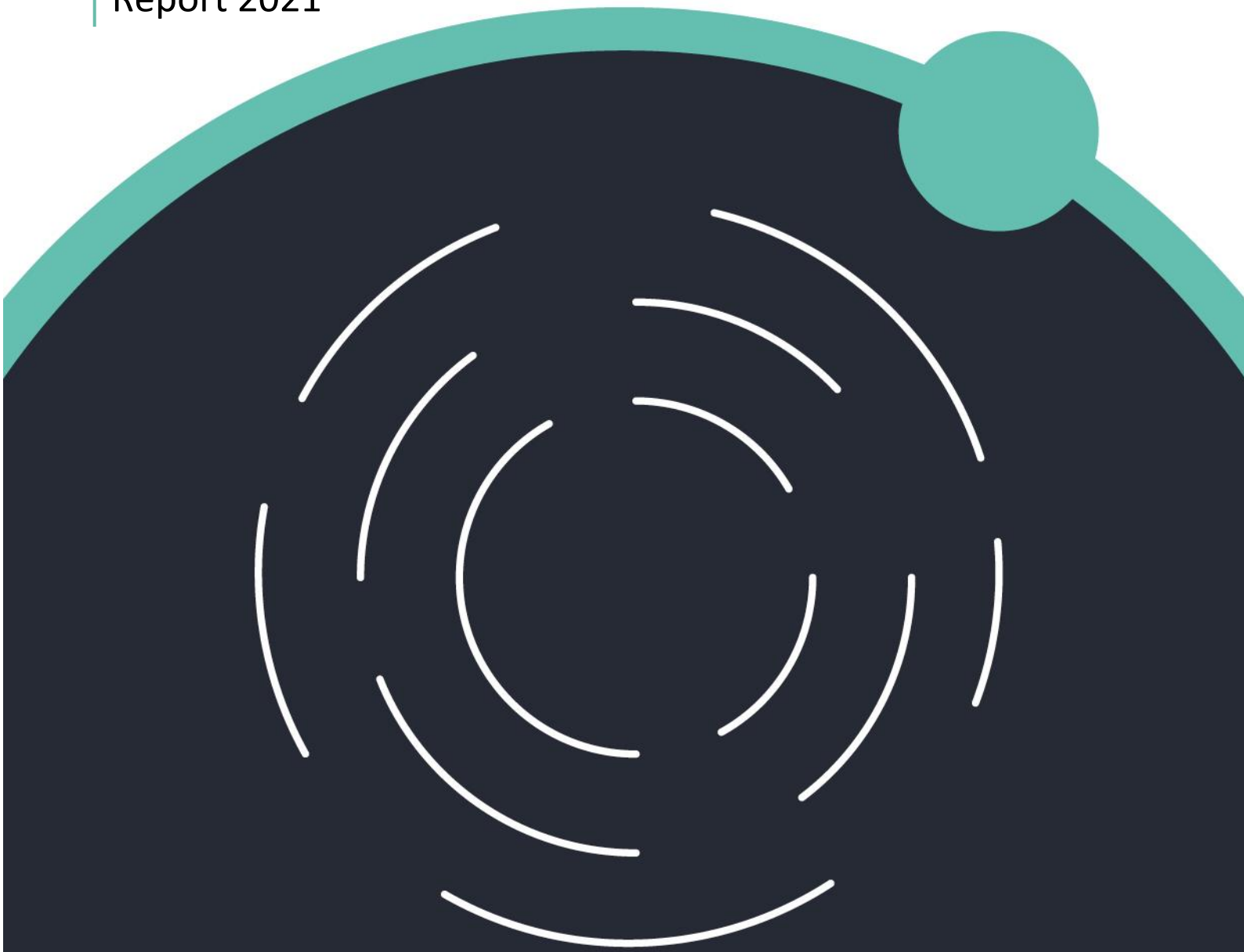
Admission Unit & St Edna's Unit, St Loman's Hospital

mhc
coimisiún meabhair - shláinte
mental health commission

Annual Inspection Report 2021



Promoting Quality, Safety and Human Rights in Mental Health

ADMISSION UNIT & ST EDNA'S UNIT, ST LOMAN'S HOSPITAL

Devlin Road, Mullingar, Co. Westmeath

Date of Publication:
Tuesday 15 February 2022

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2021 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Martina Lennon, General Manager Mental Health Services, MLM CHO

Inspection Team:
Aoife Gallaher, Lead Inspector
Sarah Jones
Carol Brennan-Forsyth

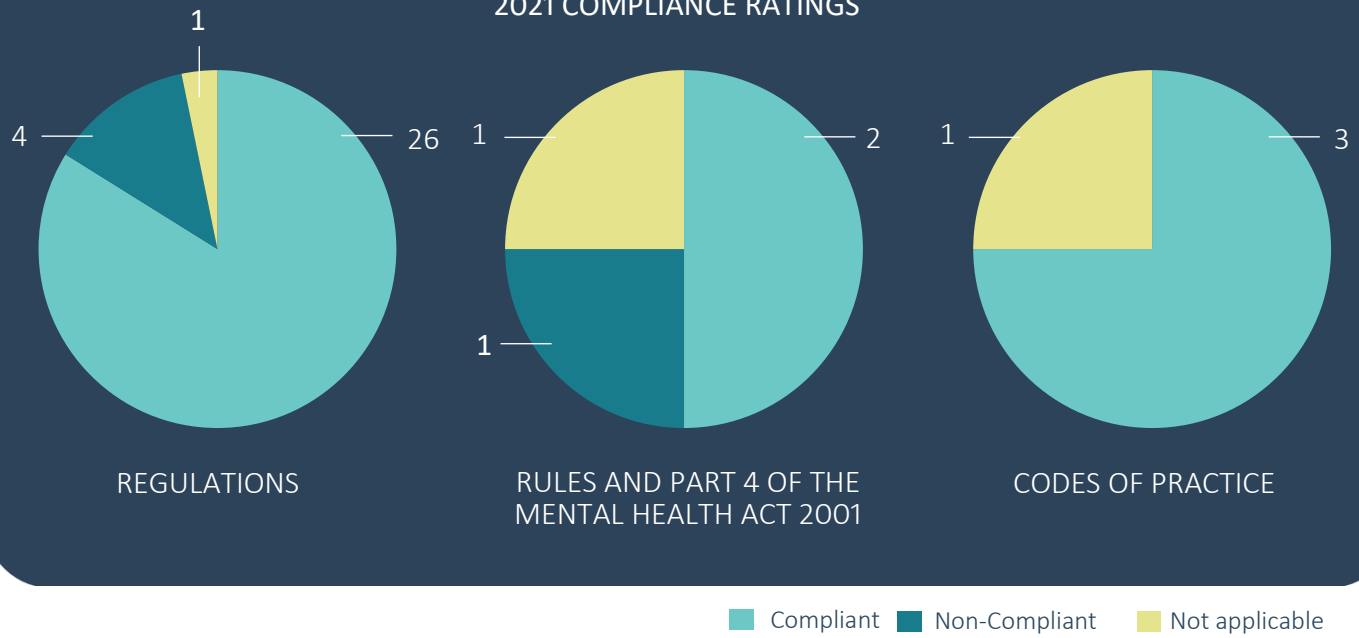
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
31 August – 3 September 2021

Previous Inspection date:
10 – 13 November 2020

Inspection Type:
Announced Annual Inspection

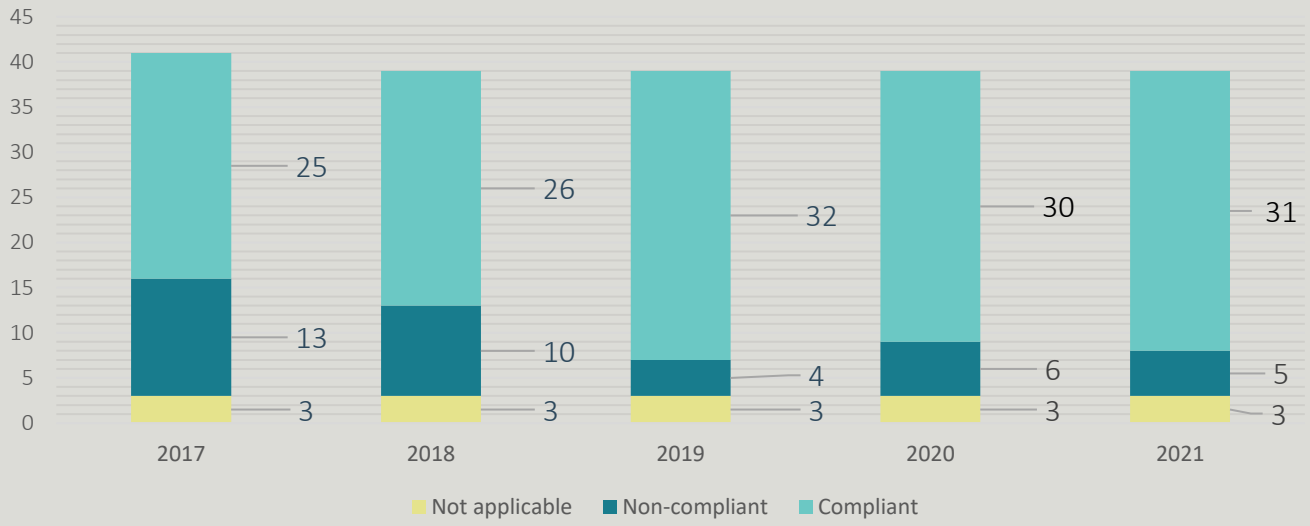
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

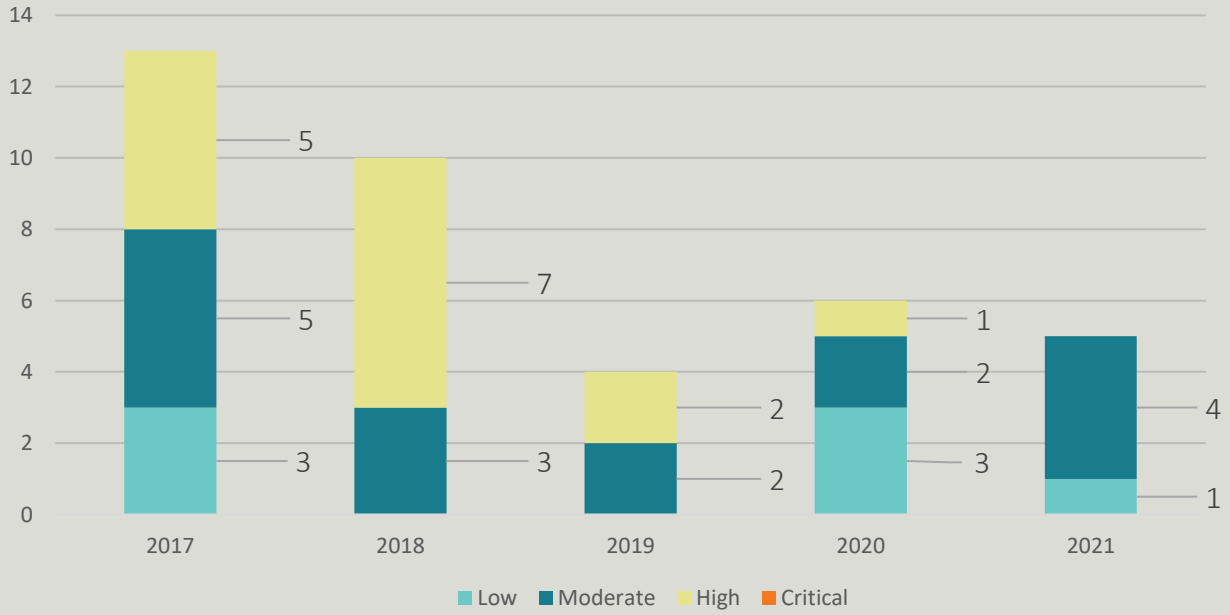
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



Contents

1.0 Inspector of Mental Health Services – Review of Findings 6
Conditions to registration 6
2.0 Quality Initiatives 11
3.0 Overview of the Approved Centre 12
3.1 Description of approved centre 12
3.2 Governance 12
3.3 Reporting on the National Clinical Guidelines 14
4.0 Compliance 15
4.1 Non-compliant areas on this inspection 15
4.2 Areas that were not applicable on this inspection 15
5.0 Service-user Experience 16
5.1 Service-user feedback 16
5.2 Advocacy 16
6.0 Feedback Meeting 18
7.0 Inspection Findings – Regulations 19
8.0 Inspection Findings – Rules 53
9.0 Inspection Findings – Mental Health Act 2001 58
10.0 Inspection Findings – Codes of Practice 61
Appendix 1: Corrective and Preventative Action Plan 68
Appendix 2: Background to the inspection process 73

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 approved centre was located on the grounds of St. Loman's Hospital Mullingar. It was a single storey 44-bed building which comprised of two units, the Admission Unit and St. Edna's Unit which was a continuing care for 20 male residents. Four community mental health teams; Mullingar North, South, Longford and Athlone alongside a psychiatry of later life team, a rehabilitation and recovery team and the Community Alcohol and Drugs Service admitted residents to the approved centre.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	66%	72%	89%	83%	86%
Regulations Rated Excellent	0	9	4	N/A	N/A

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

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 22(3): Premises, the approved centre shall develop a costed, funded and time-bound plan to minimise ligatures in the approved centre.*	A costed, funded, time-based plan was developed and submitted within timeframe.

This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide an update on the implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.	
The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.	
Condition 2: *To ensure adherence to Regulation 22(1)(c): Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance in a form and frequency prescribed by the Commission.*	There was a programme of maintenance and progress updates had been provided to the Mental Health Commission. The approved centre was kept in a good state of repair inside and outside.
The approved centre was not in breach of Condition 2 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.	
Condition 3: *To ensure adherence to Regulation 26(4) and (5): Staffing the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*	Health care staff were trained in the Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes. Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022.
The approved centre was not in breach of Condition 3 and the approved centre was compliant with Regulation 26: Staffing at the time of inspection.	

Escalation and enforcement actions since last inspection

There was no escalation or enforcement actions since the previous inspection.

Escalation and enforcement actions since this inspection

There was no escalation or enforcement actions since this inspection.

Safety in the approved centre

We found that the approved centre operated safe practices which reduced risk of harm and that effective systems were in place to safeguard patients.

- 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:

- Fire evacuation drills had not taken place in the approved centre since 2019.
- Ligature points which were identified on the approved centre's ligature audit as a medium risk, were not minimised to the lowest practicable level based on risk assessment.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities based on individual care plans and physical health monitoring that was appropriate to needs of residents.

- 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.
- Therapeutic programs included: cognitive activities, good mood activities, physical exercise groups, recovery education, gardening groups. The local external Community Integration Officer provided activities for the residents in the community and included social farming, men's shed and music groups.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

We found that the approved centre mostly provided services in a way that respected residents' privacy, dignity and autonomy.

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.

- 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, windows of the visiting room, dining room and assessment rooms which were overlooked by public areas did not have privacy blinds, at the time of the inspection.

Responsiveness to residents' needs

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

- Recreational activities included newspaper groups, movie nights, word wheels, baking, quizzes, walking, music and outings.
- 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 was a robust system of governance in place.

- The approved centre was part of the Midland Louth Meath Community Healthcare Organisation. The Longford/Westmeath Mental Health Services Catchment Management Team met monthly.
- The approved centre had a local risk register. However, risks in relation to the safe evacuation of residents in the event of a fire were not identified as fire evacuation drills had not taken place in the approved centre since 2019.
- A programme of audit was implemented within the service. A Quality and Safety team was in place within the approved centre, and they met with the Senior Management Team monthly to report on initiatives both in place and planned.
- It was evident that there were systems in place to support quality improvement that included the HSE Best Practice Guidance for Mental Health Service, The National Quality & Service User Safety Team (QSUS) and the monthly Quality and Patient Safety meetings.
- There was an organizational chart identifying the leadership and management structure.
- Part of the Area Lead for Mental Health Engagement role was working with staff to train them in facilitation of community group meetings in the approved centre. They were also involved in local monthly forum meetings. These took place in a community settings and were accessible to residents of the approved centre and family members.

- The complaints and compliments system were publicly displayed. Formal complaints were dealt with by a complaints officer who was based on the grounds of approved centre. Monthly community meetings were facilitated by staff on the unit where residents could make requests and suggestions.

COVID-19 response

The approved centre evidenced clear signage throughout the building, encouraging social distancing and hand hygiene. At the time of inspection visits had recommenced. The service developed a preparedness plan and action log which detailed specific measures to minimize risk of COVID-19 infection and monitoring of potential risks. The plan addressed issues concerning precautions for admissions, transfer and discharges, the required equipment to maintain safety, and identified designated isolation/cohorting measures.
Due to COVID-19 restrictions, communication with a peer advocate was via audio-visual link using an electronic tablet provided by the IAN.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The service developed an activities pack for residents; this could be provided to residents in the event that a period of isolation was necessary due to COVID-19.

2. A Quality Improvement Group was established for St. Edna's Ward

3. ECT Training was provided for Staff Nurses.

4. The Approved Centre was a pilot site for the reduction of restrictive practices in mental health.

5. The service organised social music nights, entitled "Band in a Van".

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Located on the grounds of St. Loman's Hospital Mullingar, the approved centre was a single storey building which comprised of two units, the Admission Unit and St. Edna's Unit, providing accommodation for 44 residents. Four community mental health teams; Mullingar North, South, Longford and Athlone alongside a psychiatry of later life team, a rehabilitation and recovery team and the Community Alcohol and Drugs Service admitted residents to the approved centre.

St. Enda's Unit provided continuing care for male residents, most of whom had been in the approved centre for several years. Sleeping accommodation consisted of single en suite bedrooms. St Edna's had capacity to accommodate 20 residents. At the time of the inspection, there was an occupancy of fifteen residents, and all were admitted over six months.

The Admission unit had reduced bed capacity from 24 to 21 beds at the time of inspection. This was done to facilitate COVID-19 social distancing and isolation measures. The Admission Unit was an acute facility providing treatment for male and female residents. Sleeping accommodation consisted of single en suite bedrooms and three double bedrooms which were being used as single occupancy.

During the inspection, there were 28 residents in total in the approved centre. There were 13 residents in the Admission Unit and 15 residents in St. Edna's. Reflecting eight vacancies on the admission unit and five vacancies in St. Edna's on the first day of the inspection. This reflected average bed occupancy levels over the previous three month period of 60%.

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

Resident Profile	
Number of registered beds	***44***
Total number of residents	**28**
Number of detained patients	7
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	18
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of the Midland Louth Meath Community Healthcare Organisation and encompassed the governance of both Longford/Westmeath Mental Health Services, and the Laois Offaly Mental Health Services. The Longford/Westmeath Mental Health Services Catchment Management Team met monthly. Minutes from the team meetings demonstrated evidence of well-structured governance

arrangements; standing agenda items included quality and patient safety, human resource issues, finance, and regulation. These meetings were attended by heads of discipline, the general manager, business manager, the risk and patient safety advisor and the area lead for mental health engagement. The area lead for mental health engagement, who had been redeployed during the pandemic, had returned to their post and attended the monthly meeting.

The key personnel with responsibility for risk management were identified by staff. The approved centre had a local risk register. Operational risks identified across the departments focused on ligature risks, staff shortages and recruitment difficulties, challenges to accommodate mandatory training needs, and lack of access to a psychiatric intensive care unit resulting in prolonged episodes of seclusion and inappropriate admissions to the approved centre. However, risks in relation to the safe evacuation of residents in the event of a fire were not identified as fire evacuation drills had not taken place in the approved centre since 2019.

A programme of audit was implemented within the service. A Quality and Safety team was in place within the approved centre, and they met with the Senior Management Team monthly to report on initiatives both in place and planned. The monthly Quality and Patient Safety meetings dealt with specific items relating to the approved centre. Meeting agenda items included a progress report update, risk management issues, and details concerning complaints, visits, incidents, and serious reportable events. However, lack of fire evacuation drills was not documented on the risk register as a health and safety risk. It was evident that there were systems in place to support quality improvement that included the HSE Best Practice Guidance for Mental Health Service, The National Quality & Service User Safety Team (QSUS) and the monthly Quality and Patient Safety meetings.

There was an organizational chart identifying the leadership and management structure. Staff were supported through their line management. Clinical supervision was provided for medical staff and the health and social care professional groups. The approved centre had two whole time equivalent staff nurse vacancies with interviews for these posts arranged within a two-week period. Seven consultant led sector teams admitted to the approved centre. The service identified the need for an additional consultant to lead a general adult team. The service management had also identified the need for a full time senior pharmacist due to limited access to pharmacy service in the Approved Centre. Access to a Dietitian and Speech and Language Therapist (SLT) was via referral. Both the Dietitian and the SLT were located off-site. Access to the SLT service was slow resulting in extended delays for urgent and routine assessments.

Governance questionnaires were completed by the heads of discipline and returned to the inspection team. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. The inspection team spoke to heads of disciplines and to the Area Lead for Mental Health engagement about their role specifically in this approved centre. An integral part of the Area Lead for Mental Health Engagement role was working with staff to train them in facilitation of community group meetings in the approved centre. They were also involved in local monthly forum meetings. These took place in a community settings and were accessible to residents of the approved centre and family members. These meetings supported access to key mental health and advocacy services.

A representative from the Irish Advocacy Network (IAN) attended the approved centre prior to the COVID-19 pandemic. Due to COVID-19 restrictions communication with a peer advocate was via audio-visual link

using an electronic tablet provided by the IAN. The complaints and compliments system were publicly displayed. Formal complaints were dealt with by a complaints officer who was based on the grounds of approved centre. Monthly community meetings were facilitated by staff on the unit. This was a forum where residents made requests and suggestions. Residents' self-isolating, due to COVID-19 were given an opportunity to voice concerns or suggestions individually. The minutes of these meetings were provided to the inspection team.

The approved centre evidenced clear signage throughout the building, encouraging social distancing and hand hygiene. At the time of inspection visits had recommenced. The service developed a preparedness plan and action log which detailed specific measures to minimize risk of COVID-19 infection and monitoring of potential risks. The plan addressed issues concerning precautions for admissions, transfer and discharges, the required equipment to maintain safety, and identified designated isolation/cohorting measures.

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 21: Privacy	✓		✓		✓		✗	Low	✗	Moderate
Regulation 22: Premises	✗	High	✗	High	✗	Moderate	✗	Moderate	✗	Moderate
Regulation 24: Health and Safety	✓		✓		✓		✓		✗	Low
Regulation 32: Risk Management Procedures	✓		✗	High	✗	High	✗	High	✗	Moderate
Rules Governing the Use of Seclusion	✗	Moderate	✗	High	✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

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

- 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.

A total of eight residents completed resident feedback questionnaires. Feedback suggested that residents understood what their individual care plan was. With five residents stating that they were involved in goal setting, one resident did not want to be involved and two stated that they were sometimes involved in goal setting. All respondents, except for one, knew the members of their multidisciplinary team. Six respondents indicated that they had space for privacy, with two stating no to this question. Seven residents requested to speak to an inspector over the phone. Comments were generally positive and complimentary of the staff, expressing satisfaction with the care and support provided by staff.

On a scale of 1-10 with 1 being poor and 10 being excellent three residents rated 10 out of ten for their overall experience of care and treatment, two residents rated eight, one rated seven, one rated six and one rated five.

5.2 Advocacy

The approved centre had an advocacy service. A representative from the Irish Advocacy Network attended the approved centre prior to COVID-19 pandemic. Due to COVID-19 restrictions communication with a peer advocate was via audio-visual link using an electronic tablet provided by the IAN. This virtual service was available weekly.

The Inspectors received a report from the IAN representative. Resident feedback to the representative, complimented the nurses for being friendly, supportive and helpful. Residents reported that the food was

lovely, that the unit was clean and that it was nice to have a private bedroom with an en suite. Residents reported enjoying using the art room. Residents in the admission unit reported that they liked being able to use the computer. Another resident reported that the unit was a quiet place to relax.

Some areas of improvement were also reported. Some residents reported that they would like to keep their mobile phones with them at all times rather than their being restrictions in place. Residents in the admissions unit would like if the art room were open more often . Online classes and therapy were cancelled during the HSE cyber attack. These services were missed by residents at that time. Residents reported that they found it difficult to isolate in a room by themselves when they first come into hospital.

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:

- Clinical Director
- Registered Proprietor
- Principal Social Worker
- Clinical Nurse Manager 3
- Assistant Director of Nursing
- Area Director of Nursing
- Hospital Administrator
- Principal Psychologist
- Occupational Therapy Manager
- Quality & Risk Advisor
- Mental Health Act Administrator
- Replacement Mental Health Act Administrator
- Consultant Psychiatrist
- Business Manager
- Lead National Consultant Hospital Doctor
- Senior Registrar

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. The approved centre used stickers which contained resident name, date of birth, medical record number, photograph, and address as resident identifiers. Two appropriate resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals and a source of safe, fresh drinking water was available at all times in easily accessible locations in the approved centre. For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. During the inspection, no residents wore nightclothes during the day.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in March 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities including a regularly monitored safe was provided for the protection of resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

Staff in the approved centre developed an activities pack for residents in isolation due to the COVID-19 pandemic. The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. Recreational activities included newspaper groups, movie nights, word wheels, baking, quizzes, walking, music and outings.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in July 2021. Visiting times were appropriate and reasonable. A separate visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. 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 operational policy and procedures relating to communication. The communications policy was last reviewed in August 2019. Residents had access to the approved centre's Wi-Fi enabled internet, cordless telephone, two electronic tablets, a computer and their own personal mobile phones with due regard to the residents' well-being, safety, and health.

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 would 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 and procedures on the conducting of searches. The policy was last reviewed in July 2021. It included all of the policy regulation requirements including:

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

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

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

reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches.

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 series of written operational policies and procedures on care of the dying. The Care of the Dying policy was last reviewed in July 2021 and the Unexpected Death policy was last reviewed in May 2020. No resident had died in the approved centre since the last inspection and the approved centre was therefore assessed for compliance on the basis of policy alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. ICP's were reviewed by the MDT on a weekly basis in the Admission Unit and three monthly in St. Edna's Unit. All ICP's were reviewed in consultation with the resident.

ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the needs of the resident population, 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.

Both the Admission Unit and St Edna's Unit had their own dedicated Occupational Therapists (OTs). The social workers and psychologists provided individual sessions and therapeutic talks. Programs were provided in groups and individually based on the resident's needs. Each unit had their own therapeutic activities timetable.

Therapeutic programs included: cognitive activities, good mood activities, physical exercise groups, recovery education, gardening groups. Due to the COVID-19 pandemic, external programs ceased in line with public health guidelines. Virtual programs such as virtual choir and vision or voice had commenced, but these virtual programs were not available at the time of the inspection due to the HSE cyber-attack, they were due to recommence in October. The local external Community Integration Officer provided activities for the residents in the community. Therapeutic activities included social farming, men's shed and music groups.

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 relation to the transfer of residents. The policy was last reviewed in May 2020. The clinical file of one resident who had been transferred from the approved centre, in an emergency situation was examined. Communications between the approved centre and the receiving facility were followed up with a written referral.

Full, complete and relevant written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred there. The transfer documentation included a letter of referral, a list of current medication and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for responding to medical emergencies and in relation to general health. The policy was last reviewed in March 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator, (AED).

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Residents received appropriate general health care interventions in line with individual care plans. Six-monthly general health assessments were inspected, in relation to three residents who were in the approved centre for a period greater than six months. These six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, diet, physical activity, a medication review and Body Mass-Index (BMI), weight and waist circumference.

The files of two residents on antipsychotic medication were inspected. The residents received an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG) heart function test. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes applicable to their age and gender, including retina check for diabetics and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a policy and procedures detailing the process around the provision of information to residents. The policy was last reviewed in March 2020.

Residents were provided with an 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 diagnosis, unless, in the treating psychiatrist's view, the provision of such information might be damaging to the resident's physical or mental health, well-being, or emotional condition. Medication information sheets as well as verbal information were provided in a format appropriate to residents' and family's needs. 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 spoke with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. Residents were dressed appropriately to ensure their privacy and dignity. Each resident was in a room on their own and their privacy was not compromised. As part of the COVID-19 precautions double bed dormitories were not shared.

Not all observation panels on doors of treatment rooms were fitted with blinds, curtains, or opaque glass. The teleconference tribunal room which also functioned as an interview room on St. Enda's Unit, was used by doctors for resident medical assessments and the same room also contained an examination couch. This teleconference/interview room did not have a blind, opaque glass or a curtain on the observation panel on the door. This was remedied with a frosted cover on the second day of inspection.

Recent works were completed on the verandas in July 2021. Veranda rooms consisted of the visiting room, dining rooms and assessment room. All windows in the verandas required blinds, which were due to be fitted by a HSE contractor at a future date. Due to the absence of the required blinds on the veranda windows at the time of the inspection, it was possible for members of the public to see into those rooms – the visiting room, dining room, and assessment room.

All bathrooms, showers, and toilets had locks on the inside of the door. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

The approved centre was non-compliant with this regulation because residents' privacy and dignity was not respected at all times. Veranda windows – i.e., windows of the visiting room, dining room and assessment rooms which were overlooked by public areas did not have privacy blinds, at the time of the inspection, 21.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(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, heated, and ventilated. Appropriate signage and sensory aids were provided to help residents orientation needs. Hazards were minimised. There was a sufficient number of toilets and showers for residents in the approved centre. Resident bedrooms were appropriately sized to address resident needs. Residents had access to sufficient indoor and outdoor space. The lighting in communal rooms was sufficiently bright and positioned to facilitate reading and other activities.

Ligature points which were identified on the approved centre's ligature audit as a medium risk, were not minimised to the lowest practicable level based on risk assessment.

The approved centre was kept in a good state of repair inside and outside. It was clean, hygienic and free from offensive odours. Suitable furnishings were provided to support resident independence and comfort. There was at least one assisted toilet per floor. Assisted devices and equipment were provided to address resident needs.

The approved centre was non-compliant with this regulation because not all ligatures were minimised to the lowest practicable level based on risk assessment, 22 (3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in May 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: medications administered, allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, date of discontinuation for each medication, and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases.

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. When a resident's medication was withheld a record was kept, and the justification was documented in the MPAR and in the clinical file. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

Medication dispensed or supplied to the resident was stored securely in a locked storage unit (e.g. drugs trolley or drawers), with the exception of medication which was recommended to be stored elsewhere (e.g. refrigerator). Scheduled 2 and 3 controlled drugs were locked in a separate locked cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

NON-COMPLIANT

Risk Rating LOW

(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 health and safety policy which was last reviewed in August 2019 and a Site-Specific Safety statement (SSSS) which was last reviewed in June 2020. Health and Safety Policy states that Site Specific Safety Statements and associated risk assessments are reviewed and updated on a regular basis, at least annually, and in the event of a significant change in the work activity or place of work. Site Specific Safety Statement was dated June 2020. These policies and statements did not include procedures relating to the health and safety of residents, staff and visitors.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre had written operational policies and procedures relating to the health and safety of residents, staff and visitors, 24 (1).

Regulation 25: Use of Closed Circuit Television

COMPLIANT

(1) The registered proprietor shall ensure that in the event of the use of closed circuit television or other such monitoring device for resident observation the following conditions will apply:

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

(b) it shall be clearly labelled and be evident;

(c) the approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

(d) it shall be incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

(e) it must not be used if a resident starts to act in a way which compromises his or her dignity.

(2) The registered proprietor shall ensure that the existence and usage of closed circuit television or other monitoring device is disclosed to the resident and/or his or her representative.

(3) The registered proprietor shall ensure that existence and usage of closed circuit television or other monitoring device is disclosed to the Inspector of Mental Health Services and/or Mental Health Commission during the inspection of the approved centre or at any time on request.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in July 2021.

There were clear signs in prominent positions to indicate where CCTV cameras were located throughout the approved centre. CCTV cameras used to observe residents were not capable of recording or storing a resident's image on a tape, disc, or hard drive. CCTV was used solely for the purposes of observing a resident by a health professional who was responsible for the welfare of that resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. The Mental Health Commission had been informed about the approved centre's use of CCTV.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in relation to the recruitment, selection and Garda vetting requirements of staff. The policy was last reviewed in September 2019. 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. There was four community mental health teams a psychiatry of later life team, a rehabilitation and recovery team, and the Community Alcohol and Drugs Service admitting to the Approved Centre. All teams included psychiatry, nursing, occupational therapy, psychology and social work staff. Access to a Dietitian and Speech and Language Therapist (SLT) was via referral. Both the Dietitian and the SLT were located off-site. Access to the SLT service was slow resulting in extended delays for urgent and routine assessments.

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. The following is a table showing the number and %'s of staff trained in the Mental Health Act 2001.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (50)	50	100%
Medical (29)	29	100%
Occupational Therapist (7)	7	100%
Social Worker (6)	6	100%
Psychologist (6)	6	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the creation of, access to, retention of and destruction of records. The Clinical Records policy was last reviewed in July 2019. 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' current status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence. Information was easy to retrieve in clinical files. The approved centre used dividers which assisted relevant staff in finding information.

Records were physically stored together and 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 were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an electronic register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 of the Mental Health Act 2001.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided facilities and 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 February 2020. It included 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 individual responsible for dealing with all complaints available in the approved centre.

The complaints procedure and the nominated person's contact details were publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints were handled promptly, appropriately and sensitively. The nominated person maintained a record of all minor and formal complaints relating to the approved centre. Residents who had made a complaint were not adversely affected by reason of the complaint having been made. All complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded, these records were in addition to and distinct from a resident's individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating MODERATE

(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 was a written policy in relation to risk management and incident management processes. The risk management policy was last reviewed in March 2019. The policy included all of the policy related regulation requirements, which were:

- The identification and assessment of risks throughout the approved centre.
- The precautions in place to control the risks identified.
- The precautions in place to control the following specified risks: resident absent without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.
- Arrangements for responding to emergencies.
- Arrangements for the protection of children and vulnerable adults from abuse.

The person with responsibility for risk was identified and known by all staff. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation.

Not all components of the risk management policy were implemented throughout the approved centre, because not all health and safety risks were adequately identified, assessed and treated. Health and safety risks in relation to residents being able to safely evacuate in the event of a fire were not remedied, due to the fact that no fire evacuation drills had taken place since 2019. The lack of fire evacuation drills taking place was not documented on the risk register as a health and safety risk that could potentially negatively

impact the evacuation process of residents in the event of a fire. The risk management policy did not identify a named person responsible for ensuring fire evacuation drills took place. Structural risks including ligature points were effectively mitigated.

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, ECT, 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 because the registered proprietor did not ensure that appropriate risk management procedures were implemented throughout the approved centre. Evacuation procedures were not adequately assessed – fire evacuation drills had not taken place in the approved centre since 2019, 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's insurance certificate and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered 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 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 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of electro-convulsive therapy (ECT) for involuntary patients. The policy was last reviewed in July 2021. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite in the Midlands Regional hospital, Mullingar for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. High-risk patients were treated in a rapid-intervention area. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one involuntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed unable to consent to receiving ECT. ECT was administered according to section 59(1)(b) of MHA 2001, as amended. A Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed by two consultant psychiatrists

for each ECT programme. A form 16 was placed in the patient's clinical file and a copy of it was sent to the MHC within five days.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, and a current mental state examination. Cognitive assessments were completed and recorded before and after each ECT session. The process was in line with best international practice by the consultant psychiatrists.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT was recorded.

The approved centre was compliant with this Rule.

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) involved in the patient's care and treatment, and as there was no evidence of the MDT seclusion episode review taking place, it was not 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 because the episode of seclusion was not reviewed by members of the multi-disciplinary team (MDT) at all, and it was therefore not 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 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had assessed the patient's capacity to consent to receive treatment and that the patient was unable to consent. A Form 17 *Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient and documented the following:

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

The form 17 also included approval by a consultant psychiatrist and authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in September 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 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 the episode.

The approved centre compliant with this Code of Practice.

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in place in relation to the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was last reviewed in July 2021. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene were stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite was located in the Midlands Regional Hospital Mullingar. The ECT suite had a private waiting area, adequately equipped treatment room, and an adequately equipped recovery room. Material and equipment for ECT, including emergency medicines, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. A named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed able to consent to receiving ECT. Consent was obtained in writing for each ECT treatment session, including anaesthesia. All consent was obtained by the consultant psychiatrist, or registered medical practitioner (RMP) under supervision of CP, prior to each ECT treatment session and recorded in clinical file. An ECT treatment pack was contained within the patient's clinical file.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, and a current

mental state examination. Cognitive assessments were completed and recorded before and after each ECT session. The process was in line with best international practice by the consultant psychiatrists.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant, current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT was recorded.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a series of separate written policies in relation to admission, transfer, and discharge. The admission policy was last reviewed in July 2021, the transfer policy was last reviewed in May 2020, and the discharge policy was last reviewed in May 2020. 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 admission, transfer, 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 and included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, social situation, housing situation, work situation, education, and dietary requirements. The resident received a full physical examination. The resident's family member was involved in the admission process, with the resident's consent.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team and the resident's family. 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 appropriate multi-disciplinary team input into discharge planning. A comprehensive discharge summary was issued on the same day of discharge. The discharge summary included details of diagnosis,

prognosis, medication, mental state at discharge, follow-up arrangements, and names and contact details of key people for follow-up. The discharge summary included risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 21: Privacy					
Reason ID : 10002387		**Residents' privacy and dignity was not respected at all times. Veranda windows – i.e., windows of the visiting room, dining room and assessment rooms which were overlooked by public areas did not have privacy blinds, at the time of the inspection, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Blinds/manifestations due for installation Monday, 6th December, 2021 for completion by Friday, 10th December, 2021	Quarterly privacy audit, December, 2021	Yes	10/12/2021	Hospital Manager
Preventative Action	Temporary manifestation in place until permanent solution complete	Quarterly privacy audit, December 2021	Yes	03/12/2021	Hospital Manager

Regulation 22: Premises					
Reason ID : 10002383		**Not all ligatures were minimised to the lowest practicable level based on risk assessment, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1.Anti-ligature works currently in progress to be complete by end Q4, 2021. Works determined by ligature audit tool (attached) 2. Ligature audit has been revised and a small portion of works identified and will be complete by Q2, 2021.	Annual Audit	Yes	31/03/2022	Clinical Director, Area Director of Nursing, Estates Manager
Preventative Action	Ligature Audit Risk Register	Agenda on Clinical Governance monthly meetings	Yes	31/03/2022	Clinical Director, Area Director of Nursing, Estates Manager

Regulation 24: Health and Safety					
Reason ID : 10002382		**The registered proprietor did not ensure that the approved centre had written operational policies and procedures relating to the health and safety of residents, staff and visitors, 24 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The operational policies and procedures relating to the Health and Safety of the residents, staff and visitors has now been updated to November, 2021 (copy attached)	Health and Safety is now a standard agenda item on the Clinical Governance meeting	Yes	03/12/2021	Catchment Management Team Mental Health Services Longford Westmeath
Preventative Action	Regulation 24 is a standing item on the Health and Safety meeting and policy will be reviewed as required	H & S agenda	Yes	03/12/2021	Catchment Management Team Mental Health Services Longford Westmeath

Regulation 32: Risk Management Procedures					
Reason ID : 10002388		**The registered proprietor did not ensure that appropriate risk management procedures were implemented throughout the approved centre. Evacuation procedures were not adequately assessed – fire evacuation drills had not taken place in the approved centre since 2019, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire evacuation drill scheduled for 21/12/2021	Ensure annual fire evacuation drills are scheduled and learnings implemented	Yes	21/12/2021	Area Director of Nursing
Preventative Action	Risk register updated every three months	Risk Register updated at monthly Clinical Governance	Yes	21/12/2021	Catchment Management Team Mental Health Services Longford Westmeath

Rules Governing the Use of Seclusion					
Reason ID : 10002381		**The episode of seclusion was not reviewed by members of the multi-disciplinary team (MDT) at all, and it was therefore not 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	Incorporate the MDT review in the revised seclusion care plan. Clinical Director has issued an email to all heads of discipline regarding this rule (see attached).	Audit 3 monthly	Yes	03/12/2021	Clinical Director
Preventative Action	Monthly audit of seclusion and findings presented to monthly QPS/CMT meeting	Audit 3 monthly	Yes	03/12/2021	CNM 3

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.

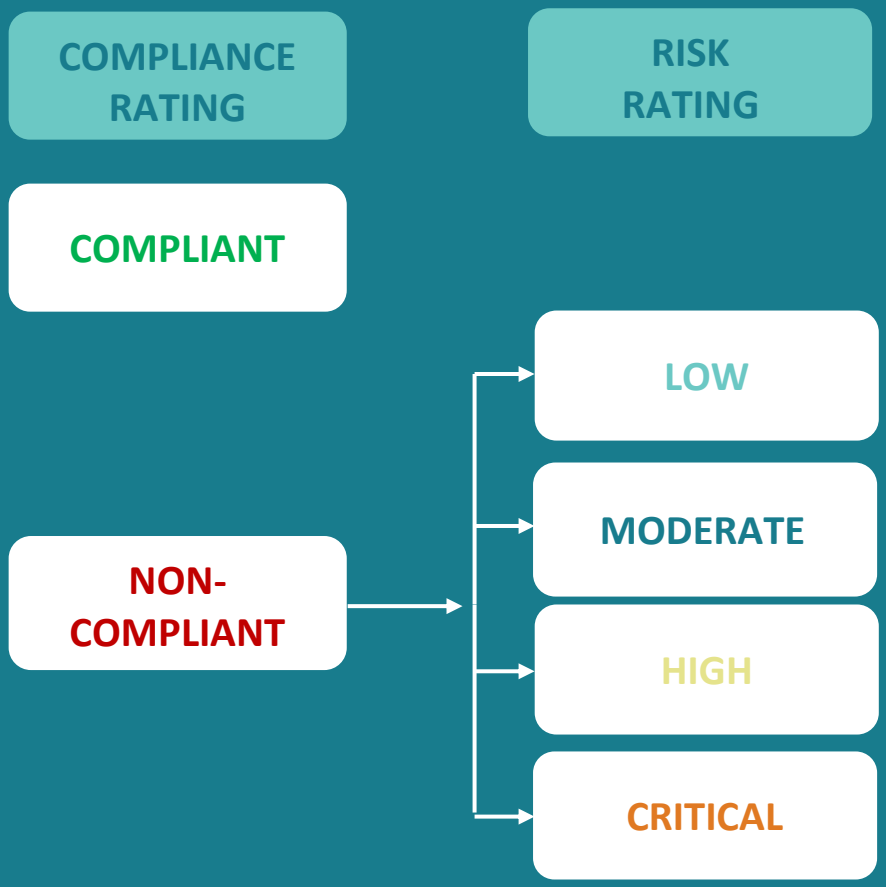
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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