Adult Acute Mental Health Unit, University Hospital Galway

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

ADULT ACUTE MENTAL HEALTH UNIT, UNIVERSITY HOSPITAL GALWAY

Adult Acute Mental Health Unit, University Hospital Galway, Newcastle Road, Galway

Date of Publication:
1 February 2023

ID Number: AC0076

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life
Mental health rehabilitation
Mental health care for people with intellectual disability

Conditions Attached:
None

Most Recent Registration Date:
30 June 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, Mental Health Services, Community Healthcare West

Inspection Team:
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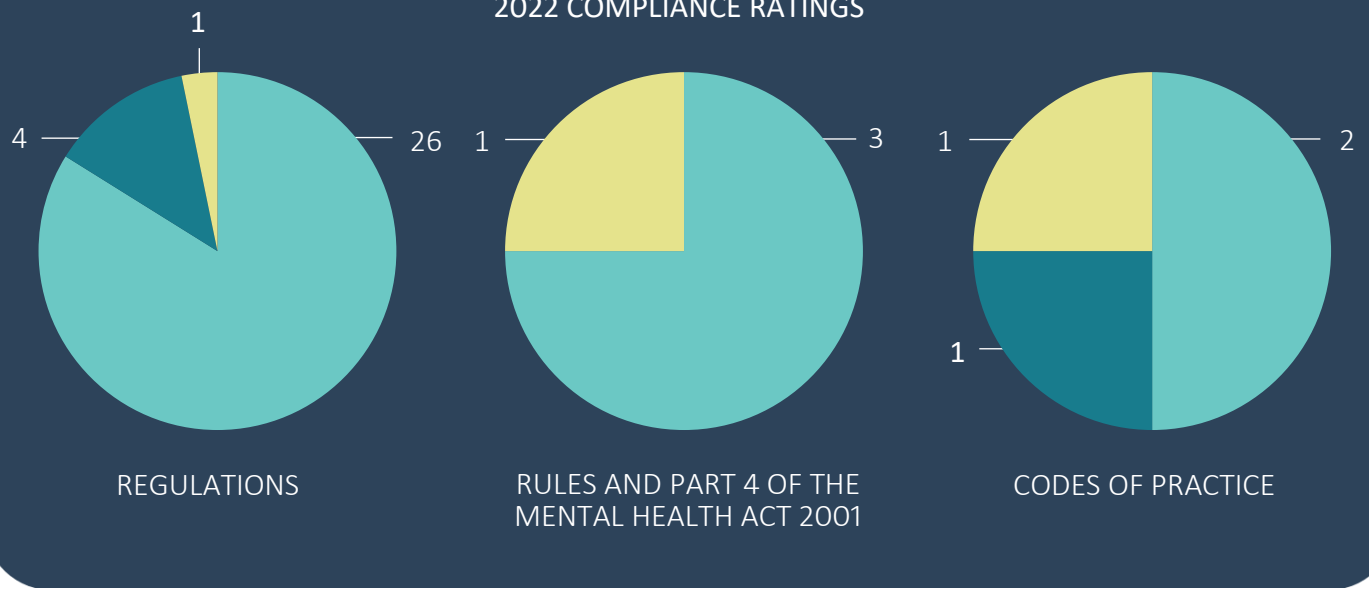
Inspection Date:
14 – 17 June 2022

Previous Inspection date:
16 – 19 Month 2021

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

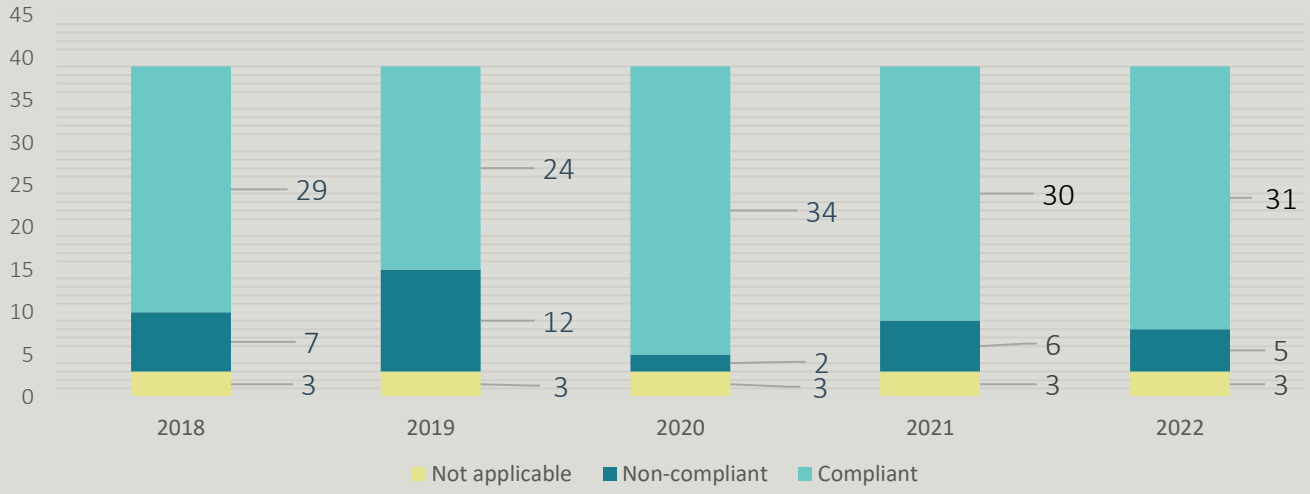
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

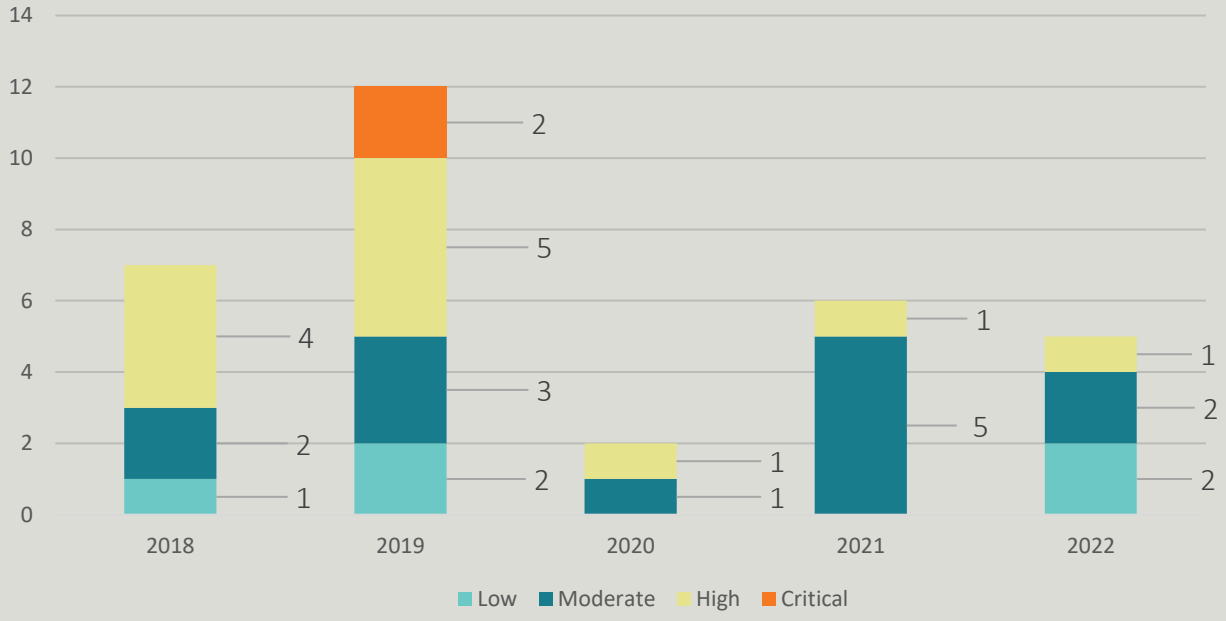
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022



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 2018 – 2022



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

The Adult Acute Mental Health Unit, University Hospital Galway was a 50-bed unit located on the grounds of the University Hospital Galway. It consisted of four separate suites: Hazel, Ash, Holly, and Oak. Thirteen consultant-led teams, including Galway sector teams, psychiatry of later life teams, a mental health intellectual disability team, a rehabilitation and recovery team, and a mental health for homeless people team, referred residents to the approved centre as appropriate. Two more consultant-led teams had admitting rights: the liaison psychiatry team, and the perinatal mental health team.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	81%	67%	94%	83%	86%

Conditions to registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety in the approved centre

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

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- Kitchen areas were clean and there was sufficient storage, preparation areas and refrigeration facilities.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.

However:

- There were a number of deficits in the prescription of medications observed in the MPARs.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to needs of residents.

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- Therapeutic programmes included: art therapy, walking for recovery groups, gentle exercise groups, psychology groups, relaxation groups, communication skills group, psychoeducation groups and yoga.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

We found that facilities and processes respected residents' privacy and dignity and that interactions respected residents' wishes in the following areas:

- Most of the bedrooms were single en suite rooms. Hazel suite contained one three-bedded and two two-bedded bedrooms. Ash suite contained one three-bedded and one two-bedded bedrooms.

- All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door.
- Noticeboards did not display resident names or other identifiable information.
- Residents were facilitated to make private phone calls.
- The approved centre was kept in a good state of repair externally and internally.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However, some of the external windows in the approved centre were in need of cleaning. The garden of Holly Suite was overgrown, and the concrete ground and benches were dirty.

Responsiveness to residents' needs

We found that the approved centre provided services in a way that met the needs of residents and their families in the following areas:

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. Activities included board games, jigsaw puzzles, books, a pool table, gym equipment, table tennis and yoga.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

However, there was a very limited supply of emergency clothing and some of the clothing available to the residents had been used previously.

Governance, Leadership and Accountability

There were governance structures and processes in place:

- The approved centre was under the governance of Community Healthcare West (formerly CHO 2), which consisted of the counties Mayo, Galway, and Roscommon. The Galway and Roscommon Mental Health Services overarching governance process encompassed the monthly Area Management Team Meeting and the Quality and Safety Committee.
- Within the approved centre, the governance was enhanced by a local Acute Unit Business Meeting which was held monthly. The Acute Unit Business Meeting was supported by various committees, and sub-groups.
- The approved centre was managing overcapacity issues with a Daily Bed Occupancy Meeting and a Delayed Discharge Committee.

- The approved centre held a risk register, which was monitored and maintained at the Acute Unit Business Meeting. Escalated risks to the Galway and Roscommon Mental Health Services risk register, were discussed monthly at the Galway and Roscommon Quality and Safety Committee Meeting.
- Incidents were reported and analysed in line with the National Incident Management System. Incidents and incident trends were discussed quarterly at the Acute Unit Business Meeting. All clinical incidents were reviewed at the respective multi-disciplinary team meetings. There was a Galway and Roscommon Serious Incident Management Team which reviewed serious incidents.
- Audit results were reviewed at the approved centre's Acute Unit Business Meeting.
- The approved centre maintained a log for minor complaints and complaints were dealt with at source, where applicable. There was a designated complaints officer who managed complaints in line with the HSE Your Service Your Say procedures.
- The Area Lead for Mental Health Engagement was a member of the Galway and Roscommon Area Management Team and the Quality and Safety Committee. There was a community Galway and Roscommon Mental Health Services forum which captured the views of previous residents of the approved centre. These service user views and issues were represented by the Area Lead for Mental Health Engagement at the appropriate committees.
- A designated advocate from the Peer Advocacy in Mental Health Network communicated service users' views and issues to the approved centre management team. The voice of the service user was sought by the approved centre through opportunities such as Comments Forms and weekly Patient Feedback Meetings.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The clinical audit committee had introduced individual care planning champion training with all staff disciplines to build enthusiasm and motivate other staff regarding individual care plans.

2. Members of the Nursing Leadership Team in the approved centre had developed an admission pack to orientate residents to the approved centre on admission.

3. A Safety Planning Group Intervention for service users experiencing recent suicidality had been facilitated by the approved centre. This was a three-week, 90-minute group which taught core skills to help services to understand their personal warning signs and develop coping strategies.

4. The social work and occupational therapy departments established a delayed discharge committee to support the treating teams to mobilise resources and systems in assisting with timely discharge. The Housing Co-ordinator advised on possible accommodation options and advocated with the councils to prioritise residents for housing.

5. The team phone for general practitioners (GPs) – as part of the COVID-19 pathway was retained to reduce presentations to the emergency department and facilitate urgent appointment at GPs request.

6. An alert system, EVOLVE (patient management system), was introduced by the pharmacist for residents on Clozapine.

7. The electroconvulsive therapy (ECT) nurse had joined the National ECT Networking Group to provide support and share learnings with other approved centres.

8. The social worker delivered psycho-education to families to assist them in navigating the mental health system. A booklet was developed to assist family members with self-care.

9. The approved centre introduced daily bed occupancy meetings to assist with managing over capacity within the approved centre.

10. A Nursing Services Strategy (2022-2027) entitled “Leading the way forward: Advancing a professional co-produced recovery service” was launched in April 2022. The strategy was co-produced by nursing, multi-task attendants, and individuals who avail of the service. The five strategic priorities for the strategy were: Person-centred care, Professional practice, Continuous service improvement, Planning and Developing our workforce, Staff health, well-being, and resilience.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Adult Acute Mental Health Unit, University Hospital Galway was located on the grounds of the University Hospital Galway. The approved centre was registered for 50 beds and consisted of four separate suites: Hazel, Ash, Holly, and Oak. Thirteen consultant-led teams, including Galway sector teams, psychiatry of later life teams, a mental health intellectual disability team, a rehabilitation and recovery team, and a mental health for homeless people team, referred residents to the approved centre as appropriate. Two more consultant-led teams had admitting rights: the liaison psychiatry team, and the perinatal mental health team.

Access to the building was facilitated by security staff. Entry was enabled following COVID-19 infection prevention and control procedures which included registration of all staff and visitors. Hazel, Oak and Ash suites were all located on the ground floor. Ash and Hazel were general adult suites which consisted of 18 and 19 beds respectively; however, the service had the option of interchanging the bed numbers between them. Most of the bedrooms were single en suite rooms. Hazel suite contained one three-bedded and two two-bedded bedrooms. Ash suite contained one three-bedded and one two-bedded bedrooms. Both Hazel and Ash suites had access to a shared area, which contained a dayroom, a games room, a quiet room, a dining area, and an outdoor garden area. Oak suite was a high observation unit and consisted of five single en suite bedrooms. Oak suite also contained a dining room, a relaxation room, a seclusion room, and an outdoor garden area.

Holly suite, located on the first floor, consisted of eight single en suite bedrooms, and was dedicated to Psychiatry of Later Life. Residents had access to an outdoor enclosed space, which contained seating areas and raised garden beds. At the time of inspection, the garden area was in need of maintenance: the ground was stained and dirty and the garden beds were overgrown. The first floor also housed administration/management offices, training rooms, an Electroconvulsive Therapy (ECT) suite and therapy facilities that included a relaxation room, an art room, and a therapy kitchen.

Internally, the premises were observed to be bright, clean, and generally well maintained. On inspection it was noted that the windows throughout the approved centre were very dirty. Internally, works had commenced to install suitable en suite doors in all bedrooms. Planned external work included heightening an external garden wall in the Oak suite. This plan was in place since the last inspection in 2021, but work had not yet commenced. It was reported by staff that the approved centre was waiting for a contractor to begin work in the coming months.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**42**
Number of detained patients	13

Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	4
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the governance of Community Healthcare West (formerly CHO 2), which consisted of the counties Mayo, Galway, and Roscommon. There were two area management teams, one for Mayo Mental Health Service, the other for the Galway and Roscommon Mental Health Services. The Galway and Roscommon Mental Health Services overarching governance process encompassed the monthly Area Management Team Meeting and the Quality and Safety Committee; minutes of these meetings were available to the inspection team. Standing agenda items included: risks and incidents management, health and safety, quality improvements, HR updates, key performance indicators and COVID-19. Within the approved centre, the governance was enhanced by a local Acute Unit Business Meeting which was held monthly. Standing items for this meeting included: clinical governance, drugs and therapeutics, audits, individual care planning, tobacco free campus and risks.

The Acute Unit Business Meeting was supported by various committees, sub-groups, and meetings which included: Consultant Meetings, Nursing Meetings between various nursing levels, Consultant and Senior Nurse Meetings, Multi-task Attendants and Nursing Meetings, Resident Feedback meetings, Galway General Hospital meetings, daily Safety Pause Meetings, the Restrictive Practice Review Committee, Safewards Steering Committee, Delayed Discharge Meetings, and Garda Liaison group Meetings.

The approved centre held a risk register, which was monitored and maintained at the Acute Unit Business Meeting. The main risks identified and monitored by the service included COVID-19, the low height of the wall in the Oak Suite garden, the need for a dedicated dietitian for the approved centre, overcapacity, and delayed discharge planning. The approved centre was managing overcapacity issues with a Daily Bed Occupancy Meeting and a Delayed Discharge Committee. The approved centre escalated risks to the Galway and Roscommon Mental Health Services risk register, where appropriate. This wider risk register was discussed monthly at the Galway and Roscommon Quality and Safety Committee Meeting. Incidents were reported and analysed in line with the National Incident Management System. Incidents and incident trends were discussed quarterly at the Acute Unit Business Meeting. All clinical incidents were reviewed at the respective multi-disciplinary team meetings. There was a Galway and Roscommon Serious Incident Management Team which reviewed serious incidents.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. There were formal and informal structures and processes in place for measuring and encouraging staff's performance and personal development. The numbers and skill mix of staffing was sufficient to meet residents' needs. A full-time psychologist had commenced in the approved centre since the last inspection. The approved centre didn't have a dedicated dietitian, they had been unable to fill the post. Residents had access to dietitians from the Child & Adolescent Mental Health Service.

The Policy and Procedure Committee provided a multi-disciplinary approach to policy development, review, approval, and dissemination. Audit results were reviewed at the approved centre's Acute Unit Business Meeting. The approved centre maintained a log for minor complaints and complaints were dealt with at source, where applicable. There was a designated complaints officer who managed complaints in line with the HSE Your Service Your Say procedures. Clinical complaints were reviewed by the clinical teams and if appropriate, the learning from these complaints were discussed and disseminated.

The Area Lead for Mental Health Engagement was a member of the Galway and Roscommon Area Management Team and the Quality and Safety Committee. There was a community Galway and Roscommon Mental Health Services forum which captured the views of previous residents of the approved centre. These service user views and issues were represented by the Area Lead for Mental Health Engagement at the appropriate committees. A designated advocate from the Peer Advocacy in Mental Health Network (previously known as the Irish Advocacy Network) visited the approved centre regularly and spoke with residents. The advocate communicated service users' views and issues to the approved centre management team. The voice of the service user was sought by the approved centre through opportunities such as Comments Forms and weekly Patient Feedback Meetings.

The approved centre had a COVID-19 contingency plan in place. Infection Prevention Control processes were clearly outlined. A COVID-19 pathway for Managing Urgent and Emergency Mental Health Assessments was developed and implemented in 2020 and remained in place to reduce the spread of infection, reduce time waiting for assessment and to increase resident satisfaction. As part of a COVID-19 pathway the approved center enhanced communication between GPs and treating teams, to reduce Emergency Department presentations.

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 2018 and 2022 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2018		2019		2020		2021		2022	
Regulation 7: Clothing	✓		✓		✓		✓		✗	Moderate
Regulation 13: Searches	✓		✓		✓		✓		✗	Moderate
Regulation 22: Premises	✓		✗	Moderate	✓		✓		✗	Low
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✗	High	✓		✓		✗	High
Code of Practice on the Use of Physical Restraint	✗	High	✓		✓		✓		✗	Low

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

4.2 Areas that were not applicable on this inspection

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

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

The inspection spoke with five residents during the inspection. Their feedback indicated that the residents liked the garden area, although one mentioned that it was not well-kept: it was overgrown. Resident's felt that their privacy was respected. Regarding the premises, one resident said that their bedroom and shower were lovely, and two residents mentioned that the approved centre was very clean. Most of the residents felt that there were enough activities in the approved centre. One mentioned that there weren't enough staff to take residents to the shop and out for walks. Feedback suggested that the residents were happy with the food. One resident said that "The nurses and doctors are excellent. I can talk with them anytime." Another said, "The nurses can't do enough; they are superb and lovely".

Two service user experience questionnaires were completed by the residents and returned to the inspection team.

- All residents indicated that they had space for privacy and that their privacy and dignity was respected.
- One resident ticked that they "always" felt safe in the approved centre, and one indicated that they "sometimes" felt safe in the approved centre.
- One resident ticked that they "always" felt they were able to discuss worries or concerns with staff as soon as they needed to, and one indicated that they 'sometimes' could.

- One resident felt they were “sometimes” able to give feedback to staff or to make complaints when they were not satisfied with any part of their stay in the approved centre, and one indicated that they didn’t have worries or concerns.
- Both residents indicated that they understood their individual care plans. One resident indicated that they were “always” involved in setting goals for their individual care plans, and one indicated that they were “sometimes” involved.
- Both questionnaires indicated that residents knew who their multi-disciplinary team (MDT). All residents indicated that they knew who their keyworkers.
- Both residents felt that there were enough activities for them during the day.

On a scale of 1-10, with 1 being poor and 10 being excellent, one resident scored five out of ten and the other ten out of ten for the overall care and in the approved centre.

5.2 Advocacy

The inspection team received a report from the Peer Advocacy Network who attended the approved centre regularly, they had compiled feedback from the service users. This information was shared with the approved centre’s senior management team.

Positive aspects of the service included:

- The food was nice.
- The relaxation classes were good.
- Service users enjoyed the art classes and the music groups.
- People really enjoyed going for the group walks.
- Staff were very knowledgeable, professional & understanding.
- The occupational therapy staff were excellent at their roles.
- The garden area was lovely.
- Creative writing groups were good.
- Nurses were helpful.
- The service users liked having their own private rooms.

Suggestions for Improvement:

- Service users would like to be able to charge their own mobile phones.
- Service users would like to be able to order a takeaway on a Saturday or Sunday.
- Some Service User’s said they had no privacy when using their en suites, as there are currently no doors.
- Service users said that the time slots for visitors can be too short.

6.0 Feedback Meeting

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

- Clinical Director
- Acting Area Director of Nursing
- Occupational Therapy Manager
- Acting Principal Social Worker
- Registered Proprietor
- Business Manager
- Consultant Psychiatrists x 2
- Area Director of Nursing
- Clinical Nurse Manager 3 x 3
- Clinical Nurse Manager 2
- ECT Nurse
- Mental Health Act Administrator
- Pharmacist
- Maintenance Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the residents' group profile and the individual residents' needs. The identifiers detailed in each resident's clinical file were checked when staff administered medications, undertook medical investigations, and provided other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The dietitian from the main hospital had input into meals and attended the approved centre on referral.

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

NON-COMPLIANT

Risk Rating MODERATE

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 in the approved centre were not provided with an adequate supply of appropriate individualised emergency clothing that took account of their preferences, dignity, bodily integrity, and religious and cultural practices. There was a very limited supply of emergency clothing and some of the clothing available to the residents had been used previously. Night clothes were not worn by residents during the day, unless otherwise specified in their individual care plan (ICP).

The approved centre was non-compliant with this regulation because the residents were not provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times, 7(1).

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 policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in November 2021. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Lockers were provided for residents, and a property store was also provided for residents to keep risk-assessed items. Secure facilities were provided for the safe keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends. Activities included board games, jigsaw puzzles, books, a pool table, gym equipment, table tennis and yoga.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in August 2020.

Visiting times were appropriate and reasonable. At the time of inspection, visits had become more flexible since many of the COVID-19 restrictions were removed. Though visits were still pre-planned, appointments outside visiting hours were catered for when required. Appropriate steps were taken to ensure the safety of residents and visitors during visits. A dedicated visitors' room was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The Holly Suite, dedicated to Psychiatry of Later Life (POLL), also had a separate dementia-friendly visitors' room within the unit area. The visiting area was suitable for child visitors: the walls featured child-friendly murals, and children had access to a box of toys in the visitors' room.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in February 2022.

Residents in the approved centre had access to mail, Internet including e-mail, telephone or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Residents also had access to guest Wi-Fi, and there were no current restrictions for any resident regarding communication at the time of inspection. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

NON-COMPLIANT

Risk Rating MODERATE

(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 policy and procedures on the conducting of searches. The policy was last reviewed in November 2021, and 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 files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

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

three searches inspected, the reason for the search had not been documented in the clinical file or in the corresponding search form template used. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that there was a written record of every search made, which included the reason for the search, 13(9).

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 protocols for care of residents who were dying, which were last reviewed in January 2020.

No deaths had occurred in the approved centre since the previous inspection and no end-of-life care was provided. Therefore, this regulation was inspected on the policy requirement only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Each resident had an Individual Care Plan (ICP). Ten ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment, and within seven days of admission. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident, weekly in an acute setting, and at least every six months for residents in a continuing care faculty. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). Therapeutic programmes included: art therapy, walking for recovery groups, gentle exercise groups, psychology groups, relaxation groups, communication skills group, psychoeducation groups and yoga. The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to transfers. The policy was last reviewed in August 2020. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in October 2021. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED).

Residents received appropriate general health care interventions in line with individual care plans. Five clinical files were examined in relation to the provision of general health services during the inspection process. Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, and body mass-index, weight, and waist circumference. Residents on anti-psychotic medication received an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender including: breast check; cervical screening; retina check (diabetics only); and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in February 2021.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs. The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team (MDT).

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets, and verbal information were provided in a format appropriate to resident needs. Medication sheets were also available different languages. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of 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, and residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. The heating in bedroom and day areas was suitable and sufficient for residents' comfort and safety. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was not found to be kept in a good state of repair externally, as some of the external windows in the approved centre were in need of cleaning. The garden of Holly Suite was overgrown, and the concrete ground and benches were dirty. However, the approved centre had a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Internally the approved centre was clean and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. All resident bedrooms were appropriately sized to address resident needs, and the approved centre provided suitable furnishing to support resident independence and comfort. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs.

The approved centre was non-compliant with the regulation because externally it was not maintained in good order, as some of the windows in the approved centre were in need of cleaning and one garden area was noted to be overgrown, the benches and concrete ground in this area were also dirty, 22(1)(a).

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

NON-COMPLIANT

Risk Rating HIGH

(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 policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in November 2021, and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. MPARs contained a detailed record of any allergies or sensitivities to medications, including if the resident had no allergies. The frequency of administration, including the minimum dose interval for 'as required' (PRN) medication, was not recorded on three of the ten MPARs inspected. A record of the date of discontinuation for medications was missing on five of the ten MPARs inspected. The Medical Council Registration Number (MCRN) and signature of the medical practitioner prescribing medication to the resident was missing for one prescribed medication and two discontinuations.

MPARs contained a record of all medications administered to the resident. All entries in the MPARs were legible. None of the MPARs documented residents who had been receiving medications for more than six months. No medications were withheld and no directions to crush medications were recorded in the inspected MPARs.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified and Scheduled 2 and 3 controlled drugs were secured separately from medications to ensure further security.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre had suitable practices in prescribing and administration of medicines to residents:

a) **In three of the ten Medication and Prescription Administration Records inspected, the frequency of administration, including the minimum dose interval for "as required" (PRN) medication, was not recorded, 23(1).**
b) **In five of the ten Medication and Prescription Administration Records inspected, the date of discontinuation for medications was not recorded, 23(1).**
c) **In one of the ten Medication and Prescription Administration Records inspected, the Medical Council Registration Number (MCRN) and signature of the medical practitioner prescribing medication to the resident was missing for one prescribed medication and two discontinuations, 23(1).**

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy were last reviewed in November 2021.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in October 2019.

There were clear signs in prominent positions where CCTV cameras or other monitoring devices were utilized throughout the approved centre. The approved centre's use of CCTV and any other monitoring system was disclosed to residents, residents' representatives, and the Mental Health Commission. Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed solely by the health professional with responsibility for the resident. CCTV was not used to monitor a resident in the event of their dignity being compromised, and all monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc, or hard drive. The CCTV located outside the front entrance of the approved centre was capable of recording and this was used for security purposes only.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy in place, which was last reviewed in February 2021. The policy covered information and procedures in relation to the recruitment, selection, and Garda vetting requirements.

The numbers and skill mix of staffing was sufficient to meet residents' needs. The approved centre had a multi-disciplinary team (MDT) which included the disciplines of psychiatry, nursing, psychology, occupational therapy, social work, and pharmacy. The approved centre was actively trying to recruit a dietitian. Residents had access to a dietitian by referral to the Child and Adolescence Mental Health Service (CAMHS) dietitians.

Staffing rosters documented that an appropriately qualified staff member was on duty at all times. Due to COVID-19 outbreaks in the approved centre, not all healthcare staff had completed their mandatory training in Basic Life Support and the Management of Violence and Aggression. For staff whose training was not up to date, there was evidence that this was directly because of COVID-19 and training had been arranged to remedy this.

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 was available to staff in the approved centre.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (68)	56	82%	68	100%	63	92%	68	100%	68	100%

Medical (33)	23	68%	33	100%	28	84%	33	100%	33	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%	1	100%
Pharmacist (1)	1	100%	1	100%	1	100%	1	100%	1	100%

The approved centre was compliant with this regulation. Though the staff training requirement in section 4 of this regulation was not met, this was due to the pandemic event and associated infection control measures within the approved centre and was therefore not deemed a reason for non-compliance.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in October 2019, and included:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence and kept in good order with no loose pages.

Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorized access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. The approved centre had a dedicated tribunal room. Staff attended Mental Health Tribunals and assisted the patient where necessary. The approved centre provided resources and facilities to access the Mental Health Tribunals remotely. In-person tribunals had resumed in the approved centre following the lifting of many of the COVID-19 restrictions, but remote facilities remained available.

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 policy and procedures in relation to the complaints process. The policy was last reviewed in February 2021, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaint's procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaint's procedure, including how to contact the nominated person, was displayed on notice boards throughout the approved centre.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint can be made. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP).

The registered proprietor ensured that the quality of service, care, and treatment was not adversely affected by reason of the complaint being made.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management as well as a Safety Statement. The policy was last reviewed in November 2021, and included all policy requirements, including the following:

- The process for identification, assessment, treatment, reporting, and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault, and accidental injury to residents or staff.
- The process for managing incidents involving residents of the approved centre.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed, or effectively mitigated.

Individual risk assessments were completed in conjunction with resident seclusion, physical restraint, specialised treatments (e.g., Electro-Convulsive Therapy), medication requirements or administration,

and resident transfer and discharge. Individual risk assessments were also completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with no conditions to registration attached. The certificate was displayed prominently in the main foyer.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated November 2021. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

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

The clinical record of one involuntary patient receiving ECT was reviewed. As the patient had been assessed as not having capacity to provide consent, ECT was administered according to section 59(1)(b) of the Mental Health Act 2001, and a Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed by two consultant psychiatrists (CPs). The Form 16 was placed in the patient's clinical file and a copy was sent to the Mental Health Commission within five days. Both CPs

assessed and recorded how ECT would benefit the patient, any discussion with and views expressed by the patient, any assistance provided in relation to the discussion and views expressed, and the patient's capacity to consent to ECT.

The programme of ECT was only prescribed by the responsible CP. The prescription for ECT was recorded in the patient's clinical file, and the record included: the reason for the decision to use ECT; alternative therapies that were considered or proved ineffective; and documentation of discussion with the patient and, where appropriate, their next of kin or representative.

The initial stimulus dose was discussed and considered by the treating CP and CP responsible for ECT in advance of treatment and prescribed accordingly. Cognitive assessments were completed before each programme of ECT, and the patient's clinical was assessed before and after each ECT treatment session. The patient's cognitive functioning was monitored throughout the ECT programme. Cognitive assessment, in line with best international practice, was completed after each ECT programme. In consultation with the patient, the CP reviewed the patient's progress and need for continuation of ECT, and if the programme of ECT was terminated, a reason was documented in the clinical file.

The patient was informed of their right to access an advocate of their choosing at any stage. Each session of ECT was documented in the clinical file together with details of the dose and duration of seizure attained.

A pre-anaesthetic assessment was also recorded in the patient's clinical file and included all requirements, such as a duration of fasting, detailed medical history and full physical exam. Anaesthetic risk was assessed and recorded by the anaesthetist, and the variation in risk was recorded before the ECT treatment. A consistent anaesthetic induction agent was used throughout the programme of ECT, unless contraindicated. The doses of anaesthetic agents used, the patient's response, the monitoring of recordings before and after treatment, and the patient's recovery were recorded, dated, signed, and placed in the clinical file by the anaesthetist. The ECT was only given by a registered medical practitioner and was administered by constant current, brief pulse ECT machine. The stimulus dosing, or recommended starting dose regimes, as relevant, was used and documented in the ECT record.

The approved centre was compliant with this rule.

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been last reviewed in February 2022.

The policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing rates of seclusion use.

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

Monitoring: An annual report on the use of seclusion had been completed. The report was available to the inspector.

Evidence of Implementation: Seclusion facilities were furnished and maintained to ensure respect for resident dignity and privacy, as far as practicable taking Rule 5.1 (direct observation) into account. Residents in seclusion had access to adequate toilet and washing facilities. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms. One episode of seclusion was reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage resident's unsafe behaviour were considered.

Three episodes of seclusion were inspected. Seclusion was initiated by a registered medical practitioner and/or registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion. The seclusion orders did not last longer than eight hours and the residents were informed of

the reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless it was detrimental to them. The residents were informed of the ending of each episode of seclusion. Residents' rights to dignity, bodily integrity, and privacy were respected. Cultural awareness and gender sensitivity were demonstrated.

A registered nurse undertook direct observation for the first hour following the initiation of each seclusion episode, with continuous observation thereafter. A written record of the residents' well-being was made by a nurse every 15 minutes, including the level of distress and behaviour displayed by each resident. Following a risk assessment, a nursing review took place every two hours. During this review, at least two staff entered the seclusion room. A medical review by a registered medical practitioner was undertaken no later than four hours after the commencement of each episode of seclusion and reviewed every four hours.

The seclusion episodes were recorded in the clinical files and seclusion register by the person who initiated seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of each episode. A copy of the seclusion register was placed in the clinical file. The episodes were reviewed by members of the multi-disciplinary team and documented in clinical files within two working days.

The approved centre was compliant with this rule.

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 files of two patients 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 undertaken a capacity assessment for both patients. One patient was assessed as having the capacity to consent, while the other was assessed as not having the capacity.

In respect of the patient with capacity to consent, a written form of consent was completed. It included: the name of the medications prescribed; confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications; details of discussion with the patient, including the nature and purpose of the medications, effects of the medications such as risks, benefits, and any views expressed by the patient; and any supports provided to the patient in relation to their decision-making.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient who did not have capacity to consent. It documented: the names of the medications prescribed; a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications, and details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the patient in relation to the discussion and their decision-making. The form also included approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

Please refer to the Mental Health Commission Codes of Practice, for further guidance for compliance in relation to each code.

Use of Physical Restraint

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had an approval date of February 2022. It addressed the following:

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

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

Evidence of Implementation: The clinical files of three residents that had been physically restrained were examined on inspection. Physical restraint had been used in rare, exceptional circumstances and the best interest of the residents. Physical restraint had been used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint had been initiated by a registered nurse. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the residents. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the residents had been completed no later than three hours after the start of the episodes of restraint. The clinical practice forms (CPFs) had been completed by the person who had initiated and ordered the use of physical restraint. However, in one episode of physical restraint, the CPF was not signed by the clinical psychiatrist within 24 hours. There was evidence that the residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff members were present during the physical restraint episodes. Completed clinical practice forms had been placed in the residents' clinical files.

The residents were afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by

members of the multi-disciplinary team and documented in the clinical file no later than two working days after episode.

The approved centre was non-compliant with this code of practice because in one episode of physical restraint the Clinical Practice Form (CPF) was not signed by the consultant psychiatrist within 24 hours, nor had the time of the signature been recorded, 5.7(c).

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated November 2021. It contained protocols that were developed in line with best international practice, including

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. Material and equipment for ECT, including emergency drugs, were in line with best international practice. There was a facility for monitoring EEG on two channels. ECT machines were regularly maintained and serviced, and this was documented. There is confirmation of servicing of ECT machines. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The file of a voluntary patient who had received ECT was reviewed. All relevant requirements relating to capacity and consent were followed by the approved centre and the appropriate information on ECT given to the resident by the consulting psychiatrist (CP). The patient had capacity to understand and received appropriate verbal and written information explaining the nature, purpose, procedure, benefits, consequences of not receiving ECT, alternative treatments, and side-effects of the treatment proposed.

The programme of ECT was only proscribed by the responsible CP. The prescription for ECT was recorded in the patient's clinical file, and the record included: the reason for the decision to use ECT; alternative therapies that were considered or proved ineffective; and documentation of discussion with the patient and, where appropriate, their next of kin or representative. The initial stimulus dose discussed and considered by the treating CP and CP responsible for ECT in advance of treatment and prescribed

accordingly. A pre-anaesthetic assessment was also recorded in the patient's clinical file and included all requirements, such as a duration of fasting, detailed medical history and full physical exam.

The resident had capacity to make a free choice whether to receive ECT or not. The resident was given 24 hours to reflect on the information they were given and was informed of their right to access an advocate of their choosing. The resident could raise questions at any time, and these were answered. The resident communicated their decision to consent to each programme of ECT in writing to the consultant psychiatrist or a registered medical practitioner. An assessment of capacity to consent was undertaken and documented. Evidence of systematic monitoring of cognitive functioning throughout the programme of ECT was documented, ensuring that the resident could give informed consent for ECT, including anaesthesia.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had separate written policies in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in September 2019, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in August 2020, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in March 2021, included all of the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, and discharge policies.

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, and all other relevant information. A key worker system was in place, full physical examination carried out, and a family member/carer was involved in the admission process with the resident's consent.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse/risks, and documented communications with the relevant general practitioner, primary care team, or community mental health team (CMHT).

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the general practitioner, primary care team, and community mental health team within three days. A comprehensive discharge summary was issued within 14 days.

The discharge summary included details of the following: diagnosis; prognosis; medication; mental state at discharge; outstanding health or social issues; follow-up arrangements; names and contact details of key people for follow-up; and risk issues such as signs of relapse. Family members, carers and advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made within one week.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 07: Clothing					
Reason ID: 10003051		**The residents were not provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times, 7(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Obtain diverse supply of clothing, get approval for a purchase order	Monitor clothing stock	Achievable	16/02/2023	Ms. Michelle Spellman, Business Manager, Veronica Concannon, CNM2 and ECT Lead
Preventative Action	Bi-annually obtain a stock of clothing from the supplies department	Audit	Achievable	16/02/2023	Veronica Concannon, CNM2 and ECT Lead, Ms. Paula McMonagle, CNM2, Ms. Ailish Curran, Staff Nurse and member of the audit committee

Regulation 13: Searches					
Reason ID: 10003050		**The registered proprietor did not ensure that there was a written record of every search made, which included the reason for the search, 13(9).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	One of the older search forms which did not specify the reason for search was in circulation and was used. All old search forms are now removed from circulation and all new template for searches are now in circulation.	Audit	Achievable	16/02/2023	Mr. Michael Bunyan, CNM2 and member of audit committee
Preventative Action	All old search form to be removed and shredded. Communication to be issued regarding using the revised template only.	Audit	Achievable	16/02/2023	Dr David McGuinness CNM3

Regulation 22: Premises					
Reason ID: 10003052		**The approved centre was non-compliant with the regulation because externally it was not maintained in good order, as some of the windows in the approved centre were in need of cleaning and one garden area was noted to be overgrown, the benches and concrete ground in this area were also dirty, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Window cleaning, gardening, and power-hosing is to take place.	Audit	Achievable	16/02/2023	Ms. Michelle Spellman, Business Manager, Mr. John Ryan, Maintenance Foreman
Preventative Action	A schedule of maintenance is to presented at the acute business meeting which will include window cleaning, gardening and power-hosing	Audit and agenda item at the Business Meeting	Achievable	16/02/2023	Mr. John Ryan, Maintenance Foreman

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID: 10003053		**In three of the ten Medication and Prescription Administration Records inspected, the frequency of administration, including the minimum dose interval for "as required" (PRN) medication, was not recorded, 23(1). In five of the ten Medication and Prescription Administration Records inspected, the date of discontinuation for medications was not recorded, 23(1) In one of the ten Medication and Prescription Administration Records inspected, the Medical Council Registration Number (MCRN) and signature of the medical practitioner prescribing medication to the resident was missing for one prescribed medication and two discontinuations, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Adapt a new MPAR (Kardex) that includes a section to record minimum dose interval for as required medication. Issue prescription reminder to prescribers to please indicate date of discontinuation and ensure signature and MCRN is on prescription.	Audit	Achievable	16/02/2023	Dr Costello, Clinical Director and Consultant Psychiatrist, Naomi Martyn, Senior Pharmacist and member of the clinical audit committee
Preventative Action	Review and audit MPARS. Include prescription reminder at induction	Audit and re-audit	Achievable	16/02/2023	Naomi Martyn, Senior Pharmacist adn member of audit committee, Dr Costello, Clinical

					Director and Consultant Psychiatrist

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID: 10003049		**In one episode of physical restraint the Clinical Practice Form (CPF) was not signed by the consultant psychiatrist within 24 hours, nor had the time of the signature been recorded, 5.7(c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The importance of timely completion of the physical restraint book by the consultant psychiatrist (within 24 hours) as per the Code of Practice is to be communicated to medical staff.	Audit and Re-audit	Achievable	16/02/2023	Dr Morgan Costello, Clinical Director and Consultant Psychiatrist
Preventative Action	Each episode of physical restraint will be presented to the restrictive practice reduction review committee	Log of all restraint to be compiled	Achievable	16/02/2023	Mr. Cian O Ceallaigh, Clinical Nurse Manager 2 (CNM2), Dr David McGuinness, CNM3

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.

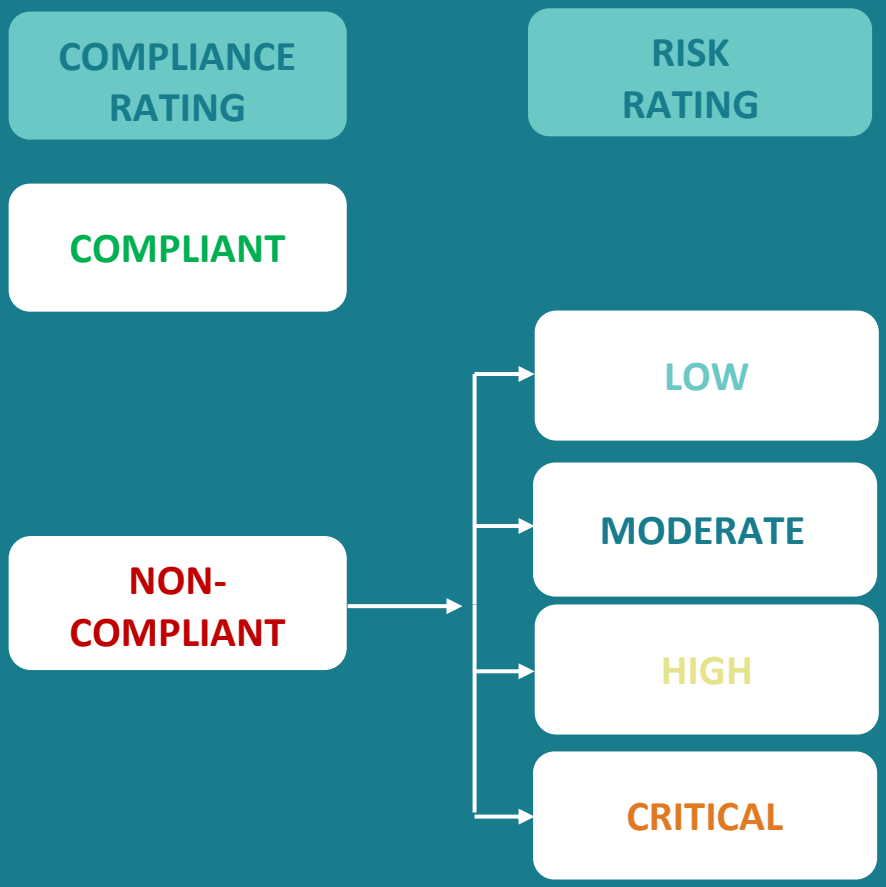
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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