Department of Psychiatry, Connolly Hospital

Annual Inspection Report 2022

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, CONNOLLY HOSPITAL

Blanchardstown, Dublin 15

Date of Publication: 3rd April 2023

ID Number: AC0133

2022 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
7 December 2021

Registered Proprietor:
HSE

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

Inspection Team:
Aoife Gallaher, Lead Inspector
Barbara Murphy
Megan Barry Sheehy
Sarah Jones

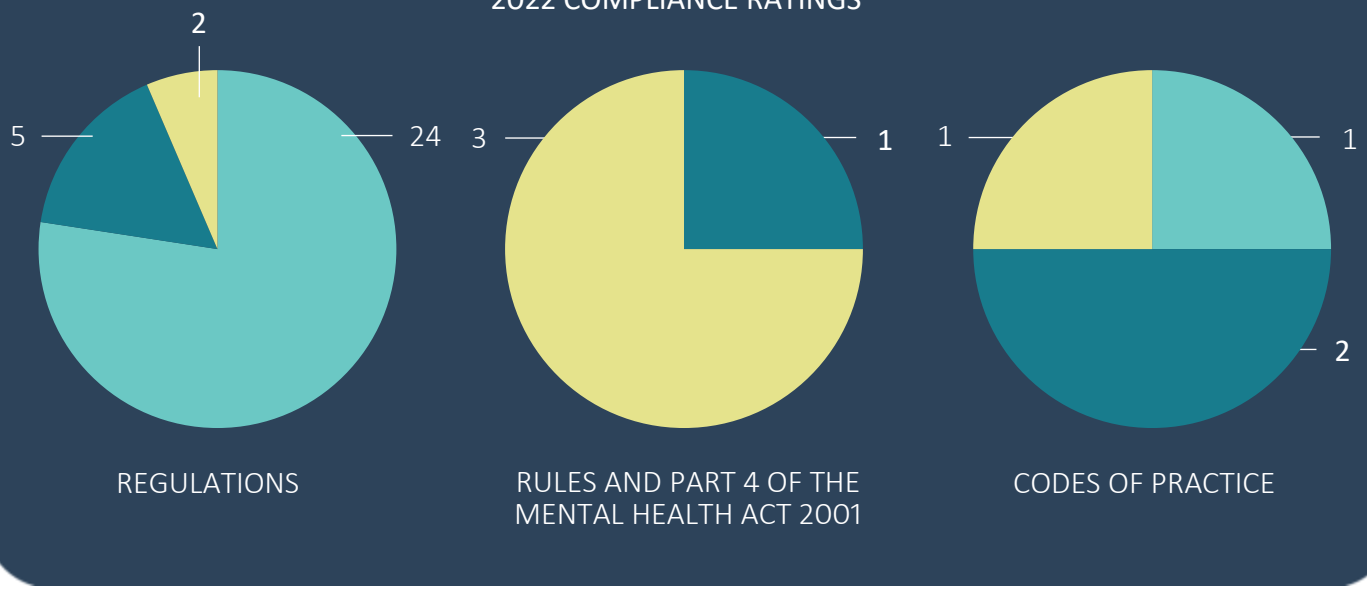
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
18 – 21 October 2022

Previous Inspection date:
13 – 16 July 2021

Inspection Type:
Announced Annual Inspection

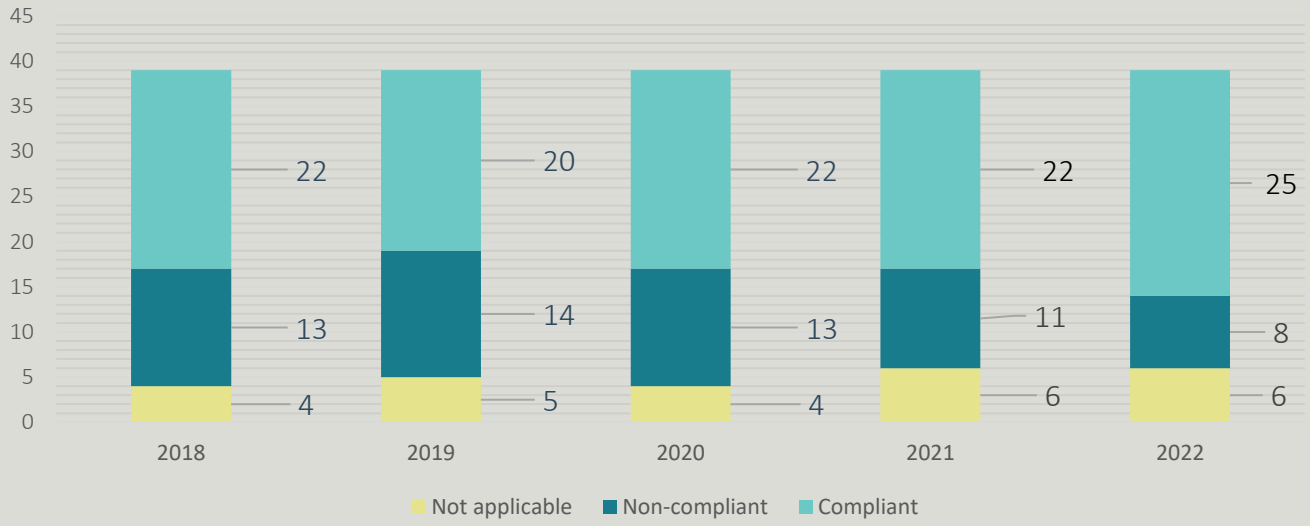
2022 COMPLIANCE RATINGS



RATINGS SUMMARY 2018 – 2022

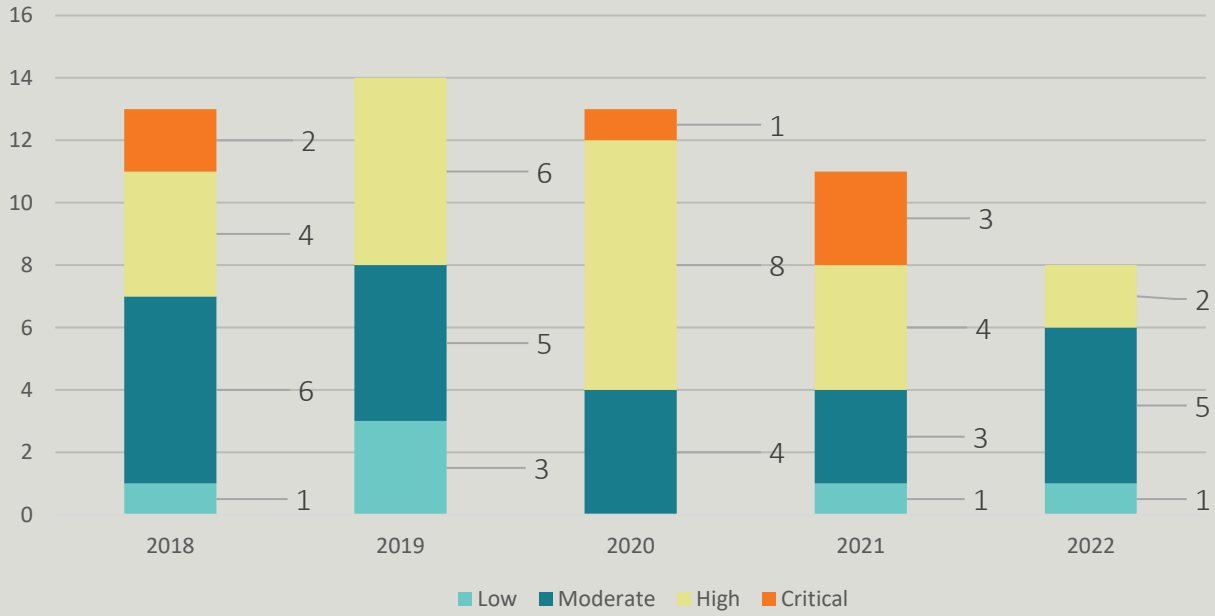
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 5
Conditions to registration 5
Ongoing escalation and enforcement actions at time of inspection 6
2.0 Quality Initiatives 9
3.0 Overview of the Approved Centre 10
3.1 Description of approved centre 10
3.2 Governance 11
3.3 Reporting on the National Clinical Guidelines 12
4.0 Compliance 13
4.1 Non-compliant areas on this inspection 13
4.2 Areas that were not applicable on this inspection 13
5.0 Service-user Experience 15
5.1 Service-user feedback 15
5.2 Advocacy 15
6.0 Feedback Meeting 17
7.0 Inspection Findings – Regulations 18
8.0 Inspection Findings – Rules 54
9.0 Inspection Findings – Mental Health Act 2001 57
10.0 Inspection Findings – Codes of Practice 58
Appendix 1: Corrective and Preventative Action Plan 65
Appendix 2: Background to the inspection process 103

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 Department of Psychiatry was located on the lower ground floor of Connolly Hospital in Blanchardstown and provided acute in-patient care ion 47 beds in the Dublin north city and county area. Nine consultant led teams admitted residents to the approved centre. Two rehabilitation teams and a team dealing with the homeless population also admitted to the centre.

Resident accommodation was on two wards: Ash Ward and Pine Ward, with accommodation for 21 residents each. A High Dependency Unit (HDU) with accommodation for up to five residents, was attached to Ash Ward.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	63%	59%	63%	67%	76%

Conditions to registration

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

Conditions	Findings
Condition 1: *The approved centre must implement the Quality Improvement Plan submitted to the Mental Health Commission by the service on 20 September 2021. The approved centre shall submit updates in a form and frequency specified by the Commission. The updates must include detail on the governance*	The approved centre was not in breach of Condition 1.

arrangements relating to how improvements are being overseen and sustained on a continuing basis.	
Condition 2: *To ensure adherence to Regulation 26: Staffing, the approved centre shall ensure that residents of the approved centre have access a suitably qualified psychologist, in accordance with their assessed needs as documented in their individual care plan, by no later than 30 June 2019.*	The approved centre was not in breach of Condition 2 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety in the approved centre

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

- Individual risk assessments were completed at admission to identify individual risk factors, including general health risks and risk of falls.
- Hazards, such as slippery floors, trip hazards, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre.
- The numbers and skill mix of staffing were sufficient to meet resident needs and an appropriately qualified staff member was on duty and in charge at all times.
- There was a minimisation of ligature points to the lowest practicable level.
- Medication was ordered, prescribed, stored and administered in a secure and safe manner.
- All healthcare staff were trained in the Mental Health Act, 2001. Fire safety training was available weekly in Connolly hospital. All disciplines, excluding all consultant psychiatrists, had completed this training in fire safety. All staff had completed Basic Life Support training.

However:

- Not all staff had completed management of violence and aggression.
- Kitchen appliances in the kitchenette in Ash Ward required cleaning.

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:

- The occupational therapist (OT) ran occupational sessions based on assessed needs on a weekly basis. There was an exercise group facilitated by a fitness instructor, and a community resource group. Psychology ran a well-being group and also conducted individual sessions.
- A "MySpace" Room was available which a non-clinical, calm, comfortable space, designed and furnished in collaboration with service users.
- A "Looking Forward Group" was established to support individuals to plan meaningful activity for the future.
- A calming box created in High Dependency Unit (HDU) contained oils, scents, candles, facial masks, hand creams for massage, stress balls, colouring books, colours and relaxation scripts.

However:

- Not all residents had satisfactory care plans in place.
- Not all residents who had been in hospital for more than six months had adequate physical reviews.

Respect for residents' privacy, dignity and autonomy

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

- Resident accommodation on both Ash and Pine Wards consisted of a mix of three single rooms, two with en suite bathrooms, three double rooms, with ensuite bathrooms, and three four-bedded rooms.
- 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.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.

However:

- Two bedrooms in Ash Ward and three bedrooms in Pine Ward did not have blinds fitted on their external windows. All these bedrooms were overlooked by offices.
- There were marks on walls throughout the approved centre, all bathroom floors were marked, and external walls were heavily marked.
- Toilets and a toilet ceiling in Ash Ward required cleaning; blinds in the dining room in Ash Ward and kitchen appliances in the kitchenette in Ash Ward required cleaning.
- Bedrooms were not adequately ventilated as none of the bedroom windows could be opened.

- Communal rooms in Ash and Pine Ward were inadequately sized to accommodate the needs of the residents.

Responsiveness to residents' needs

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

- Recreational activities were provided by the nursing department and occupational therapist (OT). There was arts and crafts, game consoles, yoga via YouTube, TV, jigsaws, mindful colouring books, word wheels, and puzzles.
- 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

- The Dublin North City Mental Health Services (DNCMHS) Management Team were responsible for overall governance and operation of the Approved Centre with the exception of Estates/Fire Maintenance which was provided for by Connolly Hospital. The DNCMHS Management Team met on a monthly basis.
- The Quality and Patient Safety Committee (QPS) met monthly and Serious Reportable Events (SREs), Serious Incidents (SIs), Incident Reports and Organisational Risk Register were standing agenda items.
- Incidents are reviewed and escalated as appropriate.
- A newly formatted risk register was maintained within the approved centre.
- A monthly Quality and Safety Walk Round (QSWR) by the Assistant Director of Nursing or delegate had commenced since the last inspection and a quarterly QSWR held by Executive Clinical Director, Clinical Director, Area Director of Nursing, Service Manager and Quality Patient and Safety Advisor (QPSA) had also commenced.
- On-line risk management training for senior management and risk management training for staff within the approved centre facilitated by the QPSA had commenced.
- A programme of clinical audit was undertaken in the approved centre.
- The complaints, compliments, and feedback system was publicly displayed.
- A comprehensive maintenance audit was carried out and a number of issues had been addressed including facilitation of regular fire drills.
- A peer advocate attended the approved centre on a weekly basis. Community meetings had been held with the residents and staff representatives. Minutes of these meetings, along with follow up and outcomes had been recorded.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. "The Safety Pause" was introduced. This was a daily risk and safety handover process for the multi-disciplinary team, guided by the 4 P's Patients, Professionals, Processes and Patterns. It was a communication platform between the team members and included a discussion on patient feedback and team morale.

2. A psychiatric emergency "Grab bag" was introduced on each ward. In the event of a psychiatric emergency this bag was readily available to grab and respond as quickly as possible.

3. "MySpace" Room was opened. This was a non-clinical, calm, comfortable space, designed and furnished in collaboration with service users

4. A "Looking Forward Group" was established. The objective of this group was to support individuals to plan meaningful activity for the future.

5. Staff Reflective Practice group facilitated by psychology department commenced

6. A calming box created in High Dependency Unit (HDU) contained oils, scents, candles, facial masks, hand creams for massage, stress balls, colouring books, colours and relaxation scripts. This was used in HDU to reduce stress, tension and also boredom.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry (DOP) was located on the lower ground floor of Connolly Hospital in Blanchardstown. Entrance was from the ground floor via a staircase. The approved centre was part of the Dublin North City and County Healthcare Organisation and provided acute in-patient accommodation for the Dublin north city and county area. Nine consultant led teams based in four catchment areas in Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. Two rehabilitation teams and a team dealing with the homeless population also admitted to the centre.

The DOP comprised of a long reception corridor with adjacent offices, a tribunal room, and a family visiting room. Resident accommodation was on two wards, Ash Ward and Pine Ward, both located off the reception corridor. The Occupational Therapy Department was located through double doors at the end of the reception corridor. Both Ash and Pine Wards had accommodation for 21 residents each. A High Dependency Unit (HDU) with accommodation for up to five residents, which incorporated a seclusion room, was attached to Ash Ward. Entrance to HDU was via Ash Ward or through a separate external entrance. Resident accommodation on both Ash and Pine Wards consisted of a mix of three single rooms, two with en suite bathrooms, three double rooms, with ensuite bathrooms, and three four-bedded rooms. There was a large, paved courtyard with raised flower beds and colourful garden furniture which was used by both wards. The day rooms on both Ash and Pine Wards were small. A multi-purpose area at the entry point to the courtyard on Ash Ward and a newly created quiet room provided further communal space on Ash Ward.

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**47**
Number of detained patients	19
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	4
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The Dublin North City Mental Health Services (DNCMHS) Management Team were responsible for overall governance and operation of the approved centre with the exception of Estates/Fire Maintenance which was provided for by Connolly Hospital. The DNCMHS Management Team met on a monthly basis. Minutes evidenced strategic agenda items to include service planning, quality and patient safety, human resources, finance, communications, and regulation/compliance. All clinical heads of department were represented and meetings were chaired by Executive Clinical Director. Governance questionnaires were completed by the heads of discipline and returned to the inspection team. The inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to monitor goal progression

The Quality and Patient Safety Committee (QPS) met monthly and Serious Reportable Events (SREs), Serious Incidents (SIs), Incident Reports and Organisational Risk Register were standing agenda items. There were key personnel with responsibility for risk management working in the approved centre. The approved centre had a standardised process for the management of risks and incidents. Incidents are reviewed and escalated as appropriate. A newly formatted risk register was maintained within the approved centre. Risks associated with COVID-19, mandatory training, admissions of minors, and risks associated with staff shortages had been escalated to the organisational risk register. A monthly Quality and Safety Walk Round (QSWR) by the Assistant Director of Nursing or delegate had commenced since the last inspection and a quarterly QSWR held by Executive Clinical Director, Clinical Director, Area Director of Nursing, Service Manager and Quality Patient and Safety Advisor (QPSA) had also commenced. On-line risk management training for senior management and risk management training for staff within the approved centre facilitated by the QPSA had commenced.

An organisational chart identified the leadership and management structures and the lines of authority and accountability within the approved centre. Clinical supervision was provided to all clinical staff. At the time of inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. Two psychologists, 1.5 whole time equivalent (WTE) two occupational therapists and an occupational therapy assistant provided therapeutic services and programmes in the approved centre. Social workers provided services using the in-reach model. Retention of nursing staff was identified as a risk and escalated to head of service. Dietitian is no longer in post. This position had been advertised and a recruitment campaign continued. There was a referral system established to access a private dietitian.

All healthcare staff were trained in the Mental Health Act, 2001. Fire safety training had become more accessible to staff, with fire training available weekly in Connolly hospital. All disciplines, excluding all consultant psychiatrists had completed this training. Not all staff had completed Management of violence and aggression and all staff had completed Basic Life Support training.

There were a number of working committees that supported and enhanced continuous quality improvement. These included; Quality and Safety, Drugs and Therapeutics, Ethics Committee, Risk Management, Health and Safety, with a nominated health and safety representative, and Staff Health and Wellbeing.

A representative from the Peer Advocacy in Mental Health attended the approved centre on a weekly basis. The complaints, compliments, and feedback system was publicly displayed. Formal complaints were dealt with by a complaints officer not based in the approved centre but who attended approved centre on a regular basis. Community meetings had been held with the residents and staff representatives. This was a forum where residents made requests and suggestions. Minutes of these meetings, along with follow up and outcomes had been recorded.

A comprehensive maintenance audit was carried out and a number of issues had been addressed including facilitation of regular fire drills. There was a programme of works which included an upcoming carpentry project for the installation of new wardrobes throughout the department and the installation of new units in the kitchens and communal rooms. Refurbishment of floors had been rolled out in phases to minimise disruption. Refurbishment of floors in Ash Ward was completed. It was planned that refurbishment of floors in Pine would be completed by the end of 2022. Installation of new windows throughout the approved centre had moved to tender process. Painting had commenced with a plan for all painting to be completed by the end of 2022.

A COVID-19 Response Plan to help prevent the spread of the COVID-19 virus was reviewed on a regular basis by the senior management team and remained a standing item on management meeting agendas.

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 15: Individual Care Plan	✗	High	✗	High	✗	High	✓		✗	Moderate
Regulation 19: General Health	✗	High	✓	High	✗	High	✗	Critical	✗	Moderate
Regulation 21: Privacy	✗	Moderate	✗	High	✗	Moderate	✗	Moderate	✗	High
Regulation 22: Premises	✗	High	✗	Low	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✗	High	✗	Critical	✗	Low
Rules Governing the Use of Seclusion	✗	Critical	✗	Low	✗	Moderate	✗	Moderate	✗	Moderate
Code of Practice on Admission of Children	✗	Moderate	✗	Moderate	✗	Moderate	✗	High	✗	Moderate
Code of Practice on Admission, Discharge and Transfer	✗	Moderate	✗	Moderate	✗	High	✗	High	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. 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 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 residents spoke to the inspection team and overall had positive comments to make. The food was praised and residents reported there was a choice of food at mealtimes. One resident commented that they queued at mealtime and that the time spent queuing impacted on the remaining time available for their meal. The majority of residents said there were not enough activities offered to them. Residents said they knew their multi-disciplinary team and were involved in their care plan. Feedback in relation to staff was positive, with residents reporting that staff were approachable and residents felt that they could talk to staff and felt listened to. All residents were happy with their accommodation.

The inspection team also received two service user experience questionnaires. One questionnaire was not fully completed. On a scale of 1-10, with 1 being poor and 10 being excellent, the residents' rating for their overall experience of care and treatment was one and four. Comments included praise for the staff and for the food

5.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative. Resident feedback to the representative included that the majority of residents were happy with the care they received. Residents said they felt they were listened to and that their concerns are taken seriously. There were positive comments about the service residents received from their social workers and appreciation for the range of activities provided by occupational therapists.

Information was available on medication and on addiction services. Advocacy was welcomed by residents and staff. Some residents said they spent a long time in the approved centre because of a lack of suitable accommodation. Some residents reported they were not aware of their key nurse or care plan and other residents said they would not tell the doctor the full extent of their illness as they believe the doctor will only increase their medication as they believed there was an overreliance on medication to treat mental health illness. Other comments from residents to the advocate included a request that independent consultants provide notice of when they will be meeting the resident. Resident feedback also included a request for a more structured day. Further feedback from residents, admitted through Accident and Emergency, to the advocate was a request for a quiet waiting area as the general waiting area can be very distressing for them.

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
- Registered Proprietor
- Interim Head of Service
- Assistant Director of Nursing
- Clinical Nurse Manager III
- Area Director of Nursing
- Service Manager
- Principal Social Worker
- Occupational Therapy Manager
- Principal Psychology Manager
- Mental Health Act Administrator
- Quality and Patient Safety Advisor
- Clinical Nurse Manager II x2

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs.

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. A dietitian and speech and language therapist were accessible by referral.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans. No resident in the approved centre was prescribed to wear night clothes during the day at the time of inspection.

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 July 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Locked property rooms with individual storage boxes were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities were provided by the nursing department and occupational therapist (0T). Residents were directed to speak with staff if they wanted to request activities. The approved centre provided access to arts and crafts, game consoles, yoga via YouTube, TV, jigsaws, mindful colouring books, word wheels, and puzzles.

The approved centre provided access to recreational activities on weekdays and during the weekend. The OT department was open for the wards during the weekend.

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 had access to the hospital chaplain and their rights to practice religion were facilitated within the approved centre insofar as 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 policy and procedures in relation to visits. The policy was last reviewed in September 2020.

Visiting times were appropriate and reasonable. There were no visiting restrictions at the time of inspection. Appropriate steps were taken to ensure the safety of residents and visitors during visits. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. 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 policy and procedures in relation to communication. The policy was last reviewed in October 2021.

Residents in the approved centre had access to mail, e-mail, Internet, telephone, or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Residents had access to their own phones and devices, and portable phones were available for residents who did not have their own. Residents had access to Wi-Fi and computers which were located in the offices and Occupational Therapy (OT) room. Electronic tablets were made available to residents on all three wards.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

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 July 2020, 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. 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 which was last reviewed in May 2021, and a policy on the sudden death of residents which was last reviewed in March 2021.

As no resident had died in the approved centre since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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, which included specific space and sections 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.

Two ICPs inspected did not identify appropriate goals for the residents, as the goals recorded were vague and non-specific. Two ICPs did not identify sufficient care and treatment interventions to attain these goals. One ICP did not document all the required resources to support the identified goals. One ICP was not given a weekly review by the MDT on one specific occasion.

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

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

a) **Two individual care plans did not identify appropriate goals.**
b) **Two individual care plans did not identify care and treatment required to achieve these goals.**
c) **One individual care plan did not contain all the required resources to support the goals identified.**
d) **One individual care plan was not given a weekly review by the multi-disciplinary team on one specific occasion.**

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 occupational therapist (OT) ran occupational sessions based on assessed needs on a weekly basis, including an occupational-based group in the High Dependency Unit on Tuesdays, and an occupational recovery group on Wednesdays. There was an exercise group facilitated by a fitness instructor on Thursdays, and a community resource group on Fridays based on assessed needs. Psychology ran a well-being group and also conducted individual sessions.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Group programmes were reviewed and evaluated periodically, dependent on the needs of a resident at the time of admission.

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 March 2021. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which was last reviewed in May 2021, and a medical emergencies policy which was last reviewed in November 2020. The approved centre had two emergency trolleys and two Automated External Defibrillators (AEDs) which staff had access to at all times. Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Four clinical files of residents who had been in the approved centre for more than six months were inspected. Six-monthly assessments for the four residents had been completed. The six-monthly general health assessments documented a physical examination, blood pressure, and smoking status. However, family history was not completed on the six-monthly general health assessment of two residents; body mass-index was not recorded on the six-monthly general health assessment of two residents; nutritional status was not recorded on the six-monthly general health assessment of one resident and dental health was not recorded on the six-monthly general health assessment of one resident. Medication review was not recorded on the six-monthly general assessment form of one resident. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

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

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

a) **The approved centre did not access each resident's general health needs at minimum every six months, as family history was not completed on the six-monthly assessment of two residents, 19(1)(b).**
b) **The approved centre did not access each resident's general health needs at minimum every six months, as body mass-index was not recorded on the six-monthly assessment of two residents, 19(1)(b).**
c) **The approved centre did not access each resident's general health needs at minimum every six months, as nutritional status was not recorded on the six-monthly assessment of one resident, 19(1)(b).**
d) **The approved centre did not access each resident's general health needs at minimum every six months, as dental health was not recorded on the six-monthly physical assessment of one resident, 19(1)(b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in July 2020.

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

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights, and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

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. Residents had access to interpretation and translation as required. Translation services were available in the approved centre via a translation agency, with details on the notice boards in the three wards.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

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. Staff sought the resident's permission before entering their room, as appropriate.

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. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

Some rooms in the approved centre were overlooked by public areas: two bedrooms in Ash Ward and three bedrooms in Pine Ward did not have blinds fitted on their external windows. All these bedrooms were overlooked by offices. One bedroom had opaque glass and the other four had privacy curtains around the beds.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity were appropriately respected at all times: two bedrooms in Ash Ward and three bedrooms in Pine Ward which were overlooked by public areas had blinds missing from their external windows.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space. The communal rooms in both Ash and Pine Wards were not adequately sized to accommodate the needs of the residents. Rooms were not ventilated, as none of the bedroom windows in the approved centre could be opened. All private 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. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in good a state of repair externally and internally. All walls in the approved centre required painting, which had commenced. External walls required a power washing and were heavily marked. All the bathroom floors in the approved centre were heavily marked.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was not clean and hygienic, however, was free from offensive odours. Toilets and a toilet ceiling in Ash Ward required cleaning. Blinds in the dining room in Ash Ward and kitchen appliances in the kitchenette in Ash Ward required cleaning.

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 were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

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

a) **The approved centre was not kept in a good state of repair externally and internally: there were marks on walls throughout the approved centre, all bathroom floors were marked, and external walls were heavily marked, 22(1)(a).**
b) **The approved centre was not clean and hygienic, however, was free from offensive odours. Toilets and a toilet ceiling in Ash Ward required cleaning; blinds in the dining room in Ash Ward and kitchen appliances in the kitchenette in Ash Ward required cleaning, 22(1)(a).**
c) **Bedrooms in the approved centre were not adequately ventilated as none of the bedroom windows could be opened, 22(1)(b).**
d) **Communal rooms in Ash and Pine Ward were inadequately sized to accommodate the needs of the residents, 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 2020, 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; the frequency of administration (including the minimum dose interval for PRN 'as required' medications); a record of all medications administered to the resident; a clear record of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible and contained the signature of the medical practitioner for each entry. 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. No medications were withheld and there were no directions to crush resident medication in the ten MPARs reviewed.

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 other medications 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 November 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating LOW

(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 April 2021, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre were sufficient to meet resident needs. The approved centre had nine multi-disciplinary teams. Two psychologists, 1.5 whole time equivalent (WTE) two occupational therapists and an occupational therapy assistant provided therapeutic services and programmes in the approved centre. Social workers provided services using the in-reach model. An appropriately qualified nurse was on duty and in charge at all times.

All healthcare staff were trained in Basic Life Support and the Mental Health Act 2001. Not all healthcare staff were trained in Fire Safety and the Management of Violence and Aggression. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. See the table below for a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (49)	49	100%	48	98%	40	90%	49	100%
Consultant Psychiatrist (9)	9	100%	7	77%	7	77%	9	100%

Medical (18)	18	100%	18	100%	18	100%	18	100%
Occupational Therapist (3)	3	100%	3	100%	3	100%	3	100%
Social Worker (10)	10	100%	10	100%	10	100%	10	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all staff received education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all healthcare staff had completed mandatory training in Fire Safety and the Management of Violence and Aggression, 26(4).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had 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 January 2021, and included the following:

- 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. A teleconference system was set up in the tribunal room to access the Mental Health Tribunals remotely where 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 in May 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 complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints 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 could 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 complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had an Incident Reporting and Management Policy (last reviewed in May 2021), a Clinical Risk Assessment and Management Policy (last reviewed in October 2020), and an Additional Risk Management Procedures Policy (last reviewed in October 2021). Together, these policies incorporated all the policy requirements for this regulation, including:

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

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

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

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission. 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

An up-to-date certificate of registration, with two conditions to registration attached, 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

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

The policy addressed the following:

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

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

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

Evidence of Implementation: Seclusion facilities were furnished and maintained to ensure respect for resident dignity and privacy, as far as practicable. 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 were 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 and/or a registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion. The seclusion orders did not last

longer than eight hours and the residents were informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion, unless it was detrimental to them. The residents were informed of the ending of an episode of seclusion. Residents' rights to dignity, bodily integrity, and privacy were respected. Cultural awareness and gender sensitivity was demonstrated. Where appropriate, the resident's next of kin or representative was informed of the use of seclusion.

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

The seclusion episodes were recorded in the clinical files and seclusion register by the person who initiated seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of each episode. A copy of the seclusion register was placed in the clinical files. One of the three episodes of seclusion was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days of the episode.

The approved centre was non-compliant with this rule because one of the three episodes of seclusion inspected was not reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days of the episode, 10.3.

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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 last reviewed in July 2020. 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.

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 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. 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. There was evidence that the residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

Where appropriate, the resident's next of kin or representative was informed of the use of physical restraint, and this was recorded 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 an opportunity to discuss the episode with members of the multi-disciplinary team involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical files no later than two working days after each episode.

The approved centre was compliant with this code of practice.

Admission of Children

NON-COMPLIANT

Risk Rating MODERATE

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 January 2022. 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: The clinical files of five children who had been admitted to the approved centre were examined on inspection. As the approved centre was not a dedicated Child and Adolescent facility, age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. Provisions were in place to ensure the safety of the children, respond to the children's special needs as young people in an adult setting, and ensure the right of the children to have their views heard.

Staff having contact with the children had undergone Garda vetting, and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Staff observation acknowledged gender sensitivity, and appropriate accommodation was designated, including age- and gender-segregated sleeping and bathroom areas.

Children had access to age-appropriate advocacy services. There was an agreement between YAP (Youth Advocacy Programmes) Ireland and Dublin North City Mental Health Services to provide independent advocacy services should a child or young person request them. Staff in the approved centre notified YAP Ireland when a child had been admitted to the unit. On admission, the child and their parent or guardian were given an information pack, detailing information about the service. Where a young person required consultation with the advocate, an appointment was set up with the support of the staff.

The children have their rights explained and information about the ward and facilities were provided in a form and language they could understand. The child's understanding of the explanation given 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. Consent for treatment was obtained from one or both parents of the children.

The Mental Health Commission was not notified of the admission of one of the five children within 72 hours.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5(b).

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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 November 2020, included all of the policy-related criteria for this code of practice.

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

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

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and other risks, and documented communications with the relevant general healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

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 relevant healthcare provider within three days. A documented comprehensive discharge summary was not present in the clinical file, and hence no comprehensive discharge summary was sent to the relevant healthcare provider within 14 days.

The preliminary discharge summary included details of the following: diagnosis, medication, and follow-up arrangements. The preliminary summary did not include the following: prognosis, mental state at discharge, outstanding health or social issues, risk issues, and names and contact details of key people to follow up. Family members, carers or advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **A documented comprehensive discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within 14 days, 38.3(b).**
b) **The preliminary discharge summary that was sent within three days did not include the following: prognosis, mental state at discharge, outstanding health or social issues, risk issues, and names and contact details of key people to follow up, 38.4.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan	
Reason ID : 10003442	**Two individual care plans did not identify appropriate goals.**
The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.	

Regulation 19: General Health					
Reason ID : 10003458		**The approved centre did not access each resident's general health needs at minimum every six months, as family history was not completed on the six-monthly assessment of two residents, 19(1)(b). The approved centre did not access each resident's general health needs at minimum every six months, as body mass-index was not recorded on the six-monthly assessment of two residents, 19(1)(b). The approved centre did not access each resident's general health needs at minimum every six months, as nutritional status was not recorded on the six-monthly assessment of one resident, 19(1)(b). The approved centre did not access each resident's general health needs at minimum every six months, as dental health was not recorded on the six-monthly physical assessment of one resident, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure all areas of the 6 Month Physical Examination document is completed by medical registered practitioner.	Audit and Education	Achievable	01/03/2023	Registered Proprietor
Preventative Action	To provide Education to medical practitioners on completing the 6 monthly physical examination document.	Audit and Education	Achievable	01/03/2023	Registered Proprietor

Regulation 21: Privacy					
Reason ID : 10003455		**The registered proprietor did not ensure that the resident's privacy and dignity were appropriately respected at all times: two bedrooms in Ash Ward and three bedrooms in Pine Ward which were overlooked by public areas had blinds missing from their external windows.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Since last inspection all external windows have blinds in situ.	Audit of Privacy regulation/ ongoing maintenance checks.	Achievable	01/12/2022	Registered Proprietor
Preventative Action	To ensure that all external windows have adequate covering to ensure the regulation of Privacy is maintained.	Audit of privacy regulation. maintenance checks.	Achievable	01/12/2022	Registered Proprietor
Reason ID : 10003456		**The registered proprietor did not ensure that resident's privacy and dignity was respected at all times as the noticeboard on Ash Ward containing full names of residents was viewable from the office door and window, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff working in the Department of Psychiatry are aware of their GDPR obligations to uphold the privacy of residents in the approved centre. Since the MHC inspection the Windows to the "Nurses Station" have been updated	Reviewed in monthly and Quarterly Quality and Safety walk round & updated to the DOP Compliance and Policy Committee	Achieved	02/11/2021	DNC Service Manager, Nurse Management, Department of Psychiatry Policy and Compliance Committee members

	with semi-transparent material and the notice boards are no longer being visible from the door and window.				
Preventative Action	Ongoing review of privacy of residents personal data as part of Monthly and Quarterly Quality and Safety Walk rounds with updated report to the DOP Policy and Compliance Committee	Assessed at the monthly and quarterly quality and safety walk arounds and documented	Achievable and Realistic.	02/11/2021	DOP Compliance and Policy Committee members

Regulation 22: Premises					
Reason ID : 10003446		**The approved centre was not kept in a good state of repair externally and internally: there were marks on walls throughout the approved centre, all bathroom floors were marked, and external walls were heavily marked, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All upgrade works are now completed including painting of all interiors throughout the approved centre. Floor coverings replaced throughout. Power washing of external walls in the central courtyard. Bathrooms due for completion in final phase of DOP upgrade.	Audit of Premises.	Achievable	01/09/2023	Registered Proprietor
Preventative Action	To ensure DOP is kept in a good state of repair.	Audit of Premises.	Achievable	01/09/2023	Registered Proprietor
Reason ID : 10003447		**The approved centre was not clean, hygienic, and free from offensive odours: toilets and a toilet ceiling in Ash Ward required cleaning; blinds in the dining room in Ash Ward and kitchen alliances in the kitchenette in Ash Ward required cleaning, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure that the approved centre is clean and kept in a good state of cleanliness. Ongoing	Hygiene and Infection control Audits.	Achievable Realistic	01/09/2023	Registered Proprietor.

	meetings with Cleaning providers to address any deficits that were found. Bathrooms due for upgrade in final phase.				
Preventative Action	To Ensure that the approved centre is clean and kept in a good state of cleanliness. Continue auditing process by cleaning providers and local management.	Infection control and hygiene Audit	Achievable	01/09/2023	Registered Proprietor
Reason ID : 10003448		**Bedrooms in the approved centre were not adequately ventilated as none of the bedroom windows could be opened, 22(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Windows are scheduled for upgrade in quarter 4 of this year.	Premises Audit	Achievable	01/12/2023	Registered Proprietor
Preventative Action	To ensure that the approved centres windows provide sufficient ventilation.	Audit to be completed on premises regulation.	achievable	01/12/2023	Registered Proprietor
Reason ID : 10003449		**Communal rooms in Ash and Pine Ward were inadequately sized to accommodate the needs of the residents, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Discussions to take place on how best to utilize communal	Audit of Premises regulation.	Achievable	01/09/2023	Registered Proprietor

	space available for residents within the approved centre. To ensure that adequate furniture is provided to enhance current space available.				
Preventative Action	Continuing discussions around the use of communal space for residents in the approved centre and ensure that adequate furniture is in situ to the space that is already available.	Audit of Premises regulation.	Achievalbe	01/09/2023	Registered Proprietor.
Reason ID : 10003450		**The approved centre was not maintained in a good structural and decorative condition. Floorings were marked, several walls had chipped paint, and some toilets were heavily stained, 22 (1, a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	CHODNCC Chief Assistant Technical Services Officer confirmed that the approved centre is maintained in good structural condition. Ongoing funding continues to be approved for the annual decorative maintenance,	Monthly and Quarterly Quality and Safety Walk rounds and documented	Achievable and Realistic	31/12/2021	Service Manager Dublin North City Mental Health Services, Technical Services Manager, Connolly Hospital and HSE CHODNCC Chief Assistant Technical Services Officer

	Painting and refurbishing of the approved center. This programme of work is underway and will be completed by December 2021. Staff in the Department have met with Connolly Hospital Technical Services and have identified the cause of staining of the toilet is a by-product of Connolly Hospital's wider infection and prevention control regimen for legionella is feature of good maintenance and not attributed to any deficit in the Approved Centre's cleaning programme.				
Preventative Action	There is approved annual funding for decorative maintenance and refurbishments of	Monthly and Quarterly Quality and Safety Walk round.	Achievable and Realistic	31/12/2021	Service Manager Dublin North City, Connolly Hospital Technical Services, CHODNCC Chief Assistant Technical Services Officer, ECD, CD, HQSSI, Estates/Maintenance

	the Department of Psychiatry. A Programme of painting, flooring and other refurbishments will be completed by December 2021. The Dublin North City Service Manager meets with Nurse Management on a monthly basis to review minor works required and escalates funding requirement for same. A Quarterly Executive Quality and Safety Walk round by the ECD, ADON, Head of Quality and Service Improvement, Estates Lead will supplement the Monthly walk round and will be documented,. The CHODNCC Head of QSSI has developed updated draft checklist that will be				

	updated as we progress to support the QSWRs scheduled for 15th November 2021				
Reason ID : 10003451		**The approved centre did not have adequate and suitable furnishings having regard to the number and mix of residents in the approved centre. Some bedrooms within the approved centre were either missing or had broken blinds, 22 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	In response to COVID 19 guidance, suitable furnishings have had to be adapted to ensure social distancing in communal areas and consultancy received from the CHODNCC Infection Prevention Control Team in this regard. The Dublin North City Service Manager has a process in place for replacement of missing and broken blinds and is ongoing. All blinds have been replaced in the approved centre and new furniture has also been ordered.	Monthly and Quarterly Quality and Safety Walk Rounds will be documented	Achievable and Realistic	31/12/2021	DNC MH Service Manager, Nurse Management, DNC MH Management Team

Preventative Action	Monthly Quality and Safety Walk checklists have been developed to assist nurse management with prompts for the identification of refurbishment matters. The Service Manager Dublin North City meets with Nurse Management on monthly basis.	Monthly Quality and Safety Walk round updates provided to the Service Manager, Dublin North City and DNC Management Team and supplemented by the Quarterly Executive Quality and Safety Walk rounds	Achievable and Realistic	31/12/2021	Service Manager, DNCMHS, Nurse Management, Dublin North City Management Team
Reason ID : 10003452		**The rooms within the approved centre's premises were not adequately ventilated. The windows within rooms of the approved centre were locked or bolted and it was not possible to open the windows, 22 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Funding has been secured and a design team has been appointed for tender for alternative windows for the Department. Ventilation of Unit will be incorporated into the design.	For focus at Monthly and Quarterly Quality and Safety Walk rounds and will be documented	Achievable and Realistic, however, may be subject to COVID challenges	31/12/2021	Service Manager Dublin North City, DNCMHS Management team and HSE Estates.
Preventative Action	Funding has been secured and a design team has been appointed to scope alternative windows for the	Focus at Monthly, Quarterly Quality and Safety Walk round and will be documented	Achievable and Realistic however, may be subject to COVID 19 challenges	31/12/2021	Service Manager, Dublin North City, DOP Managers, DNC MHS Management Team

	Department. Ventilation of Unit will be incorporated into the design. Service Manager Dublin North City has lead meetings with CHODNCC Estates, ECD, CD, ADON and DOP Managers to inform the specifications for the tender.				
Reason ID : 10003453		**All ligature points where not minimised to the lowest practicable level based on risk assessment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Ligature points identified at time of inspection and associated with bin with broken cover and Covid bins with elastic were removed from the approved centre after the inspection	Ligature Audit using validated audit tool and supplemented with Monthly and Quarterly Safety walk rounds	Achievable and Realistic	13/07/2021	DNC Service Manager, DOP Nurse Management, DNC MHS Management team
Preventative Action	Ligature points identified either during the normal course of day or at time of Audits and supplemented with observations by DOP Nurse management on the	Annual Audit and Monthly Quality and Safety Walk round.	Achievable and Realistic	02/11/2021	DNC Service Manager, Technical Services Manager, Connolly Hospital, Dublin North City Management Team

	monthly Quality and Safety Walk rounds. The Department of Psychiatry has been confirmed for the pilot of the HSE National Ligature Risk Reduction Policy and Audit Tool. Nurse Management linking with national Lead. The MHC Compliance Network Event for all Approved Centres, on 4th December 2021 will include presentation of the HSE National Ligature Risk Reduction policy and Audit Tool.				
Reason ID : 10003454		**Communal rooms on Ash and Pine Ward were inadequately sized to accommodate the needs of its residents, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Approved Centre does not and has never received complaints from residents in relation to their needs not being met due to	Monthly Quality and Safety Walk rounds, Community monthly meetings with residents, Advocacy	Achievable and Realistic	02/11/2021	Nurse Management, all MDT members, Advocacy

	the size of the communal rooms on Ash or Pine Ward. Multiple activities are provided on ward for residents across various sites within the unit, to ensure that residents have adequate level of access to activities of their choice. Due to the design of the approved there is no single large communal room that can safely hold all residents simultaneously. To mitigate this, activities are provided across a number of rooms in the approved centre and an additional room has been made available for communal activities.				
Preventative Action	Will be area of ongoing focus - there are multiple activities provided on ward for	Monthly Quality and Safety Walk round, monthly meeting with residents, Advocacy	Achievable and realistic	02/11/2021	Nurse Management, all MDT members

	residents at simultaneous times to address the residents' needs across various sites within the approved centre. There will be sufficient chairs provided for residents across across a number of rooms to compensate for the lack of one single large communal room.				

Regulation 26: Staffing					
Reason ID : 10003457		**The registered proprietor did not ensure that all staff received education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all healthcare staff had completed mandatory training in Fire Safety and the Management of Violence and Aggression, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure all staff receive education and training in Fire safety and the Management of Violence and Aggression.	Audit of Mandatory training.	Achievable	01/09/2023	Registered Proprietor
Preventative Action	Ensure all staff attend fire safety training and management of Violence and Aggression within the specific time frames.	Audit of Mandatory training	Achievable	01/09/2023	Registered Proprietor

Rules Governing the Use of Seclusion					
Reason ID : 10003428		**One of the three episodes of seclusion inspected was not reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days of the episode, 10.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure that all episodes of seclusion are reviewed by members of the MDT within the time frame outlined by the changes in the new codes and rules of practice surrounding seclusion and documented in the clinical file.	Monthly Seclusion Audit.	Achievable	01/01/2023	Registered proprietor
Preventative Action	To ensure that all episodes of seclusion are reviewed by members of the MDT within the time frame outlined by the changes in the new codes and rules of practice surrounding seclusion and documented in the clinical file.	Monthly Seclusion Audits.	Achievable	01/01/2023	Register Proprietor
Reason ID : 10003429		**There was no documentary evidence that a consultant psychiatrist was notified as soon as was practicable of the use of seclusion in two episodes, 3.2.The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours in one episode of seclusion, 3.5. A copy of the seclusion register was not placed in the clinical file in**			

		one episode of seclusion, 9.3. A reason was not recorded in the clinical file as to why one resident's next of kin or representative was not informed of the use of seclusion, A medical review by a registered medical practitioner was not completed every four hours in one episode of seclusion examined, 5.4.3.7(a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	WIll retrospecitively file the copy of the seculsion register in relevant patient's medical notes. All staff in High Dependence Unit to receive training on the policy relating to the use of Seclusion and confirm the correct processes to be followed before; during and after.	Completion of filing and training is measurable.	Achievable	30/11/2020	Clinical Director; Nursing Management and Compliance and Policy Committee.
Preventative Action	All new staff to the Department are to recieve training on the policy on Seclusion and will sign that training has been completed as part of induction. Training on Seclusion rules to be organised on rolling basis by managment and available to attend by all staff in Approved Centre. New paper	Audit of Seclusions to be performed on six monthly basis.	Achievable and Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Nursing Management; Complinace and Policy Committee.

	work to be introuced (Care Bundle) which is a sticker based checklist that ocvers all procedures of seclusion rules. This will be introduced by management to the Approved Centre in January 2021 and encourage better compliance with rules as outlined by MHC.				
Reason ID : 10003434		**There was no written record that staff had read and understood the policy relating to the use of seclusion, 10.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to recieve policy with method of recording that they have read policy. This may need to be an on-line method due to COVID19 restrictions.	To be monitored by Compliance and Policy Committee	Achievable and Realistic (COVID 19 Restrictions Dependent)	31/10/2020	Clinical Director; Head of Disciplines; Compliance Committee.
Preventative Action	All staff to recieve policy with method of recording that they have read policy. This may need to be an on-line method due to COVID19 restrictions. Policy to be included in	To be monitored by Compliance and Policy Committee	Achievable and Realistic (COVID 19 Restrictions Dependent)	31/12/2020	Clinical Director; Head of Disciplines; Compliance Committee.

	induction process for all new staff in unit.				
Reason ID : 10003435		**This episode of seclusion was not reviewed by members of the multi-disciplinary team (MDT) and documented in the clinical file within two working days after the episode of seclusion, 10.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion is used in rare and exceptional circumstances where the resident posed an immediate and serious harm to self or others and only implemented in the residents best interests. This episode of seclusion was not reviewed by members of the MDT and documented in the clinical file within two working days after the episode of seclusion. This is an individual time based incident thus was not correctable within the timeframe stipulated and will be area of focus.	Monthly Audits of seclusion being conducted	Achievable	02/11/2021	Clinical Director and all healthcare professionals involved in the use of seclusion, Department of Psychiatry Compliance and Policy Committee members
Preventative Action	Regular education/training programme for all staff involved in seclusion regarding	Monthly Audits of Seclusions preformed as part of routine Audits. Audit results are reported to the	Achievable and Realistic	02/11/2021	Clinical Director and all Healthcare professionals involved in seclusion, Department of Psychiatry Compliance

	upholding compliance with seclusion rules. Training on the use of physical restraint and procedures in relation to the use of seclusion was provided to staff in the Department of Psychiatry on the 15th of October 2021. Training in legal documentation and restrictive practice training was provided to staff in the DOP on the 19th and 27th of October 2021. This training will be provided on a rolling basis. Rules on Seclusion and Physical restraint is included in induction programme for medical staff on a 6 monthly rotation. The Seclusion Care Care plan includes a prompt for staff involved in seclusion to ensure completion of statutory bodily	Department of Compliance and Policy Committee			and Policy Committee members

	restraint and seclusion provisions of Section 69 of the Mental Health Act 2001.				
Reason ID : 10003436		**There was no documentary evidence that a consultant psychiatrist was notified as soon as was practicable of the use of seclusion in two episodes, 3.2.The seclusion register was not signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours in one episode of seclusion, 3.5. A copy of the seclusion register was not placed in the clinical file in one episode of seclusion, 9.3. A reason was not recorded in the clinical file as to why one resident's next of kin or representative was not informed of the use of seclusion, A medical review by a registered medical practitioner was not completed every four hours in one episode of seclusion examined, 5.4.3.7(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	WIll retrospecitively file the copy of the seculsion register in relevant patient's medical notes. All staff in High Dependence Unit to receive training on the policy relating to the use of Seclusion and confirm the correct processes to be followed before; during and after.	Completion of filing and training is measurable.	Achievable	30/11/2020	Clinical Director; Nursing Management and Compliance and Policy Committee.
Preventative Action	All new staff to the Department are to recieve training on the policy on Seclusion and will sign that training has	Audit of Seclusions to be performed on six monthly basis.	Achievable and Realistic (COVID19 restrictions dependent)	31/12/2020	Clinical Director; Nursing Management; Complinace and Policy Committee.

	been completed as part of induction. Training on Seclusion rules to be organised on rolling basis by managment and available to attend by all staff in Approved Centre. New paper work to be introuced (Care Bundle) which is a sticker based checklist that ocvers all procedures of seclusion rules. This will be introduced by management to the Approved Centre in January 2021 and encourage better compliance with rules as outlined by MHC.				
Reason ID : 10003441		**There was no written record that staff had read and understood the policy relating to the use of seclusion, 10.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to recieve policy with method of recording that they have read policy. This may need to be an on-line method due to COVID19 restrictions.	To be monitored by Compliance and Policy Committee	Achievable and Realistic (COVID 19 Restrictions Dependent)	31/10/2020	Clinical Director; Head of Disciplines; Compliance Committee.

Preventative Action	All staff to recieve policy with method of recording that they have read policy. This may need to be an on-line method due to COVID19 restrictions. Policy to be included in induction process for all new staff in unit.	To be monitored by Compliance and Policy Committee	Achievable and Realistic (COVID 19 Restrictions Dependent)	31/12/2020	Clinical Director; Head of Disciplines; Compliance Committee.

Code of Practice Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10003421		**Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure each minor admitted to the approved centre are individually assessed to determine age appropriate needs are met by MDT where possible.	Review of each minor admission	Achievable	01/12/2022	Registered Proprietor
Preventative Action	To ensure each minor admitted to the approved center are individually assessed to determine age appropriate needs are met by MDT where possible	Review of each minor admission	Achievable	01/12/2022	Registered Proprietor
Reason ID : 10003422		**Children did not have access to age-appropriate advocacy services, 2.5(g)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Issue previously discussed at Compliance and Policy Committee and was unable to identify approrpiate agencies. Compliance Committee will again explre options available. Policy of unit is that children	Reviewed by Compliance and Policy Committee.	Unrealistic and unachieveable. Likely that appropriate advocacy services will only be identied at the time of a prolonged admission of a child.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	are admitted for a brief time when unavoidable and awaiting transfer to apprpriate unit. Services are only able to be identified when there is aprolonged admission and this is tailored to the needs to the particular circumstances.				
Preventative Action	Compliance and Policy Committee will attempt to identify agency that will provide advocacy services.	To be reviewed by Compliance & Policy Committee	Unrealistic. As admission of a child has been an unusual event it is unlikely any advocacy service will provide input on regular basis. Likely that advocacy services will only be engaged at time of prolonged admission.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10003423		**Age-appropriate facilities and a programme of activities appropriate to age and ability of children admitted to the approved centre were not provided, 2.5(b)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Age apropriate facilites are to be provided to children on an individual basis as admission of a child is an unusual event. Policy of unit is that admission of a child is only when no other option is necessary and the	To be reveiwed by Compliance & Policy Committee.	Achievable & Realistic (Pending COVID19 restrictions) to have policy on sorcing appropriate facilites at time of prolonged admission of child.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	admission is only pending transfer to appropriate unit.				
Preventative Action	Age apropriate facilites are to be provided to children on an individual basis as admission of a child is an unusual event. Policy of unit is that admission of a child is only when no other option is necessary and the admission is only pending transfer to appropriate unit.	To be reveiwed by Compliance & Policy Committee.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10003424		**Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Department of Psychiatry is an Adult facility and only admits a child in exceptional and extenuating circumstances. Policies and procedures are in place regarding family liaison, parental consent and notification to the Mental Health	Individual Care Plan for each child and audit of ICPs by the Multi Disciplinary Team, Occupational Therapy, Social Work, Nursing and Medical staff on weekly basis.	Achievable and realistic.	02/11/2021	Clinical Director; Occupational Therapy

	Commission. When a child is admitted, age appropriate activities are available from the Occupational Therapy Department specific to the needs of the individual child. Provisions are made to ensure the safety of the child and to respond to the child's needs and ability.				
Preventative Action	The Department of Psychiatry does not routinely admit children expect in extreme circumstances. In the circumstances where child is admitted, age appropriate activities are sourced at the time specific to the needs of the individual patient. Age appropriate activity packs are available in the Occupational Therapy Department.	Individual Care Planning for child and audit of ICPs by the MDT on weekly basis	Achievable and realistic.	02/11/2021	Clinical Director; Occupational Therapy Department, Multi Disciplinary Team
Reason ID : 10003425		**Children did not have access to age-appropriate advocacy services, 2.5(g).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

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

	services for young people admitted to the Department of Psychiatry.				
Reason ID : 10003426		**Children did not have access to age-appropriate advocacy services, 2.5(g)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Issue previously discussed at Compliance and Policy Committee and was unable to identify apprporpiate agencies. Compliance Committee will again explre options available. Policy of unit is that children are admitted for a brief time when unavoidable and awaiting transfer to apprpriate unit. Services are only able to be identified when there is aprolonged admission and this is tailored to the needs to the particular circumstances.	Reviewed by Compliance and Policy Committee.	Unrealistic and unachieveable. Likely that appropriate advocacy services will only be identied at the time of a prolonged admission of a child.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Compliance and Policy Committee will attempt to identify agency that will	To be reviewed by Compliance & Policy Committee	Unrealistic. As admission of a child has been an unusual event it is unlikely any advocacy service will provide input on regular basis. Likely	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

	provide advocacy services.		that advocacy services will only be engaged at time of prolonged admission.		
Reason ID : 10003427		**Age-appropriate facilities and a programme of activities appropriate to age and ability of children admitted to the approved centre were not provided, 2.5(b)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Age apropriate facilites are to be provided to children on an individual basis as admission of a child is an unusual event. Policy of unit is that admission of a child is only when no other option is necessary and the admission is only pending transfer to appropriate unit.	To be reveiwed by Compliance & Policy Committee.	Achievable & Realistic (Pending COVID19 restrictions) to have policy on sorcing appropriate facilites at time of prolonged admission of child.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Age apropriate facilites are to be provided to children on an individual basis as admission of a child is an unusual event. Policy of unit is that admission of a child is only when no other option is necessary and the admission is only pending transfer to appropriate unit.	To be reveiwed by Compliance & Policy Committee.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10003407		**A documented comprehensive discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within 14 days, 38.3(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure that a comprehensive discharge summary is completed and present in the residents clinical file and a copy sent to the relevant health care provider within 14 days.	Audit of Admission/Discharge and transfer regulation.	Achievable	01/12/2022	Registered Proprietor
Preventative Action	To ensure that a comprehensive discharge summary is completed and present in the residents clinical file and a copy sent to the relevant health care provider within 14 days	Audit of Admission/Discharge and Transfer	Achievable	01/12/2022	Registered Proprietor
Reason ID : 10003408		**The preliminary discharge summary that was sent within three days did not include the following: prognosis, mental state at discharge, outstanding health or social issues, risk issues, and names and contact details of key people to follow up, 38.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	For Preliminary discharge summary to include Prognosis, mental state at discharge, outstanding health or social issues, risk issues and names and contact details of key follow up are completed.	Audit of Admission/Discharge and Transfer Regulation.	Achievable	01/12/2022	Registered Proprietor
Preventative Action	For Preliminary discharge summary to include Prognosis, mental state at	Audit of Admission/Discharge	Achievable	01/12/2022	Registered Proprietor

	discharge, outstanding health or social issues, risk issues and names and contact details of key follow up are completed as outlined in current Preliminary discharge document.	and Transfer regulation.			
Reason ID : 10003409		**One discharge did not include a documented discharge meeting attended by the resident, key worker and a family member, carer, or advocate, 34.4. The discharge plan for one resident did not include a reference to early warning signs of relapse and risks, 34.2. One discharge did not include a comprehensive discharge summary issued within 14 days, 38.3(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Once file identifier recieved the Service will to retrieve patient file the subject of the breach of discharge policy and inform treating team of same. Will urgently assess and ensure the team has retrospectively corrected deficit and if not, completed to date, will advise on way to remedy deficit and ensure learning. Would be grateful for File Identifier to inform this process.	QPS Committee	Once File identified will be implemented in full asap	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee; Responsible Consultant Psychiatrist.
Preventative Action	Audit on the implementation of and adherence to the dicharge Policy to be conducted on a six monthly basis. Audit results will be relayed to the teams on areas of non-compliance.	Six monthly Audit of policy.	Achievable & Realistic	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

Reason ID : 10003412		There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies, 9.1.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to be circulated Admission, Transfer and Discharge policy document with sign-in sheet to indicate that they understand same.	Audit of Policy signing logs to be done annually.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Heads of Disciplines; Compliance & Policy Committee.
Preventative Action	All staff to be circulated Admission, Transfer and Discharge olicy document with sign-in sheet. All new staff at induction to be circulated wtih all policies and sign-in sheet.	Audit of Policy signing sheets and logs to be done annually.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Heads of Disciplines; Compliance & Policy Committee.
Reason ID : 10003413		**There was no audit of the implementation of and adherence to the discharge policy, 4.19.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Audits of the implementaiton of and adherence to the Discharge Policy to completed on next Audit cycle (end of month) subject to COVID19 restrictions.	Audits reviewed by Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Updated note: Audits were suspended subsequent to Infection Prevention Control risk assessnent due to requirement to reduce footfall and mimismise numbers of staff handling charts at the Approved Centre.	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Preventative Action	Audit on Admission/Discharge/Transfer Policy to be included in six Monthly Audit cycle.	Audits reported to Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Note: Audits were suspended as an infection risk during	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

			maximum retriction level due to attempts to reduce number of people ahndling charts and reduced footfall into Approved Centre)		
Reason ID : 10003414		**A documented preliminary discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within three days because it did not exist, 38.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Clinical files for residents contain completed discharge summaries.	Audit of discharges completed in adherence to the DOP Discharge Policy.	Achievable	02/08/2021	Clinical Director, Responsible Treating Consultant Psychiatrists and Mental Health Act Administrator
Preventative Action	Mental Health Act Administrator will keep an administrative record of discharge summaries, send reminders to teams to complete discharge summaries to the relevant healthcare providers within two weeks of discharge and provide update to the Clinical Director.	Regular audit of Discharge Summaries & Register.	Achievable and Realistic	02/11/2021	Clinical Director, Responsible Treating Consultant and Mental Health Act Administrator
Reason ID : 10003415		**A documented comprehensive discharge summary was not present in the clinical file, and it was therefore not sent to the relevant healthcare provider within fourteen days because it did not exist, 38.3 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All discharge summaries completed and present in the clinical files. The Mental Health Act Administrator to	Ongoing Audit of Discharge Summaries and Patient Register.	Achievable and Realistic	02/11/2021	Clinical Director, Responsible Treating Consultants and Mental Health Act Administrator

	keep an administrative record of Discharge Summaries, send reminders to teams and prepare report for the CD, Chair, Department of Psychiatry Policy and Compliance Committee				
Preventative Action	The Mental Health Act Administrator to regularly review Discharge Summaries, send reminders to teams to complete Discharge Summaries and prepare report for the CD, Chair, Department of Psychiatry Policy and Compliance Committee	Ongoing Audit of Discharge Summaries and Patient Register with review by the Department of Psychiatry Policy and Compliance Committee	Achievable and Realistic	02/11/2021	Clinical Director, Responsible Treating Consultants and Mental Health Act Administrator
Reason ID : 10003416		**One discharge did not include a documented discharge meeting attended by the resident, key worker and a family member, carer, or advocate, 34.4. The discharge plan for one resident did not include a reference to early warning signs of relapse and risks, 34.2. One discharge did not include a comprehensive discharge summary issued within 14 days, 38.3(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Once file identifier recieved the Service will to retrieve patient file the subject of the breach of discharge policy and inform treating team of same. Will urgently assess and ensure the team has retrospectively corrected deficit and if not, completed to date, will advise on way to remedy deficit and ensure learning. Would be grateful	QPS Committee	Once File identified will be implemented in full asap	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee; Responsible Consultant Psychiatrist.

	for File Identifier to inform this process.				
Preventative Action	Audit on the implementation of and adherence to the dicharge Policy to be conducted on a six monthly basis. Audit results will be relayed to the teams on areas of non-compliance.	Six monthly Audit of policy.	Achievable & Realistic	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.
Reason ID : 10003419		**There was no documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policies, 9.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to be circulated Admission, Transfer and Discharge policy document with sign-in sheet to indicate that they understand same.	Audit of Policy signing logs to be done annually.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Heads of Disciplines; Compliance & Policy Committee.
Preventative Action	All staff to be circulated Admission, Transfer and Discharge olicy document with sign-in sheet. All new staff at induction to be circulated wtih all policies and sign-in sheet.	Audit of Policy signing sheets and logs to be done annually.	Achievable & Realistic (Pending COVID19 restrictions)	31/12/2020	Clinical Director; Nursing Management, Heads of Disciplines; Compliance & Policy Committee.
Reason ID : 10003420		**There was no audit of the implementation of and adherence to the discharge policy, 4.19.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Audits of the implementaiton of and adherence to the Discharge Policy to completed on next Audit cycle (end of month) subject to COVID19 restrictions.	Audits reviewed by Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Updated note: Audits were suspended subsequent to Infection Prevention Control risk assessnent due to requirement to	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

			reduce footfall and mimismise numbers of staff handling charts at the Approved Centre.		
Preventative Action	Audit on Admission/Discharge/Transfer Policy to be included in six Monthly Audit cycle.	Audits reported to Compliance & Policy Committee	Achievable & Realistic (Pending COVID19 restrictions. Note: Audits were suspended as an infection risk during maximum retriction level due to attempts to reduce number of people ahndling charts and reduced footfall into Approved Centre)	31/12/2020	Clinical Director; Nursing Management, Compliance & Policy Committee.

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.

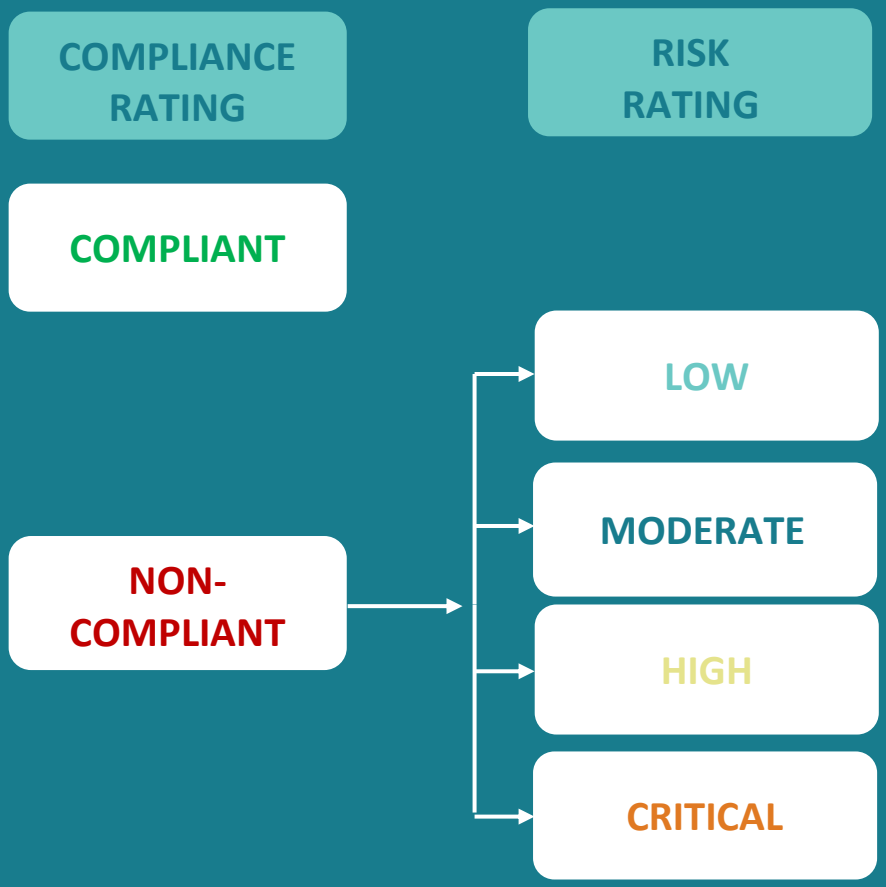
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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