St Michael's Unit, Mercy University Hospital

Annual Inspection Report 2021

Promoting Quality, Safety and Human Rights in Mental Health

ST MICHAEL'S UNIT, MERCY UNIVERSITY HOSPITAL

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

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2021 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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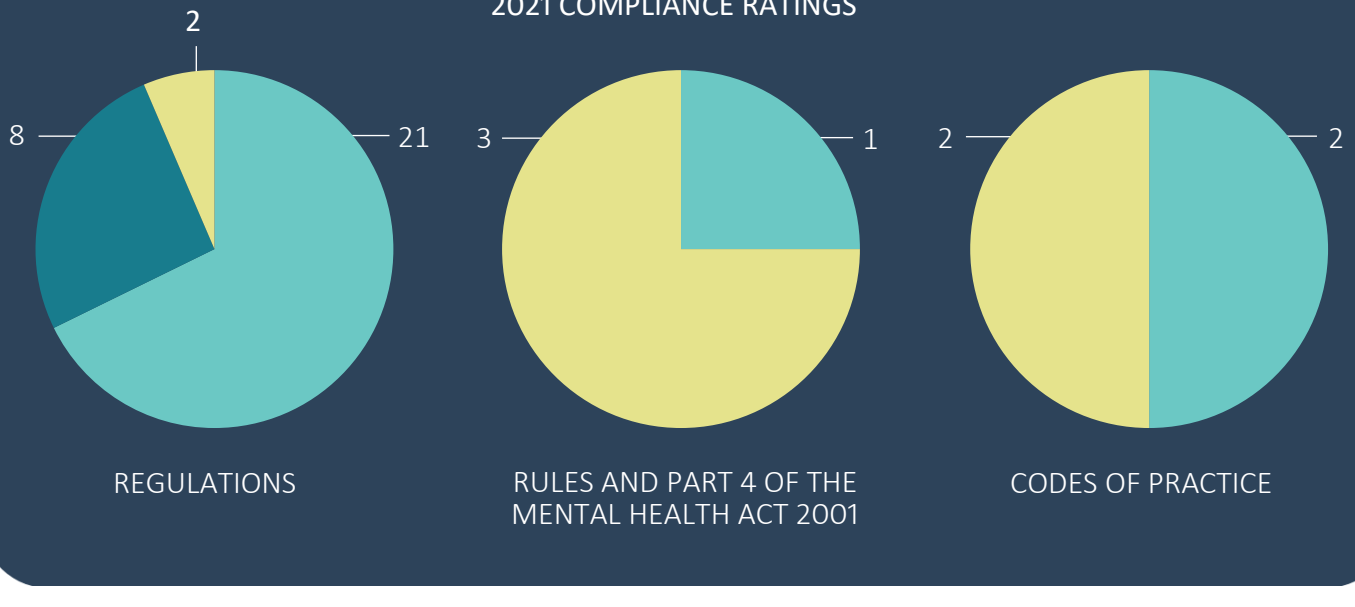
Inspection Date:
28 September – 1 October 2021

Previous Inspection date:
29 October – 2 November 2020

Inspection Type:
Announced Annual Inspection

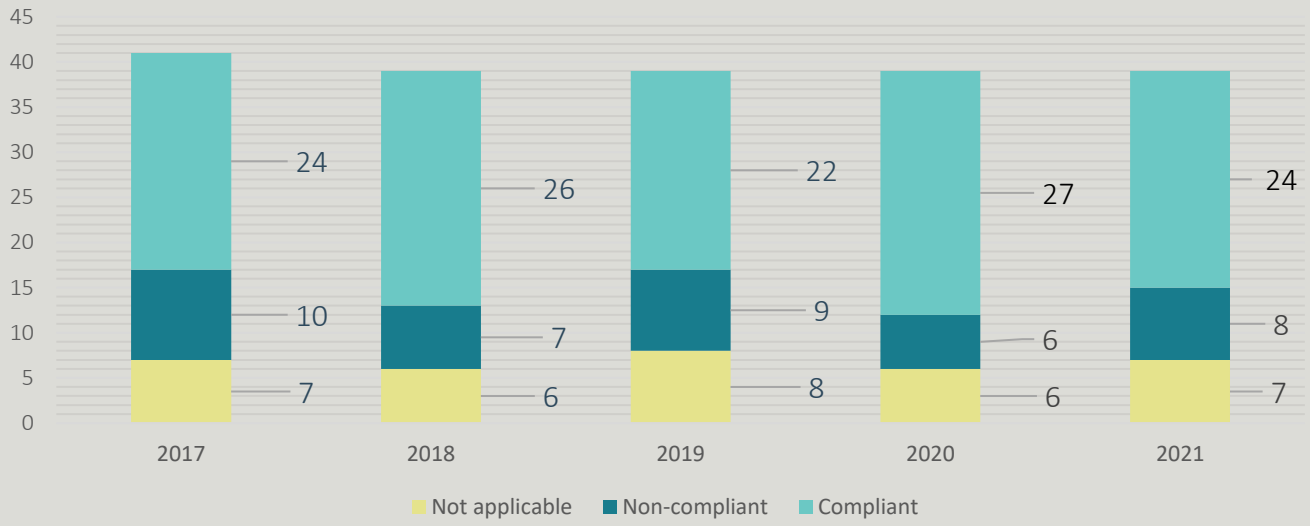
2021 COMPLIANCE RATINGS



RATINGS SUMMARY 2017 – 2021

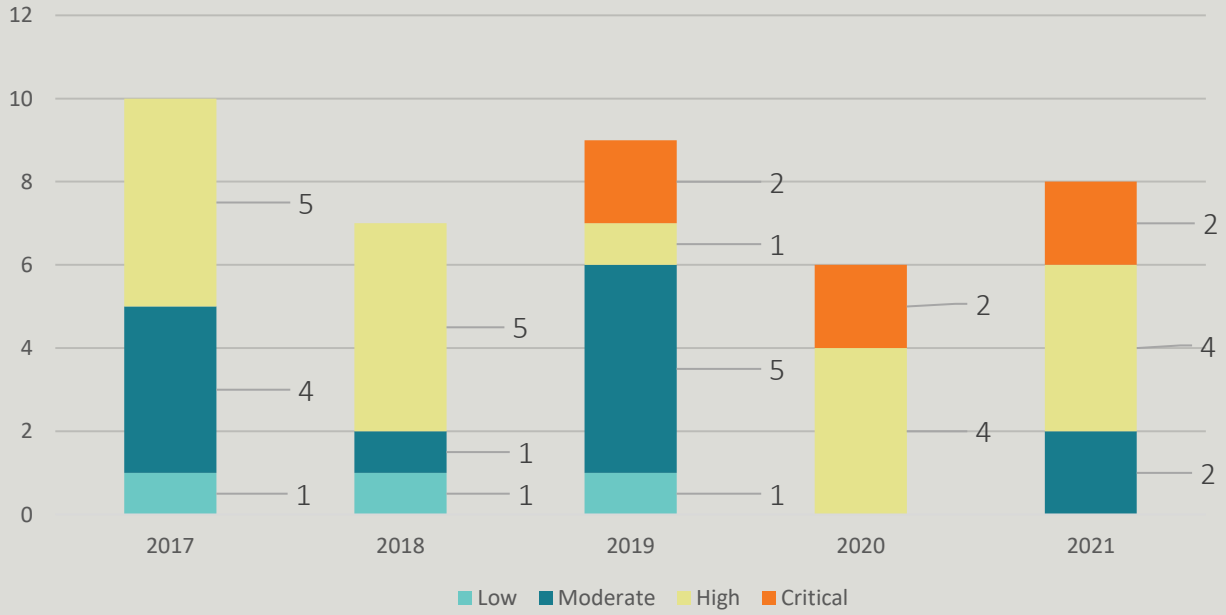
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

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

In brief

St. Michael's Unit was located in the Mercy Hospital Cork and had 50 beds, in acute and sub-acute wards. Eight multi-disciplinary teams admitted to the approved centre, these included Adult Mental Health Teams and a Psychiatry of Later Life team.

Compliance Summary	2017	2018	2019	2020	2021
% Compliance	71%	79%	71%	82%	75%
Regulations Rated Excellent	6	10	10	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(1)(a): 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*	A plan was submitted to the Mental Health Commission outlining a plan to improve the layout of the approved centre and to address ligature anchor points. This had not been implemented at the time of the inspection.

programme of maintenance in a form and frequency prescribed by the Commission.	
The approved centre was 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(3): Premises the approved centre shall develop a costed, funded and time-bound plan to minimise ligatures. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission*	A costed, funded and time-bound plan had been submitted to the Mental Health Commission to minimise ligatures anchor points.
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 22(3): Premises the approved centre shall develop a costed, funded and time-bound plan for scheduled building works to reconfigure the approved centre and ensure residents have appropriately sized sleeping accommodation and adequate communal areas. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.*	The approved centre submitted a costed, funded and time-bound plan for scheduled building works to reconfigure the approved centre and ensure residents have appropriately sized sleeping accommodation and adequate communal areas.
The approved centre was not in breach of Condition 3 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection	

Escalation and enforcement actions since last inspection

There were no escalation and enforcement action since the previous inspection.

Escalation and enforcement actions since this inspection

Following this annual Inspection of the approved centre an Immediate Action Notice (IAN) issued on 14 October 2021. It outlined eight non-compliances including critical non-compliances with Regulation 21: Privacy and Regulation 22: Premises.

It addressed the adequacy of approved centre responses in relation to all three conditions and included six immediate actions around risk management, cleaning, procuring suitable furniture, addressing lack of communal space and compliance with condition 2 related to a costed, funded and timebound plan to minimise ligatures. The Commission continues to follow up with the service in relation to same.

Safety in the approved centre

We found that the approved centre did not always operate safe practices to reduce the risk of harm.

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- 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:

- Ligature anchor points were evident throughout the approved centre, no work had been undertaken to minimise the risks associated with the ligature points since the last inspection.
- Hazards included cleaning trolleys, a large metal roll holder and several blood pressure (BP) machines which were left in the communal area at the time of the inspection.

Appropriate care and treatment of residents

We found that individual care plans and physical health monitoring did not meet the needs of the residents.

- An eating disorder care pathway had been developed for use in the approved centre and by the general medical teams in the Mercy Hospital.

However:

- Residents in the approved centre under the care of the Adult Mental Health Teams did not have access to an Occupational Therapist (OT), the dedicated OT post had been vacant for six months.
- The individual care plans inspected were not of good standard.
- The six-monthly monitoring of general health was not adequate.

Respect for residents' privacy, dignity and autonomy

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

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to a resident.

- All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass and, where rooms were overlooked by public areas, opaque glass was fitted to protect the residents' privacy.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However:

- St Michael's Unit contained single bedrooms, double bedrooms, and six bedded rooms. Two 2-bedded rooms within the sub-acute ward were not of an adequate size to ensure residents' privacy and dignity.
- The approved centre was not in a good state of repair and it was unclean in some areas: several ceiling tiles were stained, the shower flooring in the male side of the Acute Ward was stained, a glass roof in the Acute Ward was dirty, and one shower was dirty. All windows were dirty throughout the approved centre. There was a smell of smoke near the female toilet in the Sub-acute Ward at the time of the inspection.
- Not all clinical files were maintained in good order as four files inspected contained loose pages which constituted a risk to the confidentiality of residents clinical information.
- There was insufficient space to accommodate residents and store equipment:
    - On the sub-acute ward, there was a small sitting room which under normal circumstances prior to the COVID-19 could not accommodate 30 residents.
    - The approved centre had a conservatory area, however, due to on-going issues with smoking, it was locked and could only be accessed by the residents under supervision. This further limited the communal space available to residents.
    - The large communal sitting area had 12 seats for resident's use and was a thoroughfare to resident accommodation.
    - The acute ward area had limited storage space and equipment was found to be stored in corridors outside bedrooms and in the main sitting area.

Responsiveness to residents' needs

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

- Recreational activities included the following: knitting, embroidery, mindful colouring, air hockey, foosball table, ping pong table, board games, crosswords, puzzle books, DVDs, and bingo.
- The approved centre provided access to recreational activities on weekdays and during the weekend.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.

Governance of the approved centre

- St. Michaels Unit was governed by the North Lee Mental Health Services Senior Management Team. North Lee was a subsection of Cork Mental Health Services, which was part of the wider Cork Kerry Community Healthcare Organisation.
- Numerous sub-committees and working groups fed into the North Lee Senior Management Team, some of which included a COVID-19 Outbreak Control Team, a Quality and Safety Committee, St. Michaels Unit Nurse Management Group, Policies Procedures Group, Incident Review Group, an Audit Committee and an ICP Working Group.
- The Policies Procedures, Protocols and Guidelines (PPPGs) group provided a multi-disciplinary approach to policy development, review, approval, and dissemination.
- There was an audit cycle in place and audit results were monitored by the Audit Committee. The Audit Committee fed into the North Lee Mental Health Services Quality and Safety Committee.
- There was a risk management system in place, but there had been no effective reduction and improvement with the risk associated with ligature points since last inspection.
- The Area Lead for Mental Health Engagement was a member of the wider Cork Kerry Community Healthcare Organisation. Input from service users was sought by the Senior Management Team through numerous channels, such as the HSE's 'Comment, Compliment or Complaint' process and resident community meetings.

COVID-19 response

The approved centre had a COVID-19 contingency plan in place and a COVID-19 Outbreak Control Team met every six weeks to discuss procedures and risks to the unit.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. St Michael's Unit had set up a Tobacco Free Campus (TFC) Group to encourage a tobacco free campus and to support residents in using alternative coping skills. The group received a bursary of €4500 to support TFC initiatives within the approved centre.

2. The Irish Advocacy Network had provided two IT tablets for residents to liaise with them during the COVID-19 pandemic.

3. The approved centre had introduced wellness groups for residents and staff.

4. The desks at both nurses stations had been opened up to ensure that staff were more accessible to the residents.

5. A clinical nurse manager (CNM2) had been trained as an Infection Prevention & Control Link Practitioner (IPC). The purpose of this role was to act as a local resource and expert in infection prevention and control within St Michael's Unit.

6. An eating disorder care pathway had been developed for use in the approved centre and by the general medical teams in the Mercy Hospital.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

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

The 50-bedded approved centre was on the first floor of the Mercy University Hospital and comprised of acute and sub-acute wards. The acute ward contained 18 beds and the sub-acute ward had 32 beds. St. Michael's Unit provided inpatient care to the following areas: City North East, City North West, Blarney/Macroom, Cobh, Glenville, and Middletown/Youghal. Eight multi-disciplinary teams admitted to the approved centre, these included Adult Mental Health Teams and a Psychiatry of Later Life team.

St Michael's Unit contained single bedrooms, double bedrooms, and six bedded rooms. Two 2-bedded rooms within the sub-acute ward were not of an adequate size to ensure residents' privacy and dignity. The approved centre's communal areas comprised of a dining room, an occupational therapy kitchen, an occupational art room, an activities room, a gym, and a multi-purpose consultation room. On the sub-acute ward, there was a small sitting room which under normal circumstances could not accommodate 30 residents. At the time of inspection even fewer residents could access the sitting room due to the COVID-19 pandemic and continuing social distancing guidelines. The approved centre had a conservatory area which overlooked the river Lee; however, due to on-going issues with smoking, the conservatory was locked and could only be accessed by the residents under supervision. This further limited the communal space available to residents.

The acute ward area had limited storage space and equipment was found to be stored in corridors outside bedrooms and in the main sitting area. The large communal sitting area had 12 seats for resident's use and was a thoroughfare to resident accommodation. The residents' relaxation and recreational areas were very confined and residents had no access to outdoor space. As a result of this, the environment was restrictive in nature. The approved centre was found to be clean internally. The windows were found to be dirty externally.

Ligature anchor points were evident throughout the approved centre, no work had been undertaken to minimise the risks associated with the ligature points since the last inspection.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**41**
Number of detained patients	9

Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	6
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

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

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

The approved centre's registered proprietor had overall responsibility for the risk management process. St. Michael's Unit risk register was maintained by the Incident Review Group which met monthly. Members of the Incident Review Group consisted of the Assistant Director of Nursing (ADON), Clinical Nurse Manager 3 and the Clinical Director. Information in relation to the St. Michael's Unit risk register fed into the North Lee Mental Health Services Management Team and the Quality and Safety Committee when appropriate. The approved centre's risk register fed into the wider risk register maintained by the Cork Area Management Team. Incidents and trends were discussed at the monthly Incident Review Group, escalated incidences were discussed at multi-disciplinary team meetings. North Lee serious incidents, trends, and analysis were also discussed by the North Lee Quality and Safety Committee.

The most prominent risks identified by the service were in relation to ligature anchor points, risk of non-compliance with Regulation 22 Premises, risk to service users and staff regarding slips, trips and falls, unauthorised smoking in the approved centre and outbreaks of transmissible diseases. These risks were documented on the risk register; however, it was evident that there had been no effective reduction and improvement with the risk associated with ligature points since last inspection. Plans to reconfigure the approved centre had been submitted to the Mental Health Commission.

Not all disciplines had formal structures and processes in place for measuring staff performance and personal development. The formal arrangements and availability of clinical supervision varied across disciplines. The dedicated occupational therapist (OT) post for the approved centre had been vacant since March 2021. At the time of inspection an OT was providing 0.4 WTE hours for residents under the care of the POLL team. A fulltime OT was to commence in the approved centre later in October 2021. Two nurse therapists

coordinated the therapeutic programmes in the approved centre. Psychology and social work reported having an adequate compliment of staff. Both disciplines provided in reach services to the approved centre.

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

The approved centre had a COVID-19 contingency plan in place and a COVID-19 Outbreak Control Team met every six weeks to discuss procedures and risks to the unit.

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 15: Individual Care Plan	✗	High	✓		✗	Moderate	✗	High	✗	High
Regulation 16: Therapeutic Services and Programmes	✗	Moderate	✓		✓		✓		✗	Moderate
Regulation 19: General Health	✓		✗	High	✗	Moderate	✗	High	✗	High
Regulation 21: Privacy	✗	High	✗	High	✗	Critical	✗	Critical	✗	Critical
Regulation 22: Premises	✗	High	✗	High	✗	Critical	✗	Critical	✗	Critical
Regulation 26: Staffing	✗	Moderate	✗	High	✗	High	✓		✗	Moderate
Regulation 27: Maintenance of Records	✗	High	✓		✓		✓		✗	High
Regulation 32: Risk Management Procedures	✓		✓		✗	Moderate	✗	High	✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre had not admitted any children since the last inspection, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

Code of Practice on Admission of Children	As the approved centre did not any 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:

- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

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

Five service user experience questionnaires were completed and returned to the inspection team and one resident was interviewed by phone. One resident complimented the nurses and doctors for their good care, another resident stated that the staff were excellent and had a high work ethic and another respondent mentioned that the staff were very helpful and courteous. One resident said that the approved centre was very clean and another stated that the food was excellent.

Feedback from the residents stated that four of the residents understood their Individual Care Plans (ICPs) and they were involved in setting their own goals. One resident said they has never seen an ICP. Three of the respondents said they were able to discuss worries or concerns with members of staff and two residents said they could 'sometimes'. One resident mentioned the need for a garden space to improve their physical and mental health. Four residents felt that their privacy and dignity was respected, one resident felt their privacy and dignity wasn't respected. Two residents suggested more group activities during the day, one recommended having more skills based activities. One respondent stated that the woman's group was a great boost to their self-esteem. Another resident mentioned the lack of structure for the service users on the weekends.

For one resident the noise levels late at night was an issue, especially other residents playing music after 11pm. One resident suggested increasing staffing levels within the unit and two respondents highlighted a need for a designated smoking area.

5.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from the IAN representative on behalf of the residents.

One service user reported that some nurses were wonderful and caring and that trips out of the centre lifted her spirit. Another resident mentioned that the classes and groups provided by the approved centre were very helpful.

A service user reported being a smoker and not being allowed to smoke inside or outside the approved centre. The resident believed that their right to choose was being denied. Another resident reported wanting to be engaged in their discharge following a long admission; however, they didn't believe that they had been engaged in the process. One resident was transferred from the Accident and Emergency Department and their belongings were lost in transit. The service user felt that there should be a policy in place to deal with lost property whilst in transit. Residents reported that they didn't always know their status and rights and that information about the Mental Health Act in booklet or leaflet form was not always given to the residents.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Clinical Director
- Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Principal Psychologist
- Acting Occupational Therapy Manager
- Principal Social Worker
- Registered Proprietor
- Area Administrator

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. Residents had access to a dietitian and speech and language therapy where required.

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in August 2021.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP).

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP. The approved centre had secure facilities, including lockers and a property room for the safe-keeping of residents' valuables.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile seven days a week. These included the following: knitting, embroidery, mindful colouring, air hockey, foosball table, ping pong table, board games, crosswords, puzzle books, DVDs, and bingo.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to visits. The policy was last reviewed in October 2020. Visiting times were appropriate and reasonable. Due to COVID-19 precautions visitors were not permitted in the approved centre, except on compassionate grounds. The approved centre had a designated room for visitors, where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visitors room was suitable for 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 policy was last reviewed in March 2021.

Residents had access to postal mail, the approved centre's cordless telephone, and their own personal mobile phones. The internet including e-mail was available through computers located in the Nurses' Office and Nurse Therapy Rooms. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the conducting of searches. The policy was last reviewed in August 2021. It included all requirements related to:

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

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

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

in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to caring for residents who are dying. The policy was last reviewed in August 2021. No resident had passed away in the approved centre since the last inspection, and compliance for this regulation was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

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

The ICPs were developed by the MDTs following a comprehensive assessment. One ICP had not been developed within seven days of admission. Three ICPs did not identify appropriate goals for the resident, instead inappropriate goals were identified, using terminology such as 'improve symptoms', 'chest x-ray', 'tribunal' 'to complete full physical work up'. A fourth ICP did not contain any goals for the resident.

All ICPs inspected identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICPs identified the resources required to provide the care and treatment. One ICP stated that there was no access to an OT, as they were on leave.

The ICPs were not updated following review, as indicated by the residents' changing needs, condition, circumstances and goals. One ICP did not have a review by the MDT on three separate occasions.

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

a) **One individual care plan was not developed by the multi-disciplinary team (MDT) within seven days of admission.**
b) **Three individual care plans did not identify appropriate goals for the resident, a fourth individual care plan did not identify any goals for the resident.**
c) **One individual care plan was not reviewed by the MDT on three separate occasions.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating MODERATE

(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

Residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their individual care plans. The therapeutic programmes in the approved centre were facilitated by two nurse therapists. The programmes did not have input from an occupational therapist. Psychology and Social Work (SW) provided 1:1 sessions with residents where applicable. The Psychology Department ran two groups each week. Group therapeutic programmes and activities included: walking, cognitive behavioural therapy (CBT), dialectical therapy (DBT), care planning, social group, working towards discharge, anxiety management, a relaxation and guided meditation, mindfulness. Residents also had access to an art therapy studio.

The registered proprietor did not ensure that the services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Residents in the approved centre under the care of the Adult Mental Health Teams did not have access to an Occupational Therapist (OT), the dedicated OT post had been vacant for six months. At the time of inspection an OT had been sourced to fill the position and was to commence in October 2021. Residents under the care of the POLL team had access to an OT (0.40 WTE).

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 non-compliant with this regulation because:

a) **The registered proprietor did not ensure that the residents had access to an appropriate range of therapeutic services and programmes in accordance with their individual care plans. Therapeutic programmes in the approved centre did not have input from an Occupational Therapist, 16 (1).**
b) **The registered proprietor did not ensure that the services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Residents under the care of the Adult Mental Health Teams did not have access to an Occupational Therapist, 16 (2).**

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which was last reviewed in July 2020. The approved centre had an emergency resuscitation trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents could access national screening programmes available in line with their age and gender, including breast check, cervical screening, retina check for diabetics only and bowel screening.

Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs but within a six month timeframe. Three clinical files of residents who had been in the approved centre for more than six months were inspected.

All of the three residents had received a documented six-monthly general health check which was not adequately completed. All three residents had received a completed and documented physical examination, blood pressure check, smoking status, weight and body mass index (BMI). While two residents received a documented dental health check, the third resident required dental attention and there was no documented evidence to show that his dental need was followed up.

None of the three residents had received a family history assessment. Two residents did not receive a documented recording of their waist circumference. Nutritional status – diet and physical activity including sedentary lifestyle, was not completed for two residents.

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

The approved centre was non-compliant with this regulation because the six monthly general health assessment was not completed properly for all residents due to the following:

a) **Two residents did not receive a documented recording of their waist circumference, 19.1 (b).**
b) **Three residents had not received a family history assessment, 19.1 (b).**
c) **Nutritional status – diet and physical activity including sedentary lifestyle, was not completed for two residents, 19.1 (b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a policy and procedures in relation to the provision of information to residents. The policy was last reviewed in August 2021.

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

Residents were provided with written and verbal information on their diagnosis. Medication information sheets as well as verbal information were provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating CRITICAL

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

INSPECTION FINDINGS

The manner in which staff addressed and communicated with residents was respectful. Staff were discreet when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room. All bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information. Residents were facilitated to make private phone calls.

Where a resident shared a bedroom their privacy was compromised due to an overall lack of space in two of the two-bedded rooms. Specifically, Room 33 and Room 35, located in the Sub-Acute Ward were not of an adequate size so as to ensure resident privacy and dignity. The rooms were too small and cramped, and the spacing between the beds was insufficient, plus the beds and lockers were not adequately spaced.

The communal sitting room in the Sub-Acute Ward was too small to accommodate 30 residents and it was used as a thoroughfare to the activities room. There were not enough seats for all residents.

On the Acute Ward, there was a large communal sitting room in the middle of the ward, which was a thoroughfare to the resident bedrooms. The sitting room needed to accommodate 20 residents. Seating was limited to 12 chairs due to the COVID-19 pandemic precautions and social distancing guidelines

The conservatory which overlooked the river was only accessible under staff supervision, which further restricted the amount of communal space for the residents to use. Many residents were spending time around bed areas during the day at the time of the inspection.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that resident's privacy and dignity was respected at all times, due to the following reasons:

a) **The two-bedded rooms in both acute and sub-acute wards were not of an adequate size so as to ensure resident privacy and dignity.**
b) **The sitting rooms in the sub-acute acute wards were unable to accommodate all of the residents.**

c) **The conservatory was only accessible under staff supervision which limited communal space for the residents to use.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating CRITICAL

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was adequately lit heated and ventilated in all areas. There were enough toilets and showers for residents, and there was at least one assisted toilet per floor. Current national infection control guidelines were followed. Appropriate signage and sensory aids were lacking throughout the approved centre which did not fully support resident orientation needs.

Residents in the approved centre had limited access to personal indoor or outdoor space to relax and to move about in. The approved centre was designed and located on the first floor with the main entrance leading onto the street, and residents had no access to a garden or outdoor space.

Two of the two-bedded rooms in the sub-acute ward were too small to accommodate the residents, space in these rooms was very tight and privacy in this regard was acutely compromised.

On the sub-acute ward, there was a small sitting room which under normal circumstances could not accommodate 30 residents. At the time of inspection even fewer residents could access the sitting room due to the COVID-19 pandemic and social distancing guidelines. This communal room was a thoroughfare to the activity room.

In the acute ward there was one large, open communal area for residents, the space provided was not sufficient to accommodate 20 residents due to social distancing guidelines. At the time of inspection there was seating for 12 residents.

The approved centre did not have suitable furnishings to support residents' independence and comfort, there was a limited number of chairs in the communal areas. Due to the overall lack of personal space and not having enough chairs for residents, it was noted that residents were spending time around bed areas.

The conservatory area was kept locked and was only used under staff supervision to which further reduced communal space in the Sub-acute Ward. The shower areas were small including the assisted shower area- which did not have enough room for a wheelchair.

Hazards were not minimised in the approved centre. Hazards included cleaning trolleys, a large metal roll holder and several blood pressure (BP) machines which were left in the communal area at the time of the inspection. Ligatures were not minimised to the lowest practicable level based on risk assessment. There were many ligature points throughout the approved centre at the time of the inspection.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records were maintained. The approved centre was not in a good state of repair and it was unclean in some areas. At the time of the inspection several ceiling tiles were stained, the shower flooring in the male side of the Acute Ward was stained, a glass roof in the Acute Ward was dirty, and one shower was dirty. All windows were dirty throughout the approved centre.

The approved centre was not free from offensive odours. There was a smell of smoke near the female toilet in the Sub-acute Ward at the time of the inspection. The approved centre had a dedicated cleaning room and a dedicated sluice room.

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

a) **The approved centre was not free from offensive odours everywhere as a smell of cigarette smoke around the female toilet area was present at the time of the inspection, 22 (1)(a).**
b) **The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre, 22 (2).**
c) **The physical structure of the approved centre was not developed and maintained having due regard for the number and mix of residents in the approved centre, 22 (3).**
d) **Residents did not have access to a garden or outdoor space, 22 (3).**
e) **Ligature points had not been minimised in the approved centre, 22 (3).**
f) **There were several stained roof tiles at the time of inspection, 22 (3).**
g) **Hazards were not minimised in the approved centre. Cleaning trolleys, a large metal roll holder and several blood pressure (BP) machines were left in the communal area.**

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 July 2020.

Each resident had a Medication Prescription and Administration Record (MPAR), and five of these were inspected. All MPARs evidenced a record of appropriate medication management practices, including a record of the following: allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, frequency of medication, and the date of discontinuation for each 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. Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily.

Medication dispensed or supplied to the resident was stored securely in a locked storage press unless it required refrigeration. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in relation to the recruitment, selection and Garda vetting requirements. The policy was last reviewed in July 2020**.** An appropriately qualified staff member was on duty at all times, and this was documented. The numbers and skill mix of staffing were insufficient to meet resident needs. Staff reported that the dedicated occupational therapist (OT) post for the approved centre had been vacant since March 2021. At the time of inspection an OT was providing 0.4 WTE hours of input for the POLL team. Residents under the care of the adult mental health teams did not have access to an OT. Other disciplines which included nursing, psychiatry, social work and psychology had an adequate compliment of staff. Residents in the approved centre had access to a dietitian, speech and language therapist and physiotherapist when required.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre. Due to COVID-19 Pandemic, the inspection of regulatory requirements in relation to staff training 26(4) have been deferred until 2022. The following table shows the number of staff trained in the Mental Health Act 2001 and the percentage of staff trained in each discipline.

Staff Training Table

Profession	Mental Health Act 2001	
Nursing (38)	38	100%
Medical (36)	36	100%
Occupational Therapist (1)	1	100%
Social Worker (3)	3	100%
Psychologist (1)	1	100%

The approved centre was non-compliant with this regulation because the numbers and skill mix of staffing were insufficient to meet resident needs, not all residents had access to an occupational therapist 26, (2).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in July 2020. Documentation relating to food safety, health and safety, and fire inspections were maintained in the approved centre. The clinical files of five residents were inspected in relation to this regulation.

Residents records were secure and up-to-date. Not all clinical files were maintained in good order, four files inspected contained loose pages with folded corners and untidy edges.

Resident records were reflective of the resident' current status and the care and treatment being provided. Residents' records were appropriately secured throughout the approved centre from loss, destruction, tampering, or unauthorised access or use.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. A number of clinical files were not securely attached together as they had loose pages, 27 (1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a documented and up-to-date electronic register of residents. It was available to the Mental Health Commission on inspection. The register included the complete information specified in Schedule 1 to 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 operating policies and procedures required by the regulations were reviewed within the required three-year time frame.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance when the patient required assistance to attend or participate in the process, including remotely.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the complaints process. The policy was last reviewed in August 2021 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person who was available to the approved centre with responsibility for dealing with all complaints in the approved centre. The complaints procedure including how to contact the nominated person was publicised and accessible to residents, their representatives and families.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made, and this information was contained in the resident's information booklet. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made.

All minor and formal complaints were handled promptly, appropriately and sensitively by the nominated person and were recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's ICP.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

There were a written policy and site specific safety statement in relation to risk management and incident management processes. The risk management policy was last reviewed in January 2020. The policy included all of the policy related regulation requirements. 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 aspects of the risk management policy were implemented throughout the approved centre. Risk management procedures did not actively reduce identified risks to the lowest level of risk, as was reasonably practicable. At the time of the inspection there were many ligature anchor points present throughout the approved centre.

Multi-disciplinary teams (MDT) were involved in the development, implementation, and review of individual risk management processes. Corporate, health and safety 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 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 on the National Incident Management System (NIMS). 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 risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Ligature points present throughout the approved centre had not been removed or effectively mitigated, 32 (1).

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration, which included three conditions relating to the approved centre. The certificate was displayed in the foyer of the Sub-acute Ward.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical file of one patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication 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:

- 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 specific names of medications prescribed to the patient.

- 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 2021. 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: There was a written record to show that all staff involved in physical restraint had read and understood the policy.

Monitoring: The approved centre completed an annual report on the use of physical restraint and submitted it to the Mental Health Commission (MHC).

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 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.

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 September 2019, the transfer policy was last reviewed in August 2021, and the discharge policy was last reviewed in November 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 transfer, admission, and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident was inspected in relation to the admission process. Their admission was on the basis of a mental illness or mental disorder. The resident was assigned a key-worker. The resident's family member was involved in the admission process, with the resident's consent. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state, a risk assessment, work situation, education, and dietary requirements. The resident received a full physical examination.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a key-worker. A discharge meeting was held and attended by the resident and their key worker, relevant members of the 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 preliminary discharge summary was sent to relevant healthcare professionals within three days. A comprehensive discharge summary letter was issued within 14 days of discharge. The discharge summary letter included details of diagnosis, prognosis, medication, mental state at discharge, outstanding health and social issues, 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. A timely follow up appointment took place.

The approved centre compliant with this Code of Practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10002442		**One individual care plan was not developed by the multi-disciplinary team (MDT) within seven days of admission.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The CD emailed a reminder to all teams to highlight that new patients require a MDT ICP within 7 days of admission	A specific slot on ICPs to be included at the NCHD induction. All new staff to be advised of the requirements for ICPs and MHC	These actions are achievable and realistic	11/01/2022	Heads of Discipline ICP champions group CMHTs
Preventative Action	The CNM3 emailed the ICP Champions to advise that as part of the of corrective and preventative actions an addition will be made to the ICP resource folder. This addition is a reminder of all new admissions need to have an MDT ICP completed within 7 days of admission The resource folders to be kept on acute unit and subacute unit	A addition to be put in the ICP resource folder Champions are to bring the ICP resource to ICP review meetings to help support MDT members Audits to continue	These actions are achievable and realistic	11/01/2022	Heads of Discipline ICP champions group CMHTs
Reason ID : 10002443		**Three individual care plans did not identify appropriate goals for the resident, a fourth individual care plan did not identify any goals for the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	ICP Champions Group with a representative from each CMHT meet on a monthly basis and provide feedback to each CMHT regarding their effectiveness in meeting the MHC requirements and feedback on any issues highlighted. NCHD induction every 6 months to include a specific slot on ICPs and this training made available to all disciplines Regular six monthly ICP training (provided by the NL Psychology Dept) has been incorporated into the Friday MDT academic schedule	ICP audits take place monthly to enable regular monitoring. Results of audit to be forwarded to ICP Champions to address any issues arising. Ongoing feedback to local CMHTs and to the HOD Group. HODs and ICP Champions to meet quarterly. Audit updates added as a standing item to the North Lee Management Team Meeting agenda. Refresher training to be provided at induction	These actions are achievable and realistic	18/01/2022	Heads of Discipline ICP champions group Audit committee CMHTs
Preventative Action	ICP champions group to give detailed feedback on ICPs to CMHT. It is anticipated that this feedback will be focused and specific. Copy of feedback	Ongoing Feedback to local CMHT's and also overview to the HOD group. Audit updates to be discussed at the monthly North Lee Management Team Meeting One page	These actions are achievable and realistic	27/01/2022	Heads of Discipline ICP champions group Audit committee CMHTs

	summary to be shared with HOD and reviewed at HOD meetings. Each team to self audit on a quarterly basis going forward	summary of relevant audit(s) that are completed on a particular week to be displayed at the start and end of Friday morning academic teaching sessions.			
Reason ID : 10002444		**One individual care plan was not reviewed by the MDT on three separate occasions.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In the event that a patient is not present on the ward It needs to be documented on the ICP. ICP Champions to be aware of who is on the ward.	CD to issue email to advise that it is required to note on the ICP if a patient is not present on the unit	These actions are achievable and realistic	11/01/2022	Heads of Discipline ICP champions group
Preventative Action	A discussion group with the ICP Champions and Heads of Disciplines will take place on 27th January 2022 to review current issues with ICP compliance and help support the ICP Champion group	Feedback from this meeting will be brought to the next scheduled Management Team Meeting for discussion	These actions are achievable and realistic	27/01/2022	Heads of Discipline ICP champions group

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10002449		**The registered proprietor did not ensure that the residents had access to an appropriate range of therapeutic services and programmes in accordance with their individual care plans. Therapeutic programmes in the approved centre did not have input from an Occupational Therapist, 16 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A full time Occupational Therapist commenced in the Unit on 18th October 2021 to back fill the SMU OT post (maternity leave). The OT provides group and individual intervention. The OT input had also increased in July 2021 with dedicated in-patient OT input to the older adult team including their ICP. Thus OT specific individual work arising out of these ICPs is carried out by this OT	The OT facilitates a variety of task based, social and physical exercise groups as well as involvement in the creative outdoor recovery programme. The OT also provides individual work including ADL assessment, time management (structure and routine), ADL functioning (shopping, cooking etc.)	These actions are achievable and realistic	18/10/2021	OT HOD OT Team
Preventative Action	OT commenced on 18th October 2021	The OT facilitates a variety of task based, social and physical exercise groups as well as involvement	These actions are achievable and realistic	18/10/2021	OT HOD OT Team

		in the creative outdoor recovery programme. The OT also provides individual work including ADL assessment, time management (structure and routine), ADL functioning (shopping, cooking etc.)			
Reason ID : 10002450		**The registered proprietor did not ensure that the services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Residents under the care of the Adult Mental Health Teams did not have access to an Occupational Therapist, 16 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A full time Occupational Therapist commenced in the Unit on 18th October 2021 to back fill the SMU OT post (maternity leave). The OT provides group and individual intervention. The OT input had also increased in July 2021 with dedicated in-patient OT input to the older adult team	The OT facilitates a variety of task based, social and physical exercise groups as well as involvement in the creative outdoor recovery programme. The OT also provides individual work including ADL assessment, time management (structure and routine), ADL functioning	These actions are achievable and realistic	18/10/2021	OT HOD OT Team

	including their ICP. Thus OT specific individual work arising out of these ICPs is carried out by this OT.	(shopping, cooking etc.)			
Preventative Action	OT commenced on 18th October 2021	The OT facilitates a variety of task based, social and physical exercise groups as well as involvement in the creative outdoor recovery programme. The OT also provides individual work including ADL assessment, time management (structure and routine), ADL functioning (shopping, cooking etc.)	This action has been achieved.	18/10/2021	OT HOD OT Team

Regulation 19: General Health					
Reason ID : 10002470		Two residents did not receive a documented recording of their waist circumference, 19.1 (b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	A recent review of documentation on the Unit highlighted the issue of old forms being in circulation which did not include all updated sections . The Nutritional Status /physical activity/diet/sedentary lifestyle section was not included in the old version of the form Patients requiring 6 month physicals is highlighted by the Delayed Discharge Group to the audit group. The Consultant Psychiatrist representative of the Delayed Discharge Committee will discuss /remind the sector consultant psychiatrist to complete this documentation. Ongoing regular audits	Old version of the form have been removed from the Unit and replaced with the new version of the form Any concerns re incomplete documentation will be escalated to the CD /ADON and CNM3 Audits will be monitored by the audit committee.	These actions are achievable and realistic	17/01/2022	Consultants NCHDs Audit committee Delayed Discharge Committee CD/ADON/CNM3
Preventative Action	Going forward the IPC Champions will	Any concerns re deficits in	These actions are achievable and realistic	27/01/2022	Consultants NCHDs Audit committee

	monitor as part of their remit, the 6 monthly physicals forms . The Audit NCHD rep will also now actively go thru all forms monthly to ensure documentation of all sections is complete .This NCHD will bring any issues back to the ICP Champion group This will further be discussed at the meeting with between HODs and ICP Champions scheduled on 27th January 2022 A monthly audit will be undertaken and monitored by the audit committee. The audits will identify any deficits in documentation	documentation will be escalated to the CD/ADON /CNM3.			Delayed Discharge Committee CD/ADON/CNM3
Reason ID : 10002471		**Three residents had not received a family history assessment, 19.1 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CD to email the NCHD rep to highlight to the NCHD group the importance of completing all sections of the documentation.	The appointed NCHD rep to provide a learning session to NCHD on correct completion of forms	These actions are achievable and realistic	17/01/2022	Consultants NCHDs

	A template will be created by the NCHD rep and circulated to the NCHD group on how to complete a family history assessment				
Preventative Action	Training session on completion of all sections of the forms to be incorporated into NCHD induction to meet compliance in this area.	The importance of completing all sections of the form to be highlighted including instances where the patient is refusing/unable to give details noted	These actions are achievable and realistic	01/02/2022	Consultants NCHDs
Reason ID : 10002472		**Nutritional status – diet and physical activity including sedentary lifestyle, was not completed for two residents, 19.1 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A recent review of documentation on the Unit highlighted the issue of old forms being in circulation. Nutritional status was not included in the old version of the form. Patients requiring 6 month physicals will be highlighted by the Delayed Discharge Group to the audit group. The Consultant Psychiatrist representative of the	Old version of the form have been removed from the Unit and replaced with the new version of the form. Any concerns re incomplete documentation will be escalated to the CD /ADON and CNM3	These actions are achievable and realistic	17/01/2022	Consultants NCHDs Audit committee Delayed Discharge Committee CD/ADON/CNM3

	Delayed Discharge Committee will discuss /remind the sector consultant psychiatrist to complete this documentation. All staff will again be informed of the need for complete documentation CD has sent an email to all consultant psychiatrists highlighting the importance of completing all necessary documentation.				
Preventative Action	On-going regular audits will identify any deficits in documentation Going forward the IPC Champions will monitor as part of their remit, the 6 monthly physicals. The Audit NCHD rep will also now actively go through all forms monthly to ensure documentation of all sections is complete. This NCHD will bring	A monthly audit will be undertaken and monitored by the audit committee Any concerns re deficits in documentation will be escalated to the CD/ADON /CNM3.	These actions are achievable and realistic	27/01/2022	Consultants NCHDs Audit committee Delayed Discharge Committee CD/ADON/CNM3

	any issues back to the ICP Champion group This will be further discussed at the meeting with between HODs and ICP Champions scheduled on 27th January 2022				

Regulation 21: Privacy					
Reason ID : 10002465		**The two-bedded rooms in both acute and sub-acute wards were not of an adequate size so as to ensure resident privacy and dignity.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The planned capital reconfiguration of the unit will address the issues of the physical structure. The plans include a larger communal area and the re-purposing of the conservatory.	A steering group has been set up to plan for the decant of staff from SMU to facilitate the re-configuration works. Two meetings will all relevant stakeholders have taken place to date to identify alternative locations within the vicinity of SMU	These actions are achievable and realistic	04/01/2022	CHO Mgt., MUH Mgt. team Design Team
Preventative Action	The re-configuration will address accommodation issues	Re-designed proposal re-configuration of SMU approved by commission. A number of meetings have taken place between HSE Management and representatives from the MUH to appoint a design team and progress the proposed design.	These actions are achievable and realistic	31/12/2022	CHO Mgt., MUH Mgt. team Design Team
Reason ID : 10002466		**The sitting rooms in the sub-acute acute wards were unable to accommodate all of the residents.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The planned capital reconfiguration of the unit will address the issues of the physical structure. The plans include a larger communal area and the re-purposing of the conservatory. Additional space with conservatory now open daily until 10pm.	Re-designed proposal re-configuration of SMU approved by commission. A number of meetings have taken place between HSE Management and representatives from the MUH to appoint a design team and progress the proposed design.	These actions are achievable and realistic	18/01/2022	CHO Mgt., MUH Mgt. team Design Team
Preventative Action	The re-configuration will address accommodation issue	Re-designed proposal re-configuration of SMU approved by commission. A number of meetings have taken place between HSE Management and representatives from the MUH to appoint a design team and progress the proposed design.	These actions are achievable and realistic	31/12/2022	CHO Mgt., MUH Mgt. team Design Team
Reason ID : 10002467		**The conservatory was only accessible under staff supervision which limited communal space for the residents to use.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Conservatory now open daily until 10pm The plan to incorporate the	Used more for therapeutic groups	These actions are achievable and realistic	01/12/2021	Heads of Discipline All Staff

	Conservatory into the Therapy programme allows for open groups in the space. The conservatory will remain open for patients to use with intermittent supervision from MDT staff to ensure the area is safe and appropriate for all patients to use.				
Preventative Action	The conservatory will remain open to 10pm daily for patients to use with intermittent supervision from MDT staff to ensure the area is safe and appropriate for all patients to use.	Five additional smoke Detectors for the unit have been ordered with one of these designated for the conservatory area. The aim is to reduce/ stop the conservatory area being closed during the day to be ventilated due to smoking (Information attached)	These actions are achievable and realistic	11/01/2022	Heads of Discipline All Staff

Regulation 22: Premises

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 26: Staffing					
Reason ID : 10002469		**The numbers and skill mix of staffing were insufficient to meet resident needs, not all residents had access to an occupational therapist 26, (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A full time Occupational Therapist commenced in the Unit on 18th October 2021 to back fill the SMU OT post (maternity leave). The OT provides group and individual intervention. The OT input had also increased in July 2021 with dedicated in-patient OT input to the older adult team including their ICP. Thus OT specific individual work arising out of these ICPs is carried out by this OT	The OT facilitates a variety of task based, social and physical exercise groups as well as involvement in the creative outdoor recovery programme. The OT also provides individual work including ADL assessment, time management (structure and routine), ADL functioning (shopping, cooking etc.)	Complete	18/10/2021	OT HOD OT Team
Preventative Action	OT commenced on 18th October 2021	The OT facilitates a variety of task based, social and physical exercise groups as well as involvement in the creative outdoor recovery	Complete	18/10/2021	OT HOD OT Team

		programme. The OT also provides individual work including ADL assessment, time management (structure and routine), ADL functioning (shopping, cooking etc.)			

Regulation 27: Maintenance of Records					
Reason ID : 10002464		**The registered proprietor did not ensure that records were maintained in a manner to ensure completeness, accuracy and ease of retrieval. A number of clinical files were not securely attached together as they had loose pages, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Admin support to review clinical files to ensure they are in good order, well maintained and organised to ensure ease of retrieval. Additional staffing to carry out an initial review of all records Additional stationery at nurses stations so staff can repair on an ongoing basis Business case for ward clerk submitted	Monthly auditing of the maintenance of records.	These actions are achievable and realistic	18/01/2022	CD Administration staff member All MDT members
Preventative Action	Admin support to review files on a weekly basis, to ensure they are in good order, well maintained and organised to ensure ease of retrieval. All staff to complete the Healthcare Records Management course on HSE Land	Monthly auditing of the maintenance of records in place.	These actions are achievable and realistic	18/01/2022	CD Administration staff member All MDT members

Regulation 32: Risk Management Procedures					
Reason ID : 10002468		**Risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Ligature points present throughout the approved centre had not been removed or effectively mitigated, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An updated MDT Ligature Audit using the revised HSE Manchester Audit Approved Audit Tool was conducted in the Unit on 12th October 2021.	On review a number of items were identified as high risks and are being addressed as follows: Replacement of Overhead bed Lighting. Lighting has been sourced as per specification used in St Stephens Hospital. Works commenced in December 2021 under guidance of the service with 26 of the lights fitted. Installation of the remainder of the lights commenced in January 2022 The current supplier of the personal alarms conducted a walkthrough on the unit regarding relocating the personal alarms. A quote for the works is	These actions are achievable and realistic	12/10/2021	MDT HSE Estates MUH Maintenance

		awaited Dispensers/holders - alternatives are being sourced with a current lead time is 16 to 20 weeks. Pictures/wall hangings A request has been submitted to MUH Maintenance to remove wall hangings/pictures. The Art Therapist has agreed to assist in exploring suitable alternatives. Blinds – contact made with a supplier of anti-ligature blinds. A walk-through of the Unit to take place on 20th January 2022			
Preventative Action	On-going monitoring of ligature audit and associated corrective measures A number of ligature furnishings and fittings to be incorporated into larger capital project A subsequent MDT Ligature Audit to take place in March 2022	Ligature audit review as a standard item at HOD meeting (monthly) Risk Register (monthly) and QPS (quarterly) with concerns raised to Area Management Team	These actions are achievable and realistic	31/03/2022	MDT HSE Estates MUH Maintenance

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.

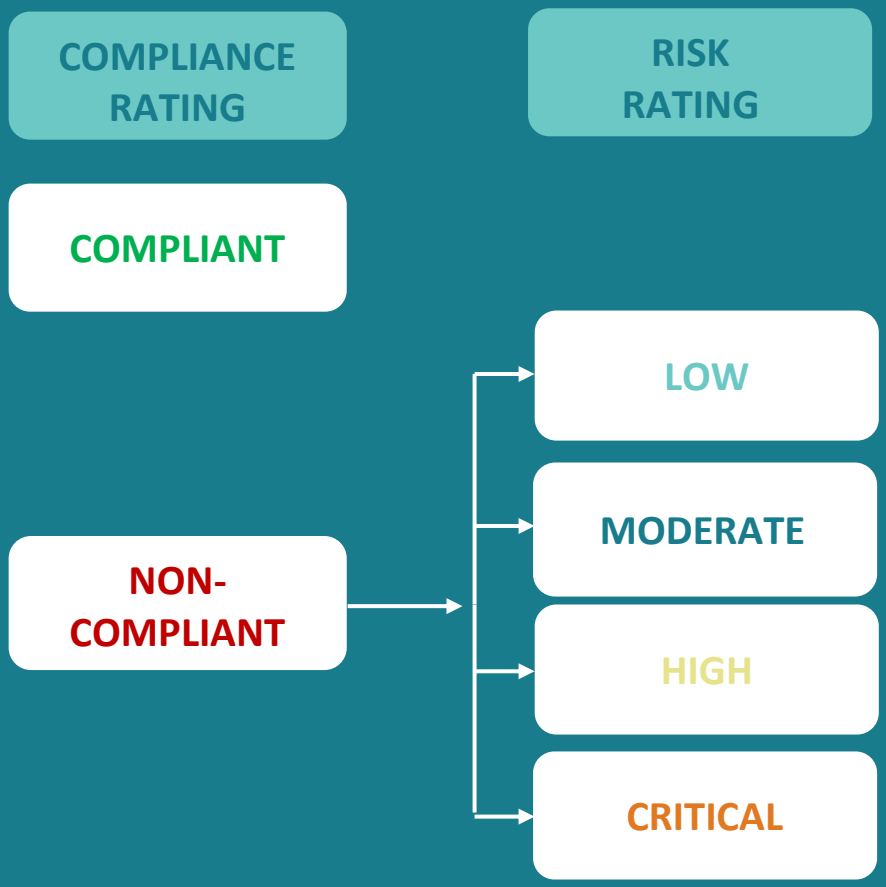
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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