Department of Psychiatry, Waterford University Hospital

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, WATERFORD UNIVERSITY HOSPITAL

Dunmore Road, Waterford

Date of Publication:
1 February 2023

ID Number: AC0152

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:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr. David Heffernan, Head of Services, CHO 5 Mental Health Services

Inspection Team:
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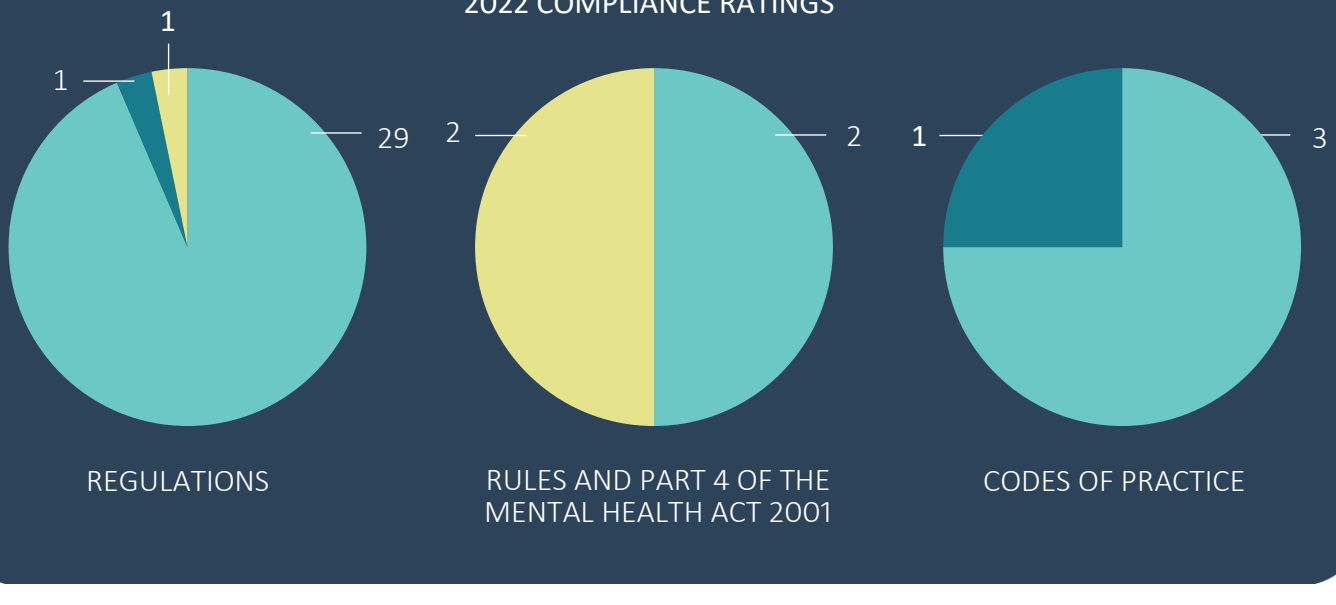
Inspection Date:
5 – 8 July 2022

Previous Inspection date:
20 – 23 April 2021

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

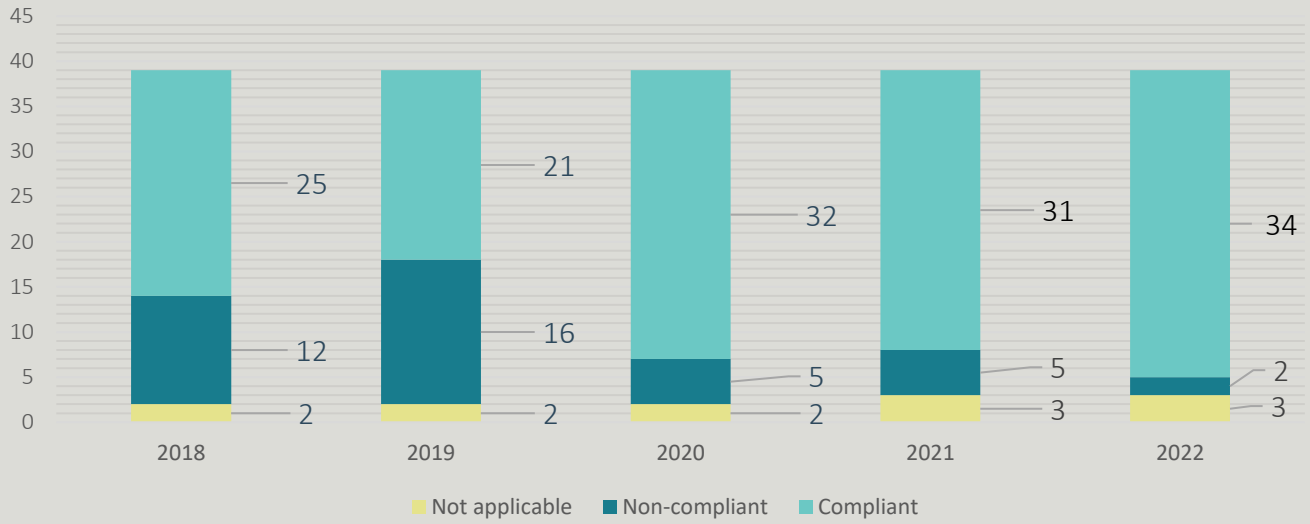
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

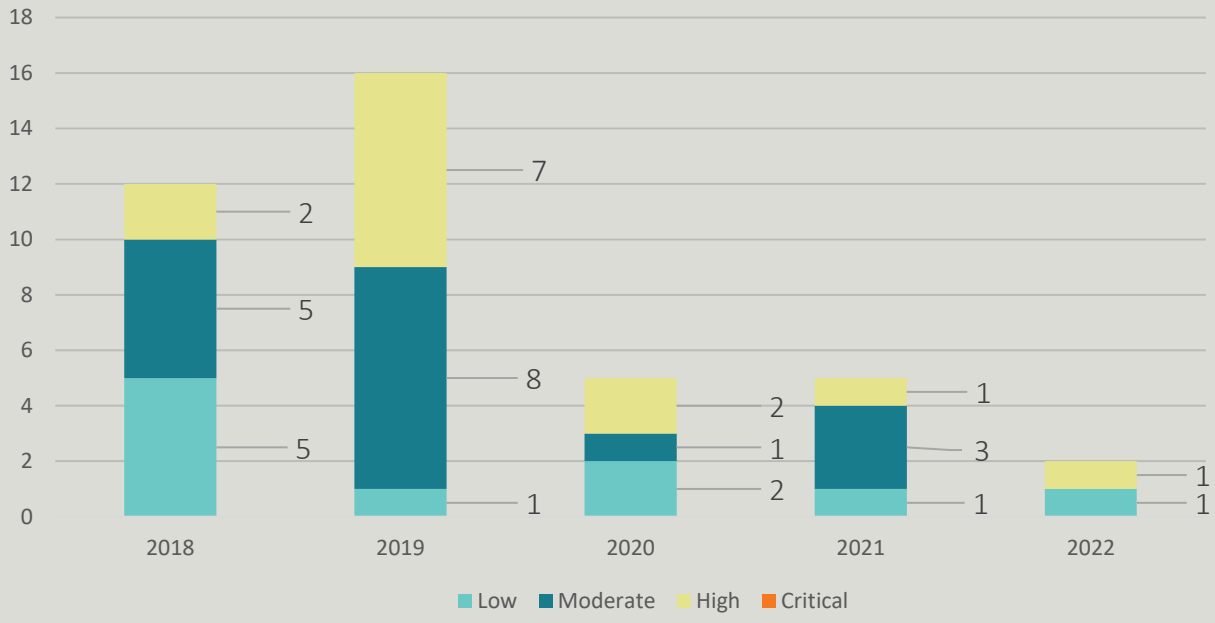
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 approved centre was located on the lower ground floor of the University Hospital Waterford. It comprised of 44 beds in two areas – an acute unit with 14 beds (Brandon Unit) and a sub-acute unit with 30 beds (Comeragh Unit). Residents were admitted to the approved centre by 13 teams: eight general adult teams, two rehabilitation teams, and three psychiatry of later life teams. At the time of inspection, there was a national capital plan to replace the DOP building with a new 60 bed unit. The design team were to begin work shortly after the inspection.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	68%	57%	86%	86%	94%

Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

Conditions	Findings
Condition 1 *To ensure adherence to Regulation 26(4) and 26(5): Staffing, the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on*	The approved centre was not in breach of Condition 1 and the approved centre was compliant with Regulation 26: Staffing at the time of inspection.

staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.	

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.
- Medication was ordered, stored and administered in a secure and safe manner.

However, not all ligature points were minimised to the lowest practicable level based on risk assessment. The approved centre had received funding to minimize remaining ligatures risks rated as high.

Appropriate care and treatment of residents

We found that staff provided therapeutic activities and physical health monitoring appropriate to needs of residents in the following areas:

- 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.
- The approved centre had seven individual care plan (ICP) champions available to all staff disciplines to offer support and guidance and had developed and implemented a new ICP booklet and resource pack. Updated ICP training was also provided to staff.

- The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents. 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.

However, there had been ten admissions of children to the approved centre since the previous inspection in April 2021. Age-appropriate facilities appropriate to age and ability were not provided. A programme of activities appropriate to age and ability was provided.

Respect for residents' privacy, dignity and autonomy

We found that facilities and processes respected residents' privacy and dignity and that interactions respected residents' wishes.

- Accommodation within the approved centre was a mixture of single and two, four, and six-bedded shared bedrooms. Bathroom facilities were a combination of en suite and shared bathrooms. 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.
- The approved centre was clean, hygienic, and free from offensive odours.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.
- The approved centre was chosen as one of 18 pilot sites nationally for the reduction of restrictive practices in mental health services. An introduction to positive behaviour support training took place as part of the approved centres overall strategy for the reduction of restrictive practices.

Responsiveness to residents' needs

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

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. There was a gym and a recreational room with arts and crafts, boardgames, music, TV, a projector and books and a new walking group.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.

- There was sufficient private space as well as areas for socialisation.

Governance, Leadership and Accountability

We found that governance structures and processes were in place.

- The Department of Psychiatry (DOP) was part of South East Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 5 and was governed under the Waterford/Wexford Mental Health Services. Governance processes encompassed Waterford/Wexford Executive Management (EMT) Meeting and the Quality and Safety Executive Committee.
- The EMT met on a monthly basis. The Quality & Safety Executive Committee (QSEC) meeting also took place on a monthly basis.
- Governance was strengthened by a local Compliance Committee meeting, Quality and Patient Safety Committee meeting, the Restrictive Practice Reduction Committee meeting, a Health and Safety Committee meeting and quality improvement working groups such as Policies Procedures Protocols and Guidance and clinical audit. Local management held a Quality Patient Safety Committee (QPSC) meeting on a monthly basis.
- Local management also held a compliance meeting on a weekly basis. Minutes from compliance meetings included agenda items such the ICP Pilot Project, compliance, bed occupancy, quality improvement initiatives, monitoring of approved centre activity, staff training and development, building related issues, and COVID-19.
- Weekly resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Peer Advocacy in Mental Health organisation contacted the approved centre on a weekly basis and spoke with residents. There was an Area Lead for Mental Health Engagement in management and governance processes.
- The approved centre had an established culture of quality improvement with the progression and development of various quality initiatives. A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a local policy group which provided a multi-disciplinary approach to policy development, review, approval and dissemination and all policies were up-to-date at the time of inspection. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The approved centre was awarded the "Sparks Innovation Front Line Award" for the "Exchange" project that was developed. This involved the installation of a traditional phone booth styled facility to enable residents to communicate in privacy with their family and friends.

2. The approved centre had seven individual care plan (ICP) champions available to all staff disciplines to offer support and guidance.

3. The approved centre had developed and implemented a new ICP booklet and resource pack. Updated ICP training was also provided to staff.

4. The approved centre had developed recreation resource packs in response to COVID-19 outbreaks and for those isolating when delivery of in person groups was not possible.

5. The approved centre commenced an initiative to increase self-esteem, and promote self-care called "Keith's Closet". This service was available by referral, whereby a walk-in wardrobe consultation provided residents with quality clothing, shoes, and accessories.

6. Two nursing staff had undertaken further education in Infection Prevention and Control (IPC) and were both training as link practitioners in IPC.

7. The approved centre was chosen as one of 18 pilot sites nationally for the reduction of restrictive practices in mental health services. An introduction to positive behaviour support training took place as part of the approved centres overall strategy for the reduction of restrictive practices.

8. The introduction of a family peer support worker.

9. A dedicated therapeutic space was created on Comeragh Unit.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located on the lower ground floor of the University Hospital Waterford. It comprised of 44 beds in two areas – an acute unit with 14 beds (Brandon Unit) and a sub-acute unit with 30 beds (Comeragh Unit).

Accommodation within the approved centre was a mixture of single and two, four, and six-bedded shared bedrooms. Bathroom facilities were a combination of en suite and shared bathrooms. Residents had access to internal communal areas and two well-maintained gardens. COVID-19 procedures were in place within the approved centre. Residents were admitted to the approved centre by 13 teams: eight general adult teams, two rehabilitation teams, and three psychiatry of later life teams.

The approved centre had recently enhanced the garden space in the Brandon Unit by repainting it. New flooring had been installed on the corridors, both units had been newly painted, and the Healing Art's artwork was installed throughout units. The approved centre also created a separate dedicated therapeutic space in the Comeragh Unit. Reduction of ligature points related improvements had also been implemented which included replacement wardrobes throughout the approved centre. A new privacy canopy had been installed in the Comeragh Unit Garden.

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

Resident Profile	
Number of registered beds	***44***
Total number of residents	**31**
Number of detained patients	7
Number of wards of court	1
Number of children	1
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	N/A

3.2 Governance

The Department of Psychiatry (DOP) was part of South East Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 5 and was governed under the Waterford/Wexford Mental Health Services. Governance processes encompassed two core monthly meetings, the Waterford/Wexford Executive Management Team Meeting and the Quality and Safety Executive Committee meeting. The DOP had established governance structures in place and a number of senior management meetings took place within the approved centre on a regular basis in order to deliver the governance processes. Governance was

strengthened by a local Compliance Committee meeting, Quality and Patient Safety Committee meeting, the Restrictive Practice Reduction Committee meeting, a Health and Safety Committee meeting and quality improvement working groups such as Policies Procedures Protocols and Guidance and clinical audit.

The Executive Management Team (EMT) met on a monthly basis. Minutes from the EMT meetings evidenced strategic agenda items to include human resource issues including staff education and training, and recruitment for vacant positions, regulation/compliance, COVID-19, financial planning. service KPI's, and mental health engagement.

The Quality & Safety Executive Committee (QSEC) meeting also took place on a monthly basis. Quality indicators and outcome measures, regulation & compliance, complaints and compliments, health and safety, staff training, clinical audit and quality improvements, incidents/near misses, mental health engagement & recovery, and risk management processes and review were each discussed by the QSEC committee. The members completed an overview of the serious incidents reported within the approved centres and reviewed any issues identified as part of their risk management strategy.

Local management held a Quality Patient Safety Committee (QPSC) meeting on a monthly basis. This meeting was attended by the service manager, deputy service manager, business manager, mental health act administrator, and representatives from medical, nursing, health and social care disciplines who were working directly in the approved centre. Mental health engagement and recovery, regulation and compliance, quality improvement, complaints and compliments, health and safety, and risk management were each discussed by the QPSC committee. The risk register was reviewed at these meetings.

Local management also held a compliance meeting on a weekly basis. Minutes from compliance meetings included agenda items such the ICP Pilot Project, compliance, bed occupancy, quality improvement initiatives, monitoring of approved centre activity, staff training and development, building related issues, and COVID-19.

The approved centre had a standardised process for the management of risks and incidents. The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had a local risk register and applicable risks had been escalated to the head of service and the executive management team risk register. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. The risk of COVID-19 was actively managed through the approved centre's risk management processes. Training in risk management had been provided to staff. Examples of identified risks for the approved centre were the COVID-19 pandemic, ligature points, staff training, the lack of maintenance structure for the DOP and risk to resident's dignity and wellbeing if overcapacity should occur. At the time of inspection, there was a national capital plan to replace the DOP building with a new 60 bed unit. The design team were to begin work shortly after the inspection.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. Health and Social care professionals, including occupational therapy, psychology, social work, physiotherapy, dietetics and speech and language therapy were accessible

to all residents. At the time of inspection however an occupational therapy post was vacant. These services were being provided to residents through cross care cover. Plans were in place to recruit and fill this role.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, and psychology. The inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. Annual staff training plans were completed to identify and address training needs. Operational risks highlighted within these questionnaires included: recruitment and retention of staff, significant demand for bed availability, COVID-19 impacts which include the risk of COVID-19 outbreaks due to limited number of isolation rooms, challenges running therapeutic/recreational groups, and the impact on staff mandatory training. The identified risks were effectively mitigated escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, weekly resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Peer Advocacy in Mental Health organisation contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre. Service user input was enhanced by the Area Lead for Mental Health Engagement in management and governance processes.

The approved centre had an established culture of quality improvement. This was evident by the ongoing refurbishment of the approved centre. The progression and development of various quality initiatives in the approved centre was also a standing agenda item at the local compliance meeting. A programme of audit was implemented by the multi-disciplinary team throughout the service. There was a local policy group which provided a multi-disciplinary approach to policy development, review, approval and dissemination and all policies were up to date at the time of inspection. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre.

The approved centre followed all public health advice in regard to the COVID-19 outbreak. Contingency planning included the potential risks posed by the COVID-19 virus. COVID-19 was a standing agenda item for the EMT meeting and the local compliance meeting and issues arising were actively managed. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.

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 22: Premises	✗	High	✗	High	✓		✗	Moderate	✗	Low
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	✗	High	✗	High	✗	High	✗	Moderate	✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

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.

Eight service user 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.
- Seven residents ticked that they "always" felt safe in the approved centre, and one indicated that they "sometimes" felt safe in the approved centre.
- Six residents ticked that they "always" felt they were able to discuss worries or concerns with staff as soon as they needed to, and two indicated that they 'sometimes' could.
- Six residents felt they were "always" 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 two indicated that they "sometimes" could.
- All residents ticked to indicate that on admission to the approved centre a member of staff had explained what was happening in a way that they could understand.
- Six residents indicated that they understood their individual care plan, two residents indicated that they did not. Seven residents indicated that they were "always" involved in setting goals for their individual care plans, and one indicated that they were "sometimes" involved.
- Seven questionnaires indicated that residents knew who their multi-disciplinary team (MDT) members were and one indicated they did not. All residents indicated that they knew who their keyworker was.

- Seven residents felt that there were enough activities during the day and one resident stated that there were not.

There was a sense of overall satisfaction with the approved centre. On a scale of 1-10, with 1 being poor and 10 being excellent, residents scored nine out of ten for overall care and treatment.

The inspection team spoke with two residents over the phone. This feedback indicated that:

- Residents knew who their keyworkers were and were informed about their individual care plans. They commented that there was a lot of input from their MDT.
- Residents commented that the group talks were extremely helpful.
- Residents commented that every effort was made by staff to help them recover.
- A family member commented that their relative was getting great care and treatment in the approved centre and that they as a family were happy with the staff.
- Residents commented that the team were great and that they were always there for them.
- Residents commented that the cleaning staff did an amazing job and were always happy to get them anything they needed.
- Residents commented that staff were great at supporting them all the time, and that staff check-in regularly and they can have one-to-one time when needed.

5.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative. The advocate visited the approved centre on a weekly basis (alternating both units each week). Face-to-face individual and group consultations had been reintroduced.

The inspection team spoke with a representative from the advocacy service who furnished the inspectors with a report detailing advocacy activity within the approved centre. Residents expressed to the advocate that the food was excellent, and they were very happy with the food choices on offer. Residents expressed that the activities provided were fantastic, they enjoyed the creative writing, the rise and shine group was very helpful, the coping skills group was very informative and that the music sessions were great fun. Residents expressed that their physical and mental health was looked after very well in the approved centre.

Residents expressed that the outdoor space looked a lot better with the seating and murals, that the approved centre was a safe place for them, and that privacy was respected. Residents spoke positively of staff saying that they were brilliant, they expressed getting very good support from nursing staff, that they were very kind and caring and that if they had a problem staff would help to sort it out. Residents expressed feeling that there was a very relaxed atmosphere in the approved centre and that it didn't feel like a hospital.

Areas in need of improvement raised by residents included that there could be more activities available during the weekend, that there should be more activities on the acute unit, that there should be psychology available for residents as it might reduce the reliance on medication, that sometimes staff don't know when they will be seeing their doctor, and that at times it was hard to sleep at night with so many people in the unit.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Clinical Director
- Assistant Director of Nursing
- Occupational Therapy Manager
- Head of Service/ Registered Proprietor Nominee
- Area Lead for Mental Health Engagement
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Clinical Nurse Manager 1
- Principal Social Worker Nominee
- Deputy Service Manager
- Principal Psychologist
- General Manager
- Service Manager

Apologies were received on behalf of the Area Director of Nursing.

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 appropriate to the resident group profile and individual residents' needs. Residents' names, medical record numbers (MRNs), and dates of birth were used as identifiers in the approved centre. Resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans.

The approved centre was compliant with this regulation

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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 all surfaces were clean and all storage areas clean and tidy. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in April 2021. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. The approved centre provided safes for residents in their bedrooms. 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. There was adequate storage space in resident bedrooms, and 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 recreational activities appropriate to the resident group profile on weekdays and during the weekend. The approved centre had a gym and a recreational room with arts and crafts, boardgames, music, TV, a projector and books. A new walking group had been established at the time of the inspection.

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 2019.

Visiting times were appropriate and reasonable, and there were no visiting restrictions for any resident at the time of inspection. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there is an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits- visitors were encouraged to use a separate entrance and exit area where they completed COVID-19 questionnaires and underwent a temperature check before being permitted to enter and a log of visitors was maintained by the approved centre. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policies and procedures in relation to communication. The policy was last reviewed in February 2021.

Residents in the approved centre had access to mail and were facilitated in sending or receiving messages or goods, unless otherwise risk-assessed with due regard to residents' well-being, safety, and health. Residents had access to their own mobile phones, Wi-Fi, iPads, phone, fax, and email. 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 complaint with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in June 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

resident and property search was available, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance for the search. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in September 2020.

The clinical files of two residents who had died were examined on inspection. Both residents were transferred from the approved centre to general healthcare facilities prior to death for appropriate treatment. The end of life care provided by the approved centre was appropriate to the residents' physical, emotional, social, psychological, and spiritual needs. Representatives, family, next of kin, and friends were involved, supported and accommodated during end of life care. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

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). The centre's Occupational Therapist (OT) and OT assistant ran two groups a day. The psychologist and social worker had input in group programmes in the approved centre. Referrals for individual psychology could be made for inpatients where necessary. Programmes which were in place for residents at the time of the inspection included: A choose your tune group, a coping skills group, a keeping well group, rise and shine groups, a creative minds group and recovery groups.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in September 2019. 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. A transfer form was completed, and the resident was accompanied by a nurse who provided all relevant information. The information included a copy of the resident's Medication Prescription and Administration Record (MPAR) which contained a list of current medications.

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 April 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, electrocardiogram (ECG) heart function, and prolactin.

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 March 2021. On admission, residents were provided with required information, including the approved centre's welcome pack detailing care and services. The information in the welcome pack was clearly and simply written, and available in the required formats to support resident's needs.

The approved centre's welcome pack included details of mealtimes and arrangements for personal property, visiting times, and residents' rights. Information regarding the complaint's procedure and relevant advocacy and voluntary agencies was also included in the welcome pack and displayed on notice boards in the approved centre. Residents were 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 information sheets included all relevant information on indications for use and any possible side-effects. The Health Products Regulatory Authority (HPRA) website and Irish Medicines website were used for up-to-date medication information. 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. A new privacy canopy had been installed in the Comeragh Unit Garden. 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. There was suitable and sufficient heating in day areas and in bedrooms where residents sat during the day. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. 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 minimized in the approved centre. Not all ligature points were minimised to the lowest practicable level based on risk assessment. At the time of inspection, the approved centre had received funding to minimize remaining ligatures risks rated as high.

The approved centre was found to be kept in good state of repair externally and internally. The approved centre had a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, 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. There was a designated cleaning room and sluice room, and the centre provided

assistive devices and equipment to address resident needs. All resident bedrooms are appropriately sized to address the resident needs, and the approved centre provided suitable furnishings to support resident independence and comfort.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the overall approved centre environment was developed and maintained with due regard to the safety of residents and patients, because not all ligature points were minimised to the lowest practicable level based on risk assessment, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in October 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. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any (or no) allergies or sensitivities to medications, a record of medications administered to the resident and the administration route for all medications, clear records of the date of discontinuation for each medication, the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident, and the Nursing and Midwifery Board of Ireland (NMBI) registration number or PIN of every nurse prescriber prescribing medication to the resident.

All entries in the MPARs were legible. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition, and this was documented in the clinical file. None of the MPARs inspected evidenced the withholding of medication, or the use of crushed medication.

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 mediations to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in March 2022. The centre's Safety Statement had also been reviewed in March 2022.

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 February 2022.

The inspection found that 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. The centre had a CCTV monitor in the annex of seclusion room and another in the nurses' station, neither of which were visible by anyone other than staff with access to those particular areas. 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 approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in March 2022, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The number and skill mix of staffing was sufficient to meet the resident needs. An appropriately qualified staff member was on duty and in charge at all times; this was documented. The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre. Residents were admitted to the approved centre by thirteen multi-disciplinary teams: eight general adult teams, two rehabilitation teams, three psychiatry of later life teams. Clinical personnel who worked directly in the approved centre included nursing staff, medical staff, one occupational therapist and one occupational therapist assistant, one social worker, and one psychologist. An occupational therapy post was vacant at the time of inspection, cross care cover was facilitated.

All staff training was documented, and staff training logs were maintained. All health care staff were trained in fire safety, basic life support and the management of violence and aggression. All healthcare staff were trained in the Mental Health Act 2001.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001		Children First	
Nursing (43)	43	100%	43	100%	43	100%	43	100%	43	100%

Consultant Psychiatrist (16)	16	100%	16	100%	16	100%	16	100%	16	100%
Medical (23)	23	100%	23	100%	23	100%	23	100%	23	100%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%
Social Worker (9)	9	100%	9	100%	9	100%	9	100%	9	100%
Psychologist (10)	10	100%	10	100%	10	100%	10	100%	10	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in June 2021, 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. 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 if required.

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 June 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 in the resident information booklet, on unit notice boards and in each bedroom. Information about the complaint's procedure, including how to contact the nominated person, was publicly displayed in 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 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 April 2022, and included the following requirements:

- 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 at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Risk assessments were also completed prior to and during resident seclusion, physical restraint, specialized treatments such as ECT, resident transfer and discharge, and in conjunction with medication requirements or administration. 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 one condition to registration attached. The certificate was displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

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 reviewed annually and was dated June 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. The training record was available to the inspector. A record of attendance at training in the use of seclusion was maintained.

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.

Three episodes 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.

Seclusion was initiated by a registered medical practitioner or registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion.

The residents were informed of the reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless it was detrimental to the resident. Residents' rights to dignity, bodily integrity, and privacy were respected. The next of kin or representative of one of the residents was informed of the seclusion, and this communication was recorded in the clinical file. Where the next of kin or representative was not informed of the use of seclusion, a reason was recorded in the clinical file.

Of the seclusion episodes inspected, one lasted less than hour, one for a minute, and one for three hours and 45 minutes. A registered nurse undertook direct observation for the first hour following the initiation of each seclusion episode, with continuous observation thereafter in respect of the episode which lasted three hours and 45 minutes. A written record of the resident's well-being was made by a nurse every 15 minutes, including the level of distress and behaviour displayed by the resident, in respect of the episodes which lasted longer than a minute. In respect of the episode which lasted three hours and 45 minutes, a nursing review took place every two hours following risk assessment.

The residents were informed of the ending of each episode of seclusion. The reason for ending seclusion was recorded in the clinical files. All uses of seclusion were clearly recorded in the clinical files and seclusion register. A copy of the seclusion register was placed in the clinical file. The episodes of seclusion were reviewed by members of the multi-disciplinary team and documented in clinical file 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 three 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 and that the three patients were unable to consent.

A Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent was completed for the patients. 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 forms 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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated June 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 medical practitioner (RMP), registered medical nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. 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 orders for physical restraint lasted for a maximum of 30 minutes. Every episode of physical restraint was recorded in the clinical files. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the consultant psychiatrist within 24 hours.

The residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. As soon as was practicable and with the resident's consent, the resident's next of kin or representative was informed of the use of physical restraint, and a record of this communication was place in the clinical file. Where next of kin or representative was not informed of the

use of physical restraint, a justification was recorded in the clinical file. Where the resident had capacity and did not consent to informing their next of kin or representative, this was documented in the clinical file.

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 practise forms had been placed in the residents' clinical files.

The residents were afforded the opportunity to discuss the episodes 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 clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

Admission of Children

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in September 2019. It addressed the following:

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

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

Evidence of Implementation: There had been ten admissions of children to the approved centre since the previous inspection. Age-appropriate facilities appropriate to age and ability were not provided. A programme of activities appropriate to age and ability was provided. Each child admitted was assessed by the approved centre's occupational therapist (OT). There was also evidence of input from the Child and Adolescent Mental Health Service (CAMHS) OT and an assessment by the Recreation and Recovery team. Children had access to the Recreational and Recovery facility when no adults were present.

The approved centre had provisions in place to ensure the safety of the children, to respond to a child's special needs as a young person in an adult setting, and to ensure the right of the child to have their views heard. Staff in contact with the children had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First Guidelines were available to all relevant staff. Appropriate accommodation was designated, including age- and gender- segregated sleeping and bathroom areas. Children in the approved centre were accommodated in a single en suite room and assigned a same gender special nurse. Observation arrangements, including assignment of designated staff members, was provided as considered clinically appropriate. Arrangements were in place for the continuation of the child's education and could be accessed by Microsoft Teams link to schools and on-line tutoring services.

Children had access to age-appropriate advocacy services. Where appropriate, children had their rights explained and information about the ward and facilities provided in a form and language they could understand, and this was recorded in the clinical file.

Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre. Appropriate visiting arrangements for families was available, including children. The Mental Health Commission was notified of all children admitted to the approved centres for adults within

72 hours of admission using the associated notification form. Consent for treatment was obtained from one or both parents.

The approved centre was non-compliant with this code of practice because age-appropriate facilities appropriate to age and ability were not available in the approved centre, 2.5(b).

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 June 2022. 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 that included appropriate waiting and recovery facilities. High-risk residents were treated in a rapid-intervention area. ECT machines were regularly serviced, and this was documented. Materials and equipment in ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for management of cardiac arrest, anaphylaxis, and malignant hyperthermia, were prominently displayed. There was a named consultant psychiatrist with overall responsibility for ECT, as well as a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses, one of whom was a designated ECT nurse were present at all times in the ECT suite when ECT was being administered.

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. 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 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 2021, included of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in September 2021, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in June 2021, included 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 and discharge plan 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 and 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.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 22: Premises					
Reason ID : 10003017		**The registered proprietor did not ensure that the overall approved centre environment was developed and maintained with due regard to the safety of residents and patients, because not all ligature points were minimised to the lowest practicable level based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Funding approved for pressure plates on doors identified as high and medium risk. Phase one of the preparatory works of the risk reduction anti- ligature work, specifically the pressure plates on identified high and medium internal doors; commenced on 11/10/2022 and was completed on 11/11/2022. Phase two of the risk reduction anti ligature works for installation of the pressure plates on identified high and medium risk internal doors is due to commence on 28/11/2022 and is	Ligature Audit will be updated to reflect the installation and completion of risk reduction anti-ligature pressure plates on identified high and medium risk internal doors. DOP Risk Register will be updated concurrently to reflect the installation and completion of risk reduction anti-ligature pressure plates on identified high and medium internal doors.	Yes, It is achievable and realistic for the service to minimise risk to the lowest possible level, funding approved and phase one complete. Phase two to commence 28/11/2022	31/03/2023	Clinical Director, General Manager Waterford & Wexford Mental Health Services, HSE Estates, Technical Services Manager and DOP Senior Nurse Management

	due to be completed by end of the first quarter 2023				
Preventative Action	Funding approved for pressure plates on doors identified as high and medium risk. Phase one of the preparatory works of the risk reduction anti- ligature work, specifically the pressure plates on identified high and medium internal doors; commenced on 11/10/2022 and was completed on 11/11/2022. Phase two of the risk reduction anti ligature works for installation of the pressure plates on identified high and medium risk internal doors is due to commence on 28/11/2022 and is due to be completed by end of the first quarter 2023	Ligature Audit will be updated to reflect the installation and completion of risk reduction anti-ligature pressure plates on identified high and medium risk internal doors. DOP Risk Register will be updated concurrently to reflect the installation and completion of risk reduction anti-ligature pressure plates on identified high and medium internal doors.	Yes, It is achievable and realistic for the service to minimise risk to the lowest possible level, funding approved and phase one complete. Phase two to commence 28/11/2022	31/03/2023	Clinical Director, General Manager Waterford & Wexford Mental Health Services, HSE Estates, Technical Services Manager and DOP Senior Nurse Management

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10002988		**Age-appropriate facilities appropriate to age and ability were not available in the approved centre, 2.5(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Prior to the admission of a child to the DOP, CAMHS Out Patients Department options explored, the assessing doctor completes referrals to all CAMHS units. In the event there is no availability of a bed in CAMHS Inpatient Units and assessed need and risk of the child is too high to be managed at home the child is then admitted to the Department of Psychiatry, University Hospital Waterford until an appropriate CAMHS bed becomes available. A single ensuite room assigned and gender appropriate 1:1 nursing special provided. In	An audit of each child's healthcare record takes place immediately post discharge. Department of Psychiatry Compliance Team maintains Child Admission statistics with admission duration and place of discharge i.e. CAMHS Inpatient Unit or CAMHS Community Mental Health Teams. This information is discussed at Department of Psychiatry Compliance Meeting and local QPSC	Yes	17/11/2022	Clinical Director, NCHDs, Treating CAMHS Consultant, CAMHS MDT Team, Recreation and Recovery and Occupational Therapy Teams

	addition to existing access to Recreation & Recovery area facilities out of hours, there is now protected time factored in Monday to Friday solely accessible to children. The child has access to private outdoor space in the courtyard garden accompanied by 1:1 nursing special.The Child is continually assessed and reviewed by the CAMHS MDT daily with family/ carer involvement. CAMHS units are contacted daily by treating consultant and the child is discharged to CAMHS unit as soon as bed becomes available.				
Preventative Action	Prior to the admission of a child to the DOP, CAMHS Out Patients Department options explored, the	An audit of each child's healthcare record takes place immediately post discharge. Department of	Yes	17/11/2022	Clinical Director, NCHDs, Treating CAMHS Consultant, CAMHS MDT Team, Recreation and Recovery and

	assessing doctor completes referrals to all CAMHS units. In the event there is no availability of a bed in CAMHS Inpatient Units and assessed need and risk of the child is too high to be managed at home the child is then admitted to the Department of Psychiatry, University Hospital Waterford until an appropriate CAMHS bed becomes available. A single ensuite room assigned and gender appropriate 1:1 nursing special provided. In addition to existing access to Recreation & Recovery area facilities out of hours, there is now protected time factored in Monday to Friday solely accessible to children. The child has access to private	Psychiatry Compliance Team maintains Child Admission statistics with admission duration and place of discharge i.e. CAMHS Inpatient Unit or CAMHS Community Mental Health Teams. This information is discussed at Department of Psychiatry Compliance Meeting and local QPSC			Occupational Therapy Teams

	outdoor space in the courtyard garden accompanied by 1:1 nursing special.The Child is continually assessed and reviewed by the CAMHS MDT daily with family/ carer involvement. CAMHS units are contacted daily by treating consultant and the child is discharged to CAMHS unit as soon as bed becomes available.				

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.

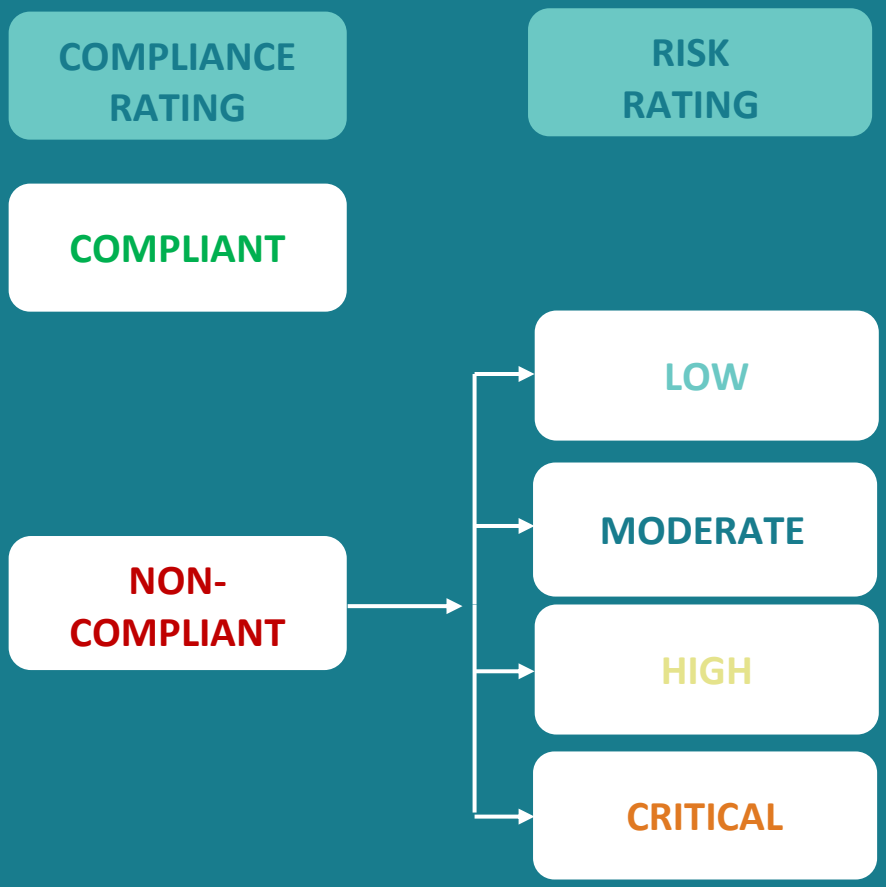
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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