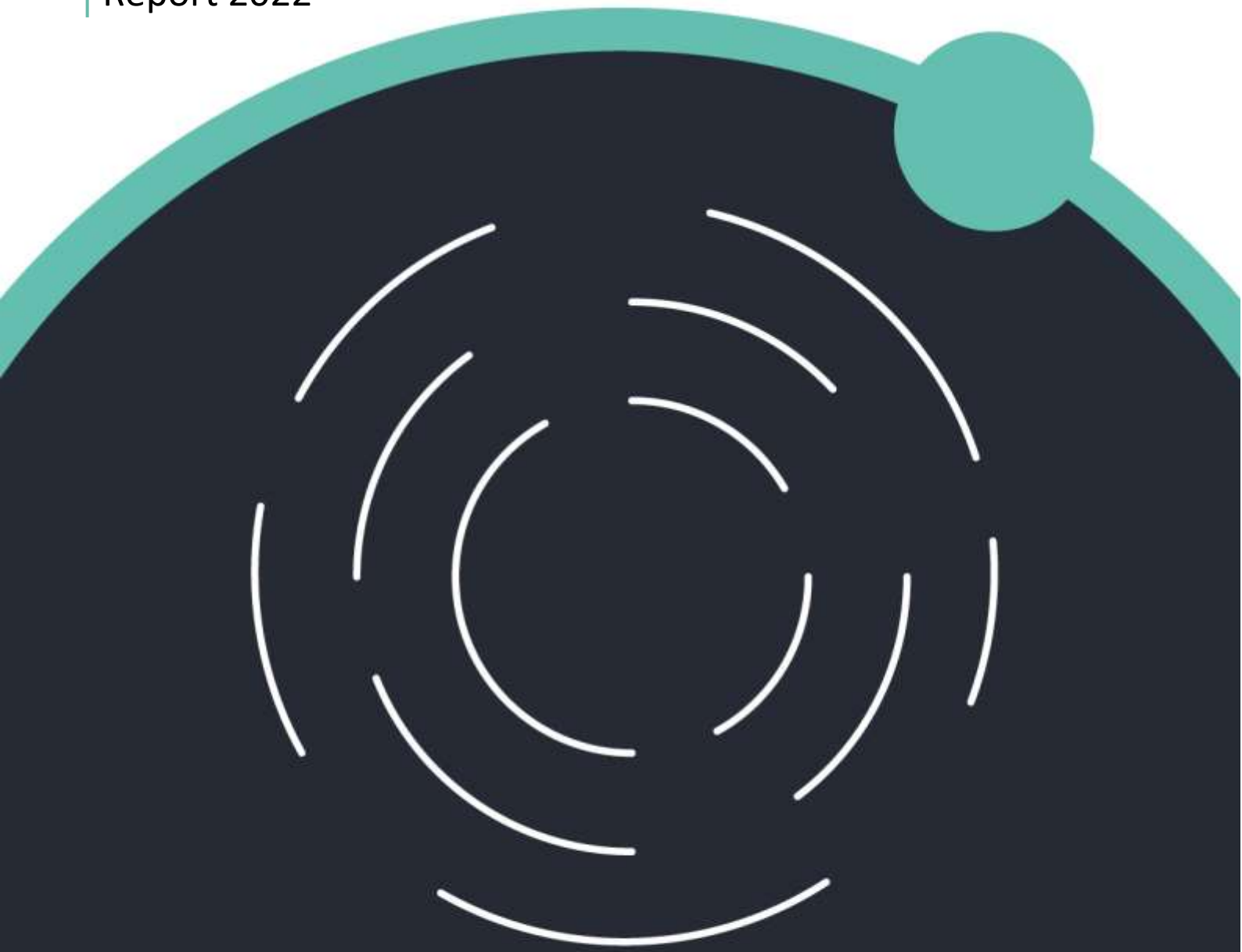
Department of Psychiatry, Roscommon University Hospital

Annual Inspection Report 2022



Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, ROSCOMMON UNIVERSITY HOSPITAL

Athlone Road, Roscommon, Co Roscommon

Date of Publication: 26th May 2023

ID Number: AC0169

2022 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2020

Registered Proprietor:
HSE

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

Inspection Team:
Kirsi Salo, Lead Inspector
Barbara Murphy
Damien Lanigan
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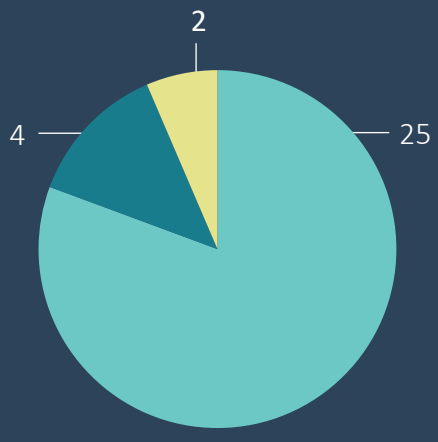
Inspection Date:
08 – 11 November 2022

Previous Inspection date:
20 – 23 July 2021

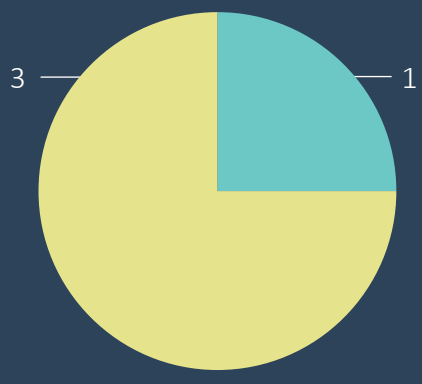
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

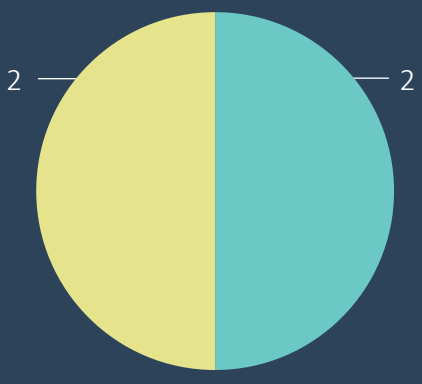
2022 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



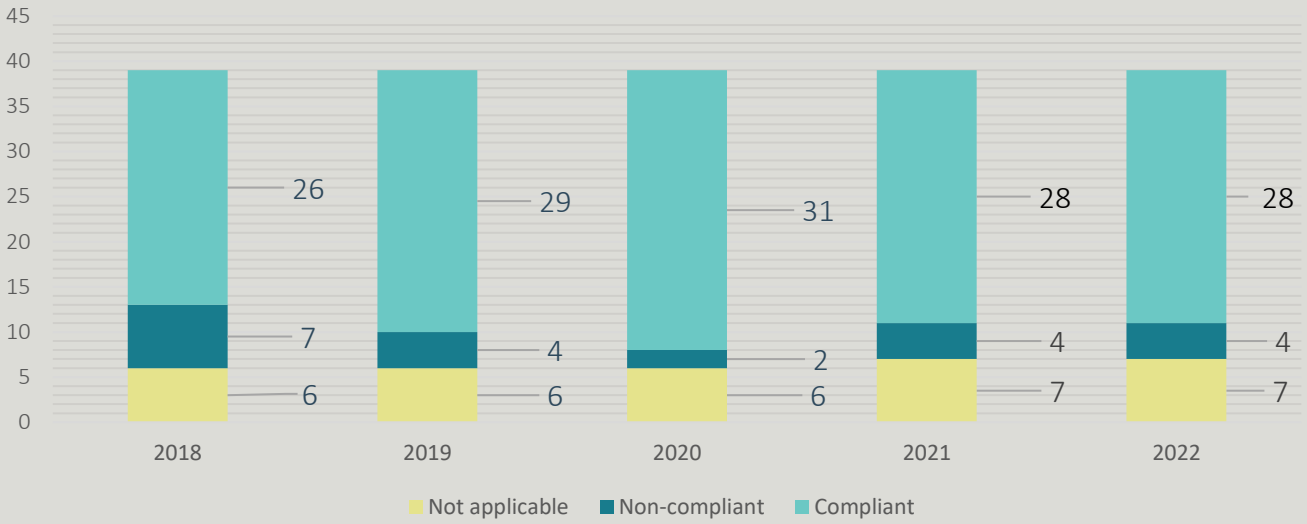
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2018 – 2022

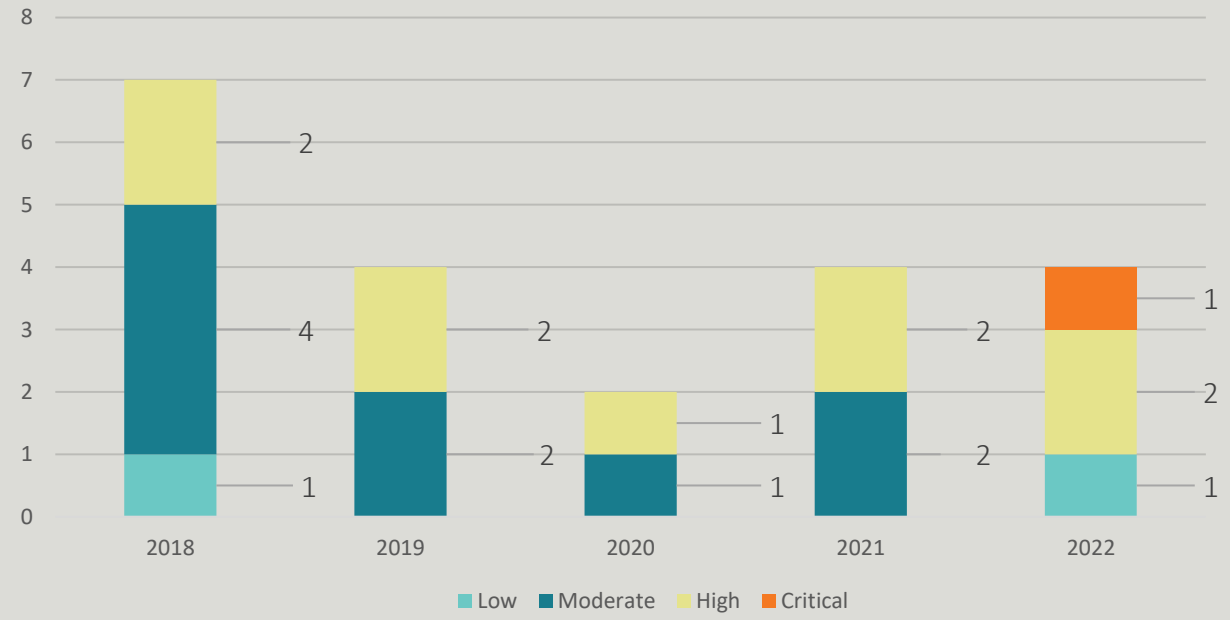
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

In brief

The approved centre was an acute mental health admissions unit, registered for maximum capacity of 24 residents. This included 22 beds in the main unit and an additional two beds at the high-dependency unit (HDU). It was located on the ground floor of the premises of the county hospital in Roscommon town. Six teams with admitting rights to the approved centre: four general adult sector teams, a rehabilitation and recovery team, and a psychiatry of later life team.

The approved centre had undertaken major refurbishment and ligature reduction works since the last inspection. Initiatives were service-user orientated. The approved centre had one non-compliance rated as a critical risk. This was due to deficits in fire safety.

Compliance Summary	2018	2019	2020	2021	2022
% Compliance	79%	88%	94%	88%	88%

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 22: Premises, the approved centre shall develop a costed, funded and time-bound plan for scheduled building works. This plan shall be developed by a date specified by the Mental Health Commission. The approved*	The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

centre shall provide a progress update on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.	
Condition 2: *To ensure adherence to Regulation 26(4) and 26(5): Staffing, the approved centre shall develop and implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.*	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.
Condition 3: *The approved centre shall only use 22 beds in the general ward at any one time. The approved centre shall provide a report to the Commission on bed occupancy and usage in a form and frequency set by the Commission.*	The approved centre was not in breach of Condition 3.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*01/12/2022*	*Critical risks identified in regards to fire safety*	*Further to the critical findings identified, the Mental Health Commission issued an Immediate Action Notice, which required the Registered Proprietor to take urgent steps, in consultation with a fire safety professional, to ensure that residents were safe from the risk of fire. The MHC continues to follow up on this matter with the registered proprietor.*

Safety in the approved centre

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

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

However:

- A number of fire doors did not provide adequate level of protection in case of a fire. The four fire doors in the approved centre were not functional: three fire doors had window panels fitted with single glazed glass, one had a gap when the door was closed, and one did not close by itself when released by the auto closing magnetic device.
- Although there was an improvement in mandatory training since the previous inspection in 2022, not all healthcare staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression.

Appropriate care and treatment of residents

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

- Each resident had a multi-disciplinary care plan which was developed and reviewed in collaboration with the resident. There were clearly defined goals with associated interventions and resourcing in place for each resident.
- The occupational therapist (OT) facilitated groups, including life skills, exercise and physical health, and sensory groups. Sessional group work included recovery talks, peer advocacy, yoga, art, music and horticulture. Psychology and social worker provided one to one support to residents.
- The six-monthly health assessment documented a physical examination, family and personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, and body mass-index, weight, and waist circumference. For residents on antipsychotic medication, an annual assessment included glucose regulation, blood lipids, and an electrocardiogram.

Respect for residents' privacy, dignity and autonomy

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

Most of the sleeping accommodation comprised of dormitory style accommodation of two, four and five beds, with three single bedrooms, and a high dependency unit with two single bedrooms and a seclusion suite. One of the single bedrooms in the main unit was en suite.

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

However:

- There was an intercom speaker system in place in the approved centre which was being used for announcements in relation to meals, exemption area, activities, and groups. It was very loud and disruptive to the residents and on occasions residents' names were called out over the speaker system.
- Two of the four-bedded dormitories were small with approximately one metre between each of the beds. One of the single bedrooms was too narrow to accommodate the positioning of a locker at the bedside.

Responsiveness to residents' needs

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

- Residents had access to a range of recreational activities during the weekdays and at the weekend. Activities included books, board games, television, DVDs, art, jigsaws, newspapers, comfort box, exercise classes, table tennis, yoga, exercises bikes and computer in the occupational therapy room, bowls, music, gardening in the courtyard, relaxation groups, and a beauty group.
- The information booklet was clearly and simply written. Residents were provided with the details of their multi-disciplinary team and written and verbal information on diagnosis and medication.
- There was a comprehensive complaints process in place.
- There was a choice of food at mealtimes.
- There was sufficient private space as well as areas for socialisation.

Governance, Leadership and Accountability

- The approved centre was in Community Healthcare West Services (previously known as CHO 2) which included counties Mayo, Galway, and Roscommon. Area Management Team meetings were held monthly and meeting minutes evidenced discussion and planning concerning key operational issues. There was also an overarching Clinical Governance Mental Health Team meeting and a separate Quality and Patient Safety Meeting chaired by the Executive Clinical Director.
- The approved centre held a monthly governance meeting and membership included the business manager, health & safety representative, quality and risk advisor, and a wide representation from members of the multi-disciplinary staff cohort.
- A risk register for the Department of Psychiatry (DOP) Roscommon was maintained and reviewed by local management. A review of the risk register was a standing item on the DOP's monthly business meeting. There was a risk management policy in place.
- The approved centre inputted all incidents into the National Incident Management System (NIMs). All clinical incidents were reviewed at the multi-disciplinary team meetings. The Patient Quality and Safety Adviser conducted quarterly incident analysis, consisting of trends and or patterns from all incidents in the DOP, which was sent to the approved centre management.
- There were regular resident community meetings (Mutual Help Meetings). The centre had suggestion boxes, and both Complaints Officer and Advocacy contact details were displayed within the approved centre.
- The approved centre had also introduced the Safe Wards programme within the unit. This programme aimed to reduce conflict between staff and service users to a lowest possible level and was successfully embedded into the service at the time of the inspection.
- The area management had conducted a service user survey across the approved centre and community services to find out the experiences of service user and how to improve the services, including the DOP services for residents. One of the main themes mentioned in the results was family involvement in the care whilst in the approved centre. The centre was at the time inspection organising training to staff regarding the topic and how to involve families more.

However, not all elements of the policy were implemented regarding identification, assessment and treatment of health and safety risks within the approved centre. The non-functioning fire doors had not been effectively identified under the centre's risk management procedures and hence had not been managed or mitigated. There was an audit commissioned by the maintenance slash estates department of Roscommon University Hospital regarding fire risk independent of the approved centre but at the time of inspection the results of the audit had not been communicated to either the approved centre management or the registered proprietor.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. **Service User Survey -** The Department of Psychiatry Roscommon has been involved with engaging with service users & family members to get feedback on their experience of the mental health services in the Roscommon/ East Galway areas. This work by the Project team has been conducted as part of the continuous service improvement.

2. **REGARI Recovery College -** the REGARI Recovery College has commenced holding on-site sessions on a weekly basis in the Department of Psychiatry Roscommon. This provided an excellent opportunity for in-patients. This encouraged those who otherwise may not have been able, to attend and become involved in a wide range of courses to meet the person's needs.

3. **Safe Wards -** The Department of Psychiatry Roscommon had introduced Safe wards programme. This was a theoretical model with 10 associated interventions designed to improve the safety of everyone involved in in-patient wards. The model provided the centre with tools to encourage staff and patients on wards to work together to reduce conflict as much as possible.

4. **The Knowledge Hub -** was a new quality initiative which had commenced in the centre. This involved staff members and students that attend the Department of Psychiatry Roscommon as part of nursing clinical placement. Students and staff members had embraced the learning environment and had presented on topics which were relevant to their educational needs.

5. **Professional Practice, Role Reflection -** This initiative had commenced for members of staff, Healthcare Assistants and Multi-Task attendants within Galway Roscommon Mental Health services. This was the first of its kind within Ireland for support staff grades within the Health Service Executive. Uptake of this initiative has increased and continued to grow. The program promoted engagement with staff in all roles to learn better ways of supporting the service users within the Department of Psychiatry Roscommon. Leaflets had also been created again to develop the culture in which all staff were be provided with role support.

6. **Family Clinic for Service Users and Families -** The family clinic was a HSE Roscommon Adult Mental Health Social Work department initiative for family members, carers and supporters/close friends of people who were inpatients at the Acute Psychiatric Unit in Roscommon Hospital. Families, carers, and supporters may play an important part in helping their loved ones through their mental health recovery journey. They may also need support and care for themselves as part of the family recovery journey. The family clinic had been established to scaffold both requirements. The clinic was especially supportive to those family members/carers whose loved ones were new to the service and engaging with mental inpatient healthcare for the first time.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was registered for maximum capacity of 24 residents. This included 22 beds in the main unit and an additional two beds at the high- dependency unit (HDU). These were used also for other residents when required. The unit was located on the premises of the county hospital on the Dublin Road in Roscommon town. It was on the ground floor, situated behind the main hospital unit.

The approved centre was divided into two main areas, both adjoining a main conservatory area located at the entrance door to the main hospital, which was locked. The main dining room, activity therapy room, sensory/relaxation room, a day room, and several offices were in one area. This area was closed off in the evening time. The second area comprised all the resident bedrooms, bathroom, and toilet facilities, the two bedded high-dependency unit, a night sitting room, a night kitchen facility, and nursing offices. Most of the sleeping accommodation comprised of dormitory style accommodation of two, four and five beds, with three single bedrooms, and a high dependency unit with two single bedrooms and a seclusion suite. One of the single bedrooms in the main unit was en suite. There was a spacious sensory garden located adjacent to the main foyer area which was available to residents outside of mealtimes.

There were six teams with admitting rights to the approved centre. There were four general adult sector teams divided by geographical areas, a rehabilitation and recovery team, and a psychiatry of later life team.

The approved centre had undertaken major refurbishment and ligature reduction works since the last inspection. The centre was clean, welcoming, and bright and all bathrooms and communal areas were fitted with anti-ligature fittings and furnishing.

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

Resident Profile	
Number of registered beds	***24***
Total number of residents	**21**
Number of detained patients	3
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	3
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Community Healthcare West Services (previously known as CHO 2) incorporated counties Mayo, Galway, and Roscommon. Area Management Team meetings were held monthly and included representation from Senior management, Clinical management, and representatives from various heads of disciplines. The Area Management Team meetings were chaired by the Head of Services and meeting minutes evidenced discussion and planning concerning key operational issues. There was also an overarching Clinical Governance Mental Health Team meeting that was also chaired by the Head of Services and a separate Quality and Patient Safety Meeting chaired by the Executive Clinical Director. Both were held monthly within the Galway/Roscommon Mental Health Service.

Locally, the approved centre held a monthly business meeting, membership included the business manager, health & safety representative, quality and risk advisor, and a wide representation from members of the multi-disciplinary staff cohort. The local business meeting was chaired by the Clinical Director (CD) or the Assistant Director of Nursing (ADON). The minutes of the Approved Centre's Business meeting indicated that the management team addressed issues such as: Health & Safety; audits; bed capacity; MHC (Mental Health Commission) reports and action plans; the risk register; serious incidents; complaints; service development as well as, staff training. Specific issues such as COVID-19 and bed occupancy were closely monitored and managed with contingency plans.

All heads of discipline had received training in risk management procedures. A risk register for the Department of Psychiatry (DOP) Roscommon was maintained and reviewed by local management and included clinical, health and safety, and structural risks. A review of the risk register was also a standing item on the DOP's monthly business meeting. There was a comprehensive risk management policy in place, however, not all elements of the policy were implemented regarding identification, assessment and treatment of health and safety risks within the approved centre. At the time of the inspection a number of fire doors did not provide adequate level of protection in case of a fire. These doors included faults such as single glazed glass, gaps between the doors and a fire door that did not close properly when released. These fire doors had not been effectively identified under the centre's risk management procedures and hence had not been managed or mitigated.

The approved centre inputted all incidents into the National Incident Management System (NIMs). All clinical incidents were reviewed at the next respective multi-disciplinary team meeting. There was a separate Patient Quality and Safety Adviser working under the Community Healthcare West Services who consulted and advised local management on incident and risk management. Any Serious Reportable Incidents (SRE's) were sent to area management and discussed in the Serious Incident Management Team (SIMT). The Patient Quality and Safety Adviser conducted quarterly incident analysis, consisting of trends and or patterns from all incidents in the DOP. This was sent to the approved centre management.

Four general adult sector teams and two specialist teams (Psychiatry of Later Life (POLL) teams and a Rehabilitation and Recovery team admitted residents to the approved centre. All the admitting teams overall had adequate numbers and skill mix of staff to meet resident needs. There were some vacancies in the teams but there were effective plans to back fill them or where the role was vacant due to leave there

were plans on how to cover the service for the duration of the leave. There was evidence of adequate and appropriate supervision structures in place within each department and the Approved Centre had an appropriate number of staff with appropriate skill mix and management cover onsite at all times.

At a local level, regular resident community meetings (Mutual Help Meeting). The Area Lead for Mental Health Engagement took part in these meetings occasionally and attended management meetings on various levels. The centre had suggestion boxes, and both Complaints Officer and Advocacy contact details were displayed within the approved centre. Residents had access to advocacy services if required. The approved centre had also introduced the Safe Wards programme within the unit. This programme aimed to reduce conflict between staff and service users to a lowest possible level. This was successfully embedded into the service at the time of the inspection and the interactions between staff and residents were warm and collaborative and there were several boards across the unit displaying information regarding the programme. The area management had conducted a service user survey across the approved centre and community services to find out the experiences of service user and how to improve the services, including the DOP services for residents. One of the main themes mentioned in the results was family involvement in the care whilst in the approved centre. The centre was at the time inspection organising training to staff regarding the topic and how to involve families more.

The approved centre was adhering to COVID-19 pandemic guidelines. Visits were allowed and were flexibly organised with a nurse onsite. Two single rooms were allocated as isolation rooms in the approved centre.

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 21: Privacy	✗	Moderate	✓		✓		✗	High	✗	High
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	High	✗	Moderate	✓		✓		✗	Low
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	Critical

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, 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 Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice 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. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

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

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

In total three questionnaires were returned, and the inspection team spoke formally with three residents.

The resident questionnaire asked for a total score for overall care and treatment, on a rating scale from 1 to 10, 1 being the poorest and 10 being the highest rating; one resident rated nine out of ten and two rated 10 out 10. The overall average resident rating from the three questionnaires returned was 9.5 out of 10.

All three respondents from the questionnaires said they were happy with how staff talked to them. They all responded that they had enough space for privacy and felt that their privacy and dignity was respected. All three responded that they always felt safe, and they always felt comfortable to give feedback to staff or to make a complaint. The open comments from the questionnaires appraised quality of care and stated that staff were very helpful.

The overall the feedback from the three resident interviews was positive. All the residents interviewed expressed that they knew their team and signed their care plans. Activities were overall thought to be good. All three residents whom the inspectors spoke to expressed that they felt safe at the unit. Residents stated that the food was good overall, and one resident reported that there was plenty of choice. All three residents interviewed stayed in shared bedrooms, but this was not an issue for any of them.

The *Peer Advocacy Network* (formerly the Irish Advocacy Network) was notified that the inspection team were in the approved centre.

5.2 Advocacy

The approved centre had an advocacy service. The Peer Advocacy network was notified of the inspection.

The inspectors did not receive a report from the Peer Advocacy in Mental Health representative.

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:

- Registered Proprietor
- Clinical Director
- General Manager
- Director of Nursing
- Occupational Therapy Manager
- Principal Social Worker
- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Clinical Nurse Manager 3 (2 CNM 3s attended)
- Risk Adviser

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. Residents were identified by name, date of birth, and medical record number (MRN).

Resident identifiers were used before administering medications, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. Meals were prepared in the kitchen of the general hospital and brought to the approved centre on a food trolley. There was a kitchenette area in the approved centre which had proper facilities for the refrigeration, storage, preparation, 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.

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 November 2021. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. These activities included books, board games, television, DVDs, art, jigsaws, newspapers, comfort box exercise classes, table tennis, yoga, exercises bikes and computer in the occupational therapy room, bowls, music, gardening in the courtyard, relaxation groups, and a beauty group.

The approved centre provided access to recreational activities on weekdays and 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' rights to practice religion were facilitated within the approved centre insofar as practicable. There was a chapel onsite which residents could access, and a chaplain service was available to residents in the approved centre.

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 August 2020.

Visiting times were appropriate and reasonable. Visits were scheduled in advance and up to six visits could be arranged daily throughout the week. There were no visiting restrictions at the time of inspection. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The approved centre provided two rooms 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, with child-friendly materials available.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in February 2020.

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 mobile phone and devices, phones for general use in the nurses' station, and a computer in the occupational therapy room.

There were no restrictions on communication for any resident at time of inspection.

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 November 2021, and included all requirements related to:

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

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

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident’s dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record of every

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

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

As there had been no deaths 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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident, weekly in the approved centre. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The occupational therapist (OT) provided one-on-one assessments as required. The OT also facilitated groups, including life skills, exercise and physical health, and sensory groups. The approved centre was awaiting the recruitment of an OT assistant and in-reach OTs attended the ICP meetings. Sessional group work included recovery talks, peer advocacy, yoga, art, music and horticulture. Psychology and social worker provided one to one support to residents.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

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

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in October 2021. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The clinical files of ten residents were examined during the inspection process. Three of these residents had been in the approved centre for longer than six months. The six-monthly health assessment for these three residents documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, and body mass-index, weight, and waist circumference. 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 compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

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 received information regarding medication via the Choice and Medication website online. Residents could access this information independently or were supported by staff where required and could print off the required information. Residents had access to interpretation and translation as required. A translation service was available in-person or over the phone for residents where required.

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

Residents in the approved centre were called by their preferred names. Staff demeanour, 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.

The manner in which staff addressed and communicated with residents did not appropriately respect resident privacy and dignity at all times. There was an intercom speaker system in place in the approved centre which was being used for announcements in relation to meals, exemption area, activities, and groups. The speaker system was very loud and disruptive to the residents and on occasions residents' names were called out over the speaker system.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. Rooms were not overlooked by public areas. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the residents' privacy and dignity was appropriately respected at all times. An intercom speaker system being used in the approved centre was very loud and disruptive to the residents.

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

Two of the four bedded dormitories were small with approximately one metre between each of the beds. One of the single bedrooms was too narrow to accommodate the positioning of a locker at the bedside. Appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were well ventilated. 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.

Health and safety hazards were not minimized in the approved centre. The four fire doors in the approved centre were not functional: three fire doors had window panels fitted with single glazed glass, one had a gap when the door was closed, and one did not close by itself when released by the auto closing magnetic device. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in good a state of repair externally and internally. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. 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 furnished to support resident independence and comfort.

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

a) **The approved centre environment was not developed and maintained with due regard to the specific needs and well-being of residents, as two of the four bedded dormitories were small in size providing limited personal space for each resident. One of the single bedrooms was too narrow to accommodate the positioning of a locker at the bedside, 22(3).**
b) **The approved centre environment was not developed and maintained with due regard to the specific needs and well-being of residents, as four radiators on the corridor and the radiators in three bedrooms were not guarded. One radiator in the day room and one in the dining room were also not guarded, 22(3).**
c) **The approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff, and visitors, as the four sets of fire doors in the approved centre were not functional - three had single glazed glass, one had a gap, and one did not close on release, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in October 2021, and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any (or no) allergies or sensitivities to medications; 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 or nurse prescriber for each entry. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

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 2021.

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 February 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 was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. 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.

All healthcare staff were trained in the Mental Health Act 2001. However, not all healthcare staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. 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 (24)	22	92%	24	100%	22	92%	24	100%
Consultant Psychiatrist (7)	7	100%	7	100 %	7	100 %	7	100%
Medical (8)	8	100%	7	88%	5	63%	8	100%

Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (Sessional Input from Community Social Workers)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Psychologist (Sessional Input from Community Psychologist)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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 were trained in Basic Life Support, 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 October 2022, 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. The approved centre provided resources and facilities 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 February 2021, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the 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

NON-COMPLIANT

Risk Rating CRITICAL

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in November 2021, and included the following:

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

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

The risk management procedures did not actively reduce risks to the lowest practicable level of risk. There were four doors on the main corridor of the approved centre which were designated as fire doors. However, none of the four were functional as fire doors: three of the fire doors had window panels were fitted with single glazed glass, one had a significant gap when the doors were closed, and one did not close by itself when released by the auto closing magnetic device. The approved centre's fire policy stated that it utilized lateral evacuation, whereby staff would evacuate residents behind a set of fire doors in the event of fire. This risk posed by the faulty fire doors was identified at the time of the

inspection and were not included on the approved centre's risk register and as a result this risk was not mitigated or managed. The fire evacuation procedures were not amended to respond to the non-operational fire doors. The centre had regular fire drills, but these did not include a mock-up evacuation of the centre and were effectively only testing the fire alarms functionality not the actual evacuation procedures in the centre.

Clinical risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Corporate risks were identified, assessed, treated, reported, and monitored as appropriate. The health and safety risk posed by the faulty doors was identified at the time of inspection and were not included in the approved centre risk register and as a result this risk was not mitigated or managed. This was due to the fact that an audit was commissioned by the maintenance/ estates department of Roscommon University Hospital refire risk independent of the approved centre but at the time of inspection the results of the audit had not been communicated to either the approved centre management or the registered proprietor. Structural risks, including ligature points, were removed or effectively mitigated.

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

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies. However, at the time of inspection the approved centre’s lateral evacuation plan was not in line with the building’s fire door functionality.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as the local risk registry did not identify faulty fire doors as risks and hence did not provide methods of mitigating the risk or a process of rectifying it, 32(1).

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with three conditions to registration attached. The certificate was prominently displayed in the approved centre. Where changes had arisen in relation to the information detailed in the certificate of registration, this was communicated to the Mental Health Commission.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

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

The policy addressed the following:

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

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

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

Evidence of Implementation: Seclusion facilities were furnished and maintained to ensure respect for resident dignity and privacy, as far as practicable. 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.

Two 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 the residents' 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' next of kin or representative was informed of the use of seclusion, and this was recorded in the clinical files.

The residents were informed of the ending of each episode of seclusion. Residents' rights to dignity, bodily integrity, and privacy were respected. Cultural awareness and gender sensitivity was demonstrated.

A registered nurse undertook direct observation for the first hour following the initiation of a 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. A medical review of the residents was undertaken no later than four hours after the commencement of each episode of seclusion and reviewed every four hours. Seclusion orders were only extended by the registered medical practitioner following examination for a further period not exceeding eight 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 the episode. A copy of the seclusion register was placed in the clinical files. The episodes were reviewed by members of the multi-disciplinary team and documented in the clinical files within two working days.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 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 February 2022. It addressed the following:

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

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

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.

As soon as practicable and with the resident's consent, the resident's next of kin or representative was informed of the use of physical restraint, and this was recorded in the clinical file. Where the next of kin or representative was not informed, the justification for 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. Special consideration was given when restraining a resident who was known by the staff involved in physical restraint to have experienced physical or sexual abuse. 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, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in October 2022, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in April 2022, 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, risk assessment, 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 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 comprehensive discharge summary was issued within 14 days.

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

The approved centre was compliant with the code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 21: Privacy					
Reason ID : 10003790		**The registered proprietor did not ensure that the residents' privacy and dignity was appropriately respected at all times. An intercom speaker system being used in the approved centre was very loud and disruptive to the residents.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The use of the intercom has been reviewed and its use has been restricted and its volume and frequency of use reduced. Service user input regarding its use is also being sough and further modification may occur following same.	Yes, Through feedback from our Mutual Help meetings and a log of same will be kept. Also individual feedback will be encouraged.	Yes. There should be no barriers to the implementation.	16/06/2023	HCA's, RPN's, CNM 2's and CNM 3's
Preventative Action	Ongoing monitoring and will require feedback regarding the intercom over a 2 month period from service users and will use this feedback to modify use of the intercom.	Yes, 2 months to complete service user survey and action plan from same.	Yes, Will monitor its use on an ongoing basis through the Mutual Help meetings and approved unit nurse management meetings.	30/06/2023	CNM 2's and CNM 3's

Regulation 22: Premises					
Reason ID : 10003776		**The approved centre environment was not developed and maintained with due regard to the specific needs and well-being of residents, as two of the four bedded dormitories were small in size providing limited personal space for each resident. One of the single bedrooms was too narrow to accommodate the positioning of a locker at the bedside, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Each service users storage needs will be individually assesses. Each service user in these rooms will be offered additional storage space. They will be provided with an additional locker in the storage room at the end of the unit. They will have a key for their additional locker and can access it 24/7. In the single room and individual locker is available but not beside the bed. (Planning for a new build unit to fully address this non compliance is in progress).	Yes A log will be kept documenting the provision of additional locker space. Also service user feedback will be sought regarding this issue at our biweekly mutual help meeting.	Yes	21/04/2023	HCA's, RPN's, CNM 2's, CNM 3's

Preventative Action	There is currently a working group reviewing in regards to the planning and development of a new purpose built approved centre on the grounds of RUH.	Yes Monitoring work developments on this project.	Yes	17/04/2026	Registered Proprietor, Clinical Director, ADON, Head of Service, Area Management Team.
Reason ID : 10003777		**The approved centre environment was not developed and maintained with due regard to the specific needs and well-being of residents, as four radiators on the corridor and the radiators in three bedrooms were not guarded. One radiator in the day room and one in the dining room were also not guarded, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Maintenance Manager within RUH is reviewing and going to source radiator covers that meet all statutory and regularity requirements.	Yes Observation	Yes	26/05/2023	RUH Maintenance Manager, Registered Proprietor, CNM 3's and ADON.
Preventative Action	RUH Maintenance Manager is to complete a full review of all the radiators and heating system within the approved centre.	Yes	Yes	25/08/2023	RUH Maintenance Manager.
Reason ID : 10003778		**The approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff, and visitors, as the four sets of fire doors in the approved centre were not functional - three had single glazed glass, one had a gap, and one did not close on release, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Fitting of approved replacement doors which meets all statutory and regulatory requirements commenced on the 05.04.2023 and expected that all non compliant doors will be completed by mid May 2023. In the interim there are control measures in place within the unit (please see attached risk assessment).	Yes Direct observation	Yes	25/05/2023	RUH Maintenance Manager, HSE Estates Fire Officer, Registered Proprietor, CHO 2 Health and Safety Officer, QPS Advisor, CNM 2's, CNM 3's, ADON, Clinical Director
Preventative Action	RUH Maintenance Manager to conduct at a minimum an annual inspection to ensure that all statutory and regularity health and safety and fire regulations pertaining to structural fixtures and fittings within the approved centre are adhered	Yes	Yes	26/04/2024	RUH Maintenance Manager, HSE Estates Fire Officer.

	to and maintained to a high standard.				

Regulation 26: Staffing					
Reason ID : 10003793		**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 were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Basic Life Support Training; This will take place here on the Dept of Psychiatry on the following dates: Friday 12th May 2023 Friday 19th May 2023 Friday 19th may 2023 it should also be noted that in the past month , 2 members of our Nursing Staff within the Approved Centre have qualified as BLS trainers and will be able to facilitate regular training of Staff Fire Safety: On-Line fire training is continuing here within the Approved Centre. On receipt of the	The Staff Training Register will be Audited on a quarterly basis	The feasibility of the actions are Realistic	04/10/2023	ADON CNM 3s CNM 2s Clinical Director Heads of Disciplines

	new Fire Risk Assessment, Fire Policy and Evacuation Plan which are currently being prepared by "Factfire" on-site Fire Training will re-commence on the Approved Centre Management of Violence and Aggression: On the week commencing 27/2/23 , 5 members of staff completed the 5 day TMVA training TMVA training is arranged for the following dates: 2 Day refresher : 26/27 April 23 & 10/11 May 23 5 day Training: commencing the week beginning 22/5/23				
Preventative Action	On going Staff training to continue Continue the " train the Trainer" Programme	Regular Audit of training register	The feasibility of the action is Realistic	04/10/2023	ADON CNM 3s CNM 2s Clinical Director Heads of Disciplines

Regulation 32: Risk Management Procedures					
Reason ID : 10003792		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre, as the local risk registry did not identify faulty fire doors as risks and hence did not provide methods of mitigating the risk or a process of rectifying it, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The local risk register has been updated to include the presence of faulty fire doors. Mitigation measures have been put in place.	Yes Via viewing the updated risk register.	Yes	14/04/2023	QPS Advisor, CHO2 Health and Safety Officer, RUH Maintenance Manager, HSE Estates Fire Officer, CNM3 and ADON
Preventative Action	Regular review of the risk register by all members of the MDT, QPS, CHO2 Health and Safety Officer, RUH Maintenance Manager to ensure it is up to date.	Yes by viewing minutes of monthly business/governance meetings and the risk register.	Yes	21/04/2023	RUH Maintenance Manager, Estates Fire Officer, QPS adviser, CHO2 Health and Safety Officer, CNM2's, CNM3's, ADON, Clinical Director all members of the MDT.

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.

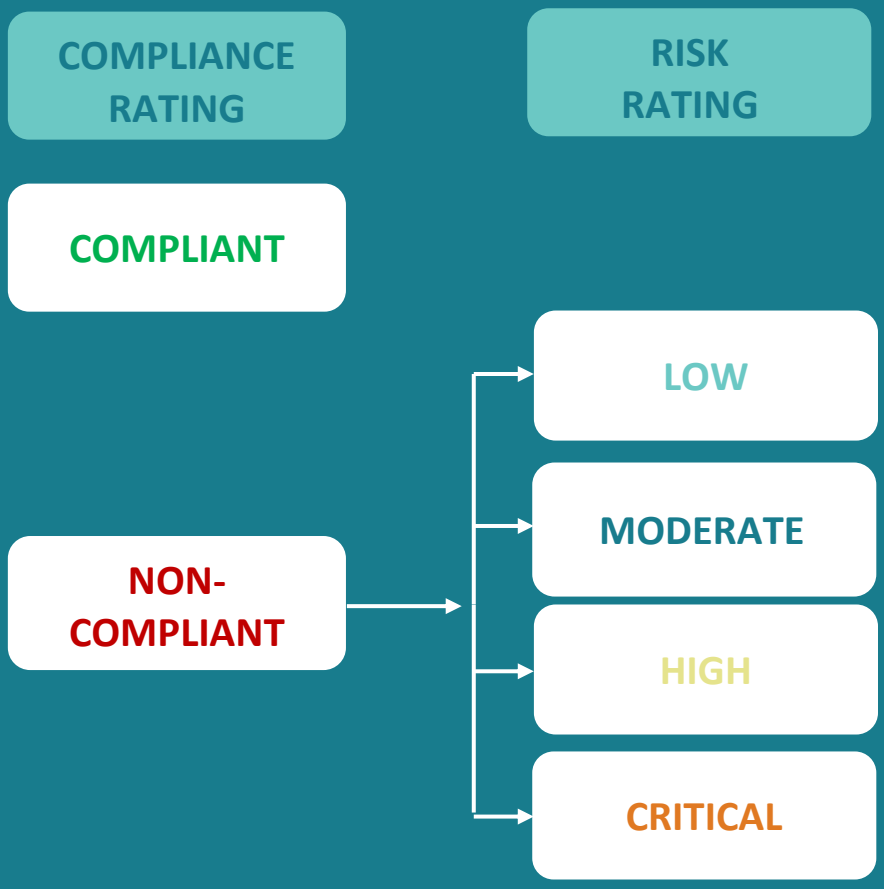
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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