the design.	For focus at Monthly and Quarterly Quality and Safety Walk rounds and will be documented	Achievable and Realistic, however, may be subject to COVID challenges	31/12/2021	Service Manager Dublin North City, DNCMHS Management team and HSE Estates.
Preventative Action	Funding has been secured and a design team has been appointed to scope alternative windows for the Department. Ventilation of Unit will be incorporated into the design. Service Manager Dublin North City has lead meetings with CHODNCC Estates,	Focus at Monthly, Quarterly Quality and Safety Walk round and will be documented	Achievable and Realistic however, may be subject to COVID 19 challenges	31/12/2021	Service Manager, Dublin North City, DOP Managers, DNC MHS Management Team

	ECD, CD, ADON and DOP Managers to inform the specifications for the tender.				
Reason ID : 10002261		**All ligature points where not minimised to the lowest practicable level based on risk assessment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Ligature points identified at time of inspection and associated with bin with broken cover and Covid bins with elastic were removed from the approved centre after the inspection	Ligature Audit using validated audit tool and supplemented with Monthly and Quarterly Safety walk rounds	Achievable and Realistic	13/07/2021	DNC Service Manager, DOP Nurse Management, DNC MHS Management team
Preventative Action	Ligature points identified either during the normal course of day or at time of Audits and supplemented with observations by DOP Nurse management on the monthly Quality and Safety Walk rounds. The Department of	Annual Audit and Monthly Quality and Safety Walk round.	Achievable and Realistic	02/11/2021	DNC Service Manager, Technical Services Manager, Connolly Hospital, Dublin North City Management Team

	Psychiatry has been confirmed for the pilot of the HSE National Ligature Risk Reduction Policy and Audit Tool. Nurse Management linking with national Lead. The MHC Compliance Network Event for all Approved Centres, on 4th December 2021 will include presentation of the HSE National Ligature Risk Reduction policy and Audit Tool.				
Reason ID : 10002262		**Communal rooms on Ash and Pine Ward were inadequately sized to accommodate the needs of its residents, 22(3).**			
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) for this reason for non-compliance within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.					

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10002263		**One medication, prescription, and administration record did not document a record of the date of discontinuation for nine medications, 23, 1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	One of the 5 MPARs inspected had no documented record of the date of discontinuation for nine medications, this incident was time bound and thus not correctible. However, audits of MPARS are conducted on quarterly basis and reviewed at the Department of Psychiatry Policy and Compliance Committee.	Audits of MPARs conducted by medical staff on 3 monthly basis.	Achievable and Realistic.	02/11/2021	Clinical Director; Responsible Consultant Psychiatrists and Department of Psychiatry Policy and Compliance Committee members
Preventative Action	Chief II Pharmacist provided education session to medical staff in the DOP following the inspection findings. Regular education	Regular Audit of MPARs (3 monthly), and audits reviewed at the DOP Policy and Compliance Committee	Achievable and Realistic.	02/11/2021	Clinical Director; Responsible Consultant Psychiatrists; Non Consultant Hospital Doctors.

	sessions to NCHDs each 6 months will be provided at induction by Clinical Pharmacy Department.	meeting. Dublin North City MH Management Team			

Regulation 26: Staffing					
Reason ID : 10002271		**Not all staff had completed mandatory training on the Mental Health Act 2001, 26 (4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Two medical staff, one Consultant Psychiatrist and one Senior Registrar, have not provided evidence of completion of the MH Act 2001 training. Their line managers, Head of Service Mental Health and Clinical Director are progressing reminders for same	Line Managers sending reminders to the medical staff to submit HSEland training certificates.	Achievable	02/11/2021	Clinical Director; Head of Service Mental Health
Preventative Action	All Heads of Discipline responsible for ensure all of their staff have completed mandatory training. Staff on commencement of employment to have Mandatory Training requirements as part of Induction Programme. NCHDs	Quarterly Audit of staff mandatory training updated to the Department of Psychiatry Policy and Compliance Committee	Achievable	02/11/2021	Clinical Director; Head of Disciplines.

	to be given a 4 week period to complete mandatory training from the time of commencement of employment. For existing staff deficits in time limited training will be managed on a rolling programme by the relevant line managers				

Regulation 28: Register of Residents					
Reason ID : 10002264		**The register of residents was not up to date, 28 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Register of residents currently up to date.	Ongoing review of register by Compliance Committee.	Achievable and Realistic.	02/11/2021	Mental Health Act Administrator; Department of Psychiatry Policy and Compliance Committee Members
Preventative Action	Register of residents currently up to date.	Ongoing review of register by DOP Policy and Compliance Committee.	Achievable and Realistic.	02/11/2021	Mental Health Act Administrator; Department of Psychiatry Policy and Compliance Committee members
Reason ID : 10002265		**The register did not contain the complete information specified in Schedule 1 to the Mental Health Act 2001. The discharge date was not recorded on the register for 17 residents, and the diagnosis on discharge was not recorded for 25 residents, 28 (1).**			
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) for this reason for non-compliance within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.					

Regulation 32: Risk Management Procedures					
Reason ID : 10002267		**The risk management and incident management policies did not include the person with overall responsibility for risk management or the responsibilities of the registered proprietor, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Head of Quality, Safety and Service Improvement and dedicated QPS Lead have been providing support Risk Management and Incident Management Policies. There has been review with DOP Service leads and the policies have been revised, to include the Dublin North City Management team as having overall responsibility for risk management. The point of contact for overall responsibility for day to day risk management is the Assistant Director of	Updates of Policies will be reviewed by DOP Policy and Compliance Committee and for approval by Dublin North City Mental Health Services Management team.	This is achievable and realistic.	02/11/2021	Head of QPSSI/DNC QPS Advisor, DOP staff, Dublin North City Mental Health Services Management team.

	Nursing Assistant, DOP.				
Preventative Action	Risk management and incident management policies have been revised to include the Dublin North City Management team as having overall responsibility for risk management. the point of contact is the Director of Nursing Assistant for the DOP. The Head of Quality, Safety and Service Improvement and dedicated QPS Lead have been providing support Risk Management and Incident Management Policies and programme of onsite training proposed for staff in the DOP.	Updates of Policies will be reviewed by Compliance Committee and signed off by Dublin North City Mental Health Services Management team.	Achievable and Realistic	02/11/2021	Head of QPSSI/DNC QPS Advisor, DOP staff, Dublin North City Mental Health Services Management team.

Reason ID : 10002268		The risk management policy did not include the process for identification, assessment, treatment, reporting, and monitoring of organisational risks, and structural risks-including ligature points and capacity risks relating to the number of residents in the approved centre, 32 (1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Head of Quality, Safety and Service Improvement and dedicated QPS Lead have been providing support Risk Management Policies. There has been review with DOP Service leads and the policies have been revised, and updated to include the process for identification, assessment, treatment, reporting and monitoring of organisational risks and structural risks including ligature points and ligature points and capacity risks relating to the number of residents	Policy is updated by Compliance Committee with approval by the Dublin North City Management Team	Achievable and Realistic	02/11/2021	Head of QSSI/ DNC QPS Advisor, DOP staff, Dublin North City Management team

	in the approved centre				
Preventative Action	Risk Management policy has not been updated to include the process for identification, assessment, treatment, reporting and monitoring of organisational risks and structural risks including ligature points and ligature points and capacity risks relating to the number of residents in the approved centre. The Head of Quality, Safety and Service Improvement and dedicated QPS Lead will lead training support for staff in the update Risk Management Policies.	Policy is updated by Compliance Committee with approval by the Dublin North City Management Team	Achievable and Realistic	02/11/2021	HQPSSI/DNC QPS Lead, DOP Staff, Dublin North City Management team
Reason ID : 10002269		**The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk due to a fire leaf bedroom door being damaged and removed on Pine Ward and not replaced. This was not escalated as a health and safety risk that could potentially impact the safe**			

		evacuation of residents in the event of a fire. This risk was not identified, assessed, treated, reported, or monitored on the risk register, 32(1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire Leaf bedroom door has now been replaced in Pine ward. The Head of Quality, Safety and Service Improvement, Dublin North City QPS Lead and CHODNCC Fire Officer have been providing consultancy and support to staff in the DOP to uphold Risk Management procedures in the DOP. The ADON has joined the Connolly Hospital Fire Safety Committee and Fire agenda item on DNC Management Team and QPS meetings. 2 Health and Safety Nominees confirmed for the DOP (1 Nursing and 1 Occupational	Monthly Quality and Safety walk round.	Achievable Realistic.	22/07/2021	DNC Service Manager, DOP Staff, HQSSI/DNC QPS Advisor, DOP Staff, Connolly Hospital technical services and DNC Management Team.

	Therapy), training sourced through the CHODNCC Health and Safety Advisors and they will join CHODNCC H&S Community of Practice Group.				
Preventative Action	Conjoint Working group has been established between the DNC Mental Health Services, Senior Management Connolly Hospital and Estates/Maintenance. A prioritisation process for maintenance issues and an escalation pathway for category 1 items such as Fire Doors has been created to deal with future maintenance issue. An SLA between the DOP and Dublin North City Mental Health Services has been developed and for	Focus at Monthly and Quarterly Quality and Safety walk rounds and will be documented	Achievable/Realistic	02/11/2021	DNC Mental Health Service Management Team and Connolly Hospital Management Team

	review at meeting on Wednesday 10th November @ 4:00pm				
Reason ID : 10002270		**There was no person with a clear role and responsibility for fire safety and ensuring fire drills were completed. No fire drills had taken place, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Assistant Director of Nursing in the DOP is responsible for fire safety and ensuring fire drills are completed. Consultancy and Guidance was provided in the approved centre by the CHODNCC Fire Office. A Fire drill was completed on the 27th of July 2021.	Quarterly Audits of Staff Training for review at the DOP Policy and Compliance Committee	Achievable and Realistic	27/07/2021	CHODNCC Fire Officer, DOP staff, Dublin North City Mental Health Service Management Team
Preventative Action	A person has now been identified as Director of Nursing Assistant as responsible for fire safety and ensuring fire drills are completed. A Fire	Quarterly Audits of Staff Mandatory Training for review at the DOP Policy and Compliance Committee.	Achievable and Realistic	02/11/2021	Dublin North City Mental Health Service Management Team

	drill has now been completed 27th of July 2021. The ADON/Nurse Manager has attended monthly meetings of the Connolly Hospital Fire Safety Committee.				

Rules Governing the Use of Seclusion					
Reason ID : 10002249		**This episode of seclusion was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion, 10.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion is used in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others and only implemented in the residents best interests. This episode of seclusion was not reviewed by members of the MDT and documented in the clinical file within two working days after the episode of seclusion. This is an individual time based incident thus was not correctable within the timeframe stipulated and will be area of focus.	Monthly Audits of seclusion being conducted	Achievable	02/11/2021	Clinical Director and all healthcare professionals involved in the use of seclusion, Department of Psychiatry Compliance and Policy Committee members

Preventative Action	Regular education/training programme for all staff involved in seclusion regarding upholding compliance with seclusion rules. Training on the use of physical restraint and procedures in relation to the use of seclusion was provided to staff in the Department of Psychiatry on the 15th of October 2021. Training in legal documentation and restrictive practice training was provided to staff in the DOP on the 19th and 27th of October 2021. This training will be provided on a rolling basis. Rules on Seclusion and Physical restraint is included in induction programme for	Monthly Audits of Seclusions preformed as part of routine Audits. Audit results are reported to the Department of Compliance and Policy Committee	Achievable and Realistic	02/11/2021	Clinical Director and all Healthcare professionals involved in seclusion, Department of Psychiatry Compliance and Policy Committee members

	medical staff on a 6 monthly rotation. The Seclusion Care Care plan includes a prompt for staff involved in seclusion to ensure completion of statutory bodily restraint and seclusion provisions of Section 69 of the Mental Health Act 2001.				

Code of Practice Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10002245		**Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Department of Psychiatry is an Adult facility and only admits a child in exceptional and extenuating circumstances. Policies and procedures are in place regarding family liaison, parental consent and notification to the Mental Health Commission. When a child is admitted, age appropriate activities are available from the Occupational Therapy Department specific to the needs of the individual child. Provisions are made to ensure the safety of the child	Individual Care Plan for each child and audit of ICPs by the Multi Disciplinary Team, Occupational Therapy, Social Work, Nursing and Medical staff on weekly basis.	Achievable and realistic.	02/11/2021	Clinical Director; Occupational Therapy

	and to respond to the child's needs and ability.				
Preventative Action	The Department of Psychiatry does not routinely admit children expect in extreme circumstances. In the circumstances where child is admitted, age appropriate activities are sourced at the time specific to the needs of the individual patient. Age appropriate activity packs are available in the Occupational Therapy Department.	Individual Care Planning for child and audit of ICPs by the MDT on weekly basis	Achievable and realistic.	02/11/2021	Clinical Director; Occupational Therapy Department, Multi Disciplinary Team
Reason ID : 10002246		**Children did not have access to age-appropriate advocacy services, 2.5(g).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Department of Psychiatry Connolly Hospital will admit a child in exceptional circumstances and advices are taken	Compliance Committee addresses all areas of non-compliance at regular meetings.	Achievable	02/11/2021	Department of Psychiatry Policy and Compliance Committee will review all practicable efforts to ensure compliance

	from the Child and Adolescent Mental Health Service, CAMHS. The child has their rights explained and information about the facility in a form and language they can understand with parents/guardians involvement where possible.				with this Code of Practice
Preventative Action	Department of Psychiatry Connolly Hospital does not routinely admit children. Since the MHC Regulatory Compliance Meeting, Area Director of Nursing has contacted the CEO, Youth Advisory Programme, YAP, to explore available opportunities for age appropriate advocacy services for young people admitted to	Compliance Committee addresses all areas of non-compliance at regular meetings.	Achievable	02/11/2021	ADON and Policy and Compliance Committee.

	the Department of Psychiatry.				

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10002238		**A documented preliminary discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within three days because it did not exist, 38.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Clinical files for residents contain completed discharge summaries.	Audit of discharges completed in adherence to the DOP Discharge Policy.	Achievable	02/08/2021	Clinical Director, Responsible Treating Consultant Psychiatrists and Mental Health Act Administrator
Preventative Action	Mental Health Act Administrator will keep an administrative record of discharge summaries, send reminders to teams to complete discharge summaries to the relevant healthcare providers within two weeks of discharge and provide update to the Clinical Director.	Regular audit of Discharge Summaries & Register.	Achievable and Realistic	02/11/2021	Clinical Director, Responsible Treating Consultant and Mental Health Act Administrator
Reason ID : 10002239		**A documented comprehensive discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within fourteen days because it did not exist, 38.3 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	All discharge summaries completed and present in the clinical files. The Mental Health Act Administrator to keep an administrative record of Discharge Summaries, send reminders to teams and prepare report for the CD, Chair, Department of Psychiatry Policy and Compliance Committee	Ongoing Audit of Discharge Summaries and Patient Register.	Achievable and Realistic	02/11/2021	Clinical Director, Responsible Treating Consultants and Mental Health Act Administrator
Preventative Action	The Mental Health Act Administrator to regularly review Discharge Summaries, send reminders to teams to complete Discharge Summaries and prepare report for the CD, Chair, Department of Psychiatry Policy and Compliance Committee	Ongoing Audit of Discharge Summaries and Patient Register with review by the Department of Psychiatry Policy and Compliance Committee	Achievable and Realistic	02/11/2021	Clinical Director, Responsible Treating Consultants and Mental Health Act Administrator

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.

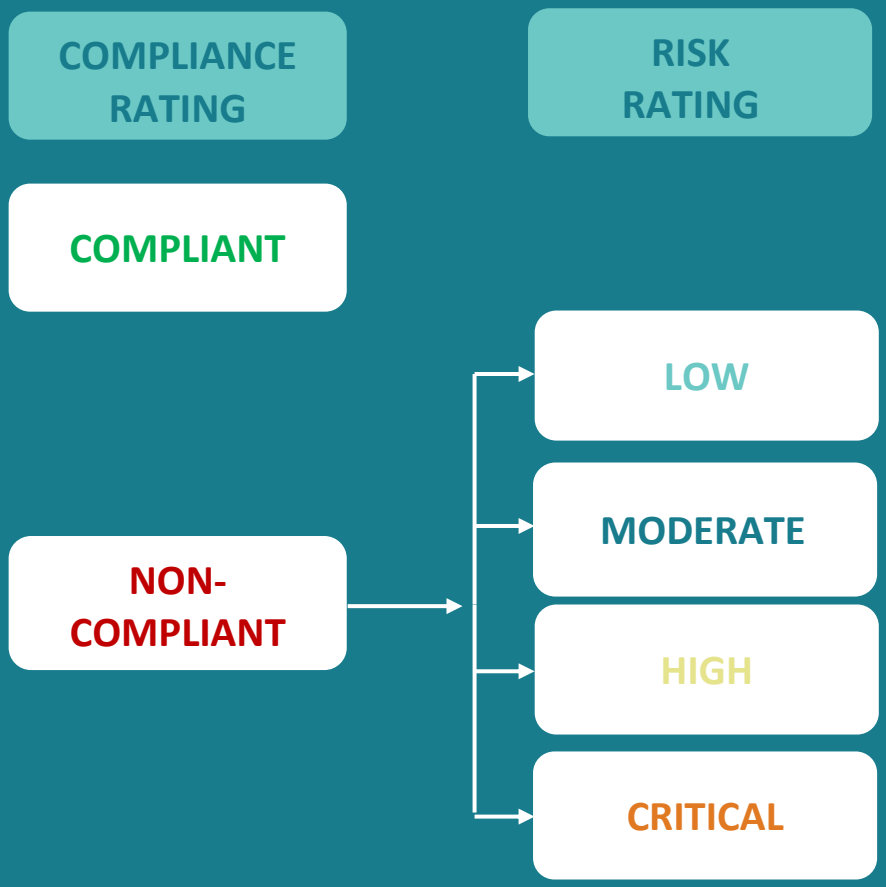
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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