# Adult Mental Health Unit, Mayo University Hospital

Annual Inspection Report 2022

*Promoting Quality, Safety and Human Rights in Mental Health*

# ADULT MENTAL HEALTH UNIT, MAYO UNIVERSITY HOSPITAL

Castlebar, Co. Mayo

**Date of Publication:** 29th June 2023

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## 2022 Approved Centre Inspection Report (Mental Health Act 2001)

**Approved Centre Type:**
Adult Mental Health Care Unit

**Conditions Attached:**
Yes

**Most Recent Registration Date:**
01 March 2020

**Registered Proprietor:**
HSE

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

**Inspection Team:**
Mary Connellan, Lead Inspector
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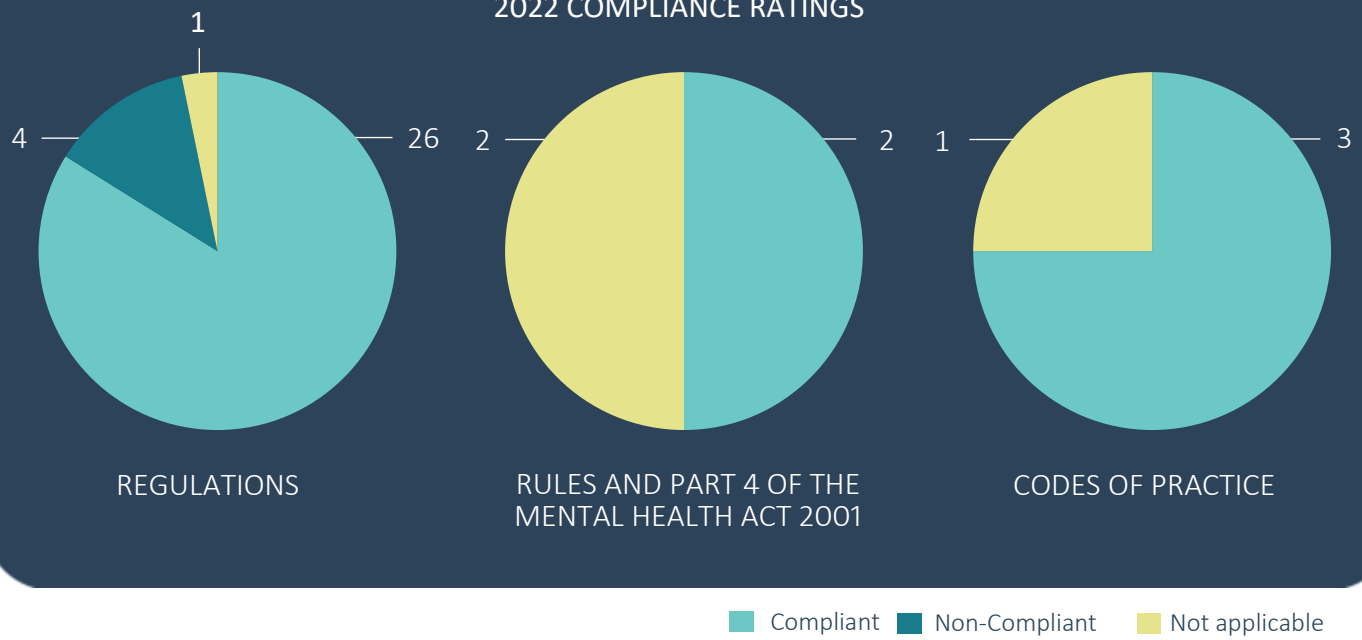
**Inspection Date:**
11 - 14 October 2022

**Previous Inspection date:**
13 – 16 July 2021

**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Inspection Type:**
Announced Annual Inspection

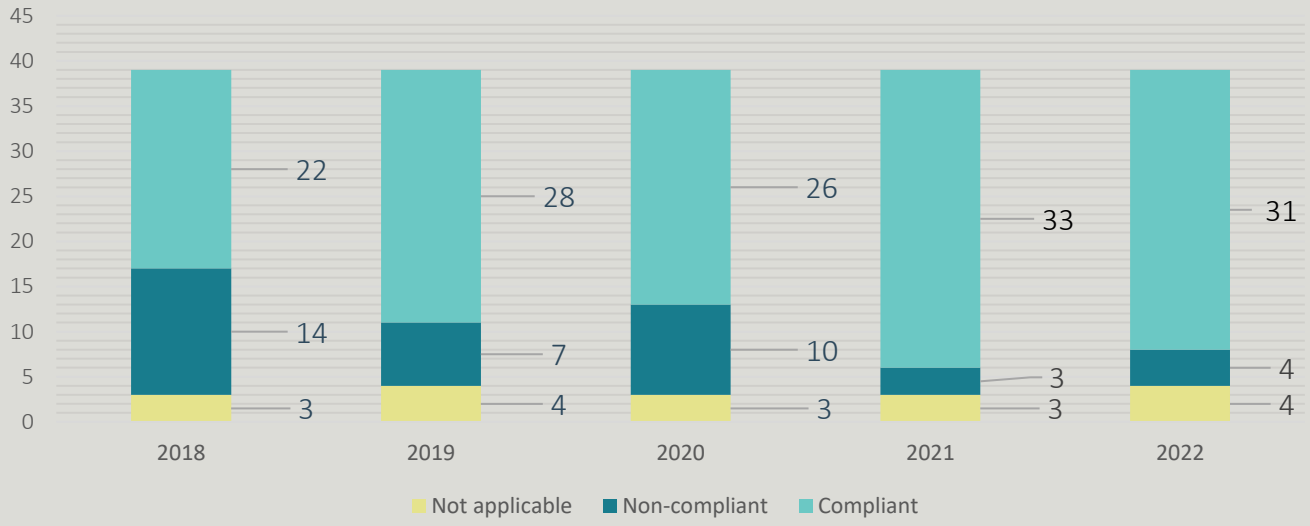
2022 COMPLIANCE RATINGS



## RATINGS SUMMARY 2018 – 2022

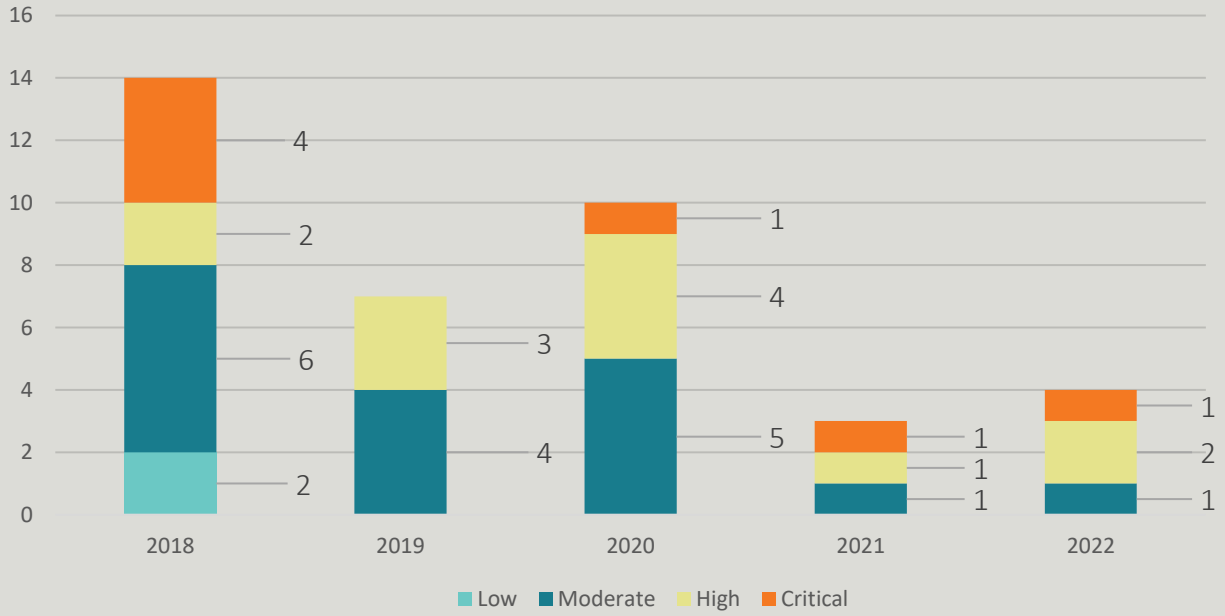
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

### CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2018 – 2022




Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

### CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2018 – 2022



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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 Adult Mental Health Unit (AMHU) was located on the campus of Mayo University Hospital (MUH). It encompassed five general adult community mental health sector teams, with two Psychiatry of Old Age (POA) community teams, one Rehabilitation and Recovery team and one Mental Health Intellectual Disability team that had admitting rights to the approved centre. There was a liaison psychiatry team working directly in MUH. A Memory Assessment and Support Service operated on an outpatient basis. An in-reach model of care was provided for the residents by their respective care team.

The approved centre was subdivided into a main ward and a High Dependency Unit (HDU). There had been extensive refurbishment and anti-ligature works since the last inspection.

| Compliance Summary | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| % Compliance | 61% | 80% | 72% | 92% | 89% |

## Conditions to registration

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

| Conditions | Findings |
|---|---|
| **Condition 1:**<br>*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* | The approved centre was not in breach of Condition 1 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection. |

| | |
|---|---|
| *approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.* | |
| **Condition 2:**<br>*To ensure adherence to Regulation 22(1)(c): Premises, the approved centre shall implement a programme of maintenance to ensure the premises are safe and meet the needs of the resident group. The approved centre shall provide a progress update to the Mental Health Commission on the programme of maintenance 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 22: Premises at the time of inspection. |
| **Condition 3:**<br>*To ensure adherence to Regulation 22(3): Premises, the approved centre shall develop a costed, funded and time-bound plan to minimise ligatures. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.* | The approved centre was not in breach of Condition 3 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection. |

## Ongoing escalation and enforcement actions at time of inspection

| Enforcement Action | Date applied | Reasons | Outcome |
|---|---|---|---|
| *Immediate Action Notice* | *30/07/2021* | *Fire risks identified during 2021 annual inspection* | *Due to lack of satisfactory response to the Immediate Action Notice the MHC decided to escalate this matter to the registered proprietor who was required to attend a Regulatory Compliance Meeting.* |
| *Regulatory compliance meeting* | *18/10/2021* | Satisfactory response to the Immediate Action Notice was not received | *Further to the Regulatory Compliance Meeting, the registered proprietor took remedial action and submitted adequate assurances relating to fire certificates, fire drills and fire training for staff. Necessary steps have also been taken to ensure the appropriate replacement of fire doors throughout the approved centre. The MHC continues to monitor this matter.* |

## Escalation and enforcement actions commenced following this inspection

| Enforcement Action | Date applied | Reasons | Outcome |
|---|---|---|---|
| *Immediate enforcement action* | *01/11/2022* | *Critical risks identified with Regulation 26: Staffing* | *Further to the Immediate Action Notice issued in relation to Regulation 26: Staffing the registered proprietor has reviewed and amended their staffing levels. The monitoring is ongoing.* |

## 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.
- An appropriately qualified staff member was on duty and in charge at all times.
- Medication was ordered, stored and administered in a secure and safe manner.

However:

- The number of registered psychiatric nurses in the approved centre was not sufficient and not in line with the centre's registration requirements to meet resident needs, with consideration to the size and layout of the approved centre. In December 2021, there were 39 registered nurses on the roster for the approved centre; in September 2022, that number had reduced by almost 25% to 29. This was rated as a critical risk by the inspectors. However, this risk was not documented in the approved centre's risk register.
- Ligature anchor points were not minimised to the lowest practicable level.

## 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.

- There was a weekly group Individual Recovery Care Plans (IRCP) group. This was facilitated by occupational therapists, with the aim of residents learning about the individual care planning process and to promote the resident being an active member of their recovery care planning.
- There was a Peer Support Worker (PSW) available to the residents.
- Mayo Recovery College provided a range of courses and groups for the residents.
- Therapeutic programmes and services provided by the centre included occupational therapy, art therapy, cognitive behavioural therapy (CBT), and anxiety management skills.
- There was a therapeutic services and programmes monitoring group which was attended by health and social care professionals, nursing staff, the physical health nurse, CBT therapist, recovery co-ordinator, and peer support worker.
- The six-monthly health assessment documented a physical examination, family and personal history, smoking status, dental health, 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. A physical health information tool had been developed and introduced into the service.

However:

- For one resident the six-monthly assessment did not record blood pressure or nutritional status.
- Referral to the dietetic service where indicated, had not been offered, at the time of inspection.

## 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:**

- The main ward comprised of two single bedrooms and six dormitory style rooms with four or five beds in each room. The HDU had four single bedrooms and a seclusion 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.
- There was a visiting room where residents could meet their visitors in private.
- Staff treated and communicated with residents in a respectful manner.
- There had been extensive refurbishment and anti-ligature works since the last inspection that included replacement of fire doors, replacement of windows, upgrading of bathrooms, painting, and renewal of soft finishings. Works were ongoing at the time of inspection.

However, the approved centre was not kept in good a state of repair externally and internally:

- Windowsills were dirty and the paint on the walls was peeling off.
- In one single room paint on the walls and skirting board was peeling off.
- In a single room in the HDU, the wall was damaged, poorly repaired, and in need of painting.
- Floor coverings were badly marked and scuffed throughout resident bedrooms, activities rooms, main corridors, and in the tribunal room.

- A redundant cooker hood needed to be removed from the occupational therapy (OT) activities room.
- A ceiling tile in the OT assessment kitchen was badly stained due to water leaking into a vent pipe.
- The covering of an accordion door in the OT activity room was damaged.

## Responsiveness to residents' needs

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

- Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. Ward-based activities included board games, books, jigsaws, TV, and library books which were available on request. Exercise equipment was also available for resident use.
- 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.
- At the time of inspection there were a number of residents who were considered to have a delayed discharge, mainly due to the difficulties in sourcing appropriate accommodation. Mayo Mental Health Services had a Tenancy Support Worker, through a Community Living Implementation group.

## Governance, Leadership and Accountability

**There were governance structures and processes in place.**

- The approved centre was part of Community Healthcare West and was governed under the Mayo Mental Health Services (MMHS). The Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee (QPSC) meeting were both held monthly.
- The approved centre was closely aligned with Mayo University Hospital (MUH) for premises and maintenance, food supplies and pharmaceutical products and services. Senior management of the approved centre held quarterly meetings with the general manager from MUH to discuss mutual issues.
- The Adult Mental Health Unit management meeting was held monthly and attended by medical, nursing, administrative, and health and social care professionals. There was a weekly Clinical Risk and Governance meeting that discussed clinical concerns.
- Risk management was supported by a Quality and Patient Safety (QPS) advisor who worked across the Mayo Mental Health Service. There were clear processes around risk assessments, maintaining a local risk register and escalation to the QPS committee for the Area Management Team (AMT) risk register as applicable.
- A review of the nursing rosters indicated that the number of registered psychiatric nurses working both day and night shifts varied considerably. There was evidence that just over half of the shifts had the required numbers of registered psychiatric nurses on duty. There was evidence that staff worked additional hours or time in lieu to help manage the staff shortages.

- There was a Judgement Support Framework (JSF) working group to improve compliance with regulations and improve quality of care.
- A representative from the Peer Advocacy in Mental Health service attended the approved centre on a weekly basis to meet with residents. There was a weekly *Patient Protected Time* meeting, attended by residents and senior staff working in the approved centre.
- The complaints procedure was publicly displayed, naming both the local and regional complaints managers with contact details.

However, nursing staff shortages resulting in decreased numbers on shift in the approved centre had not been identified as a risk, assessed and included on the risk register. It was therefore difficult to assess the manner in which this risk was being managed.

# 2.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

1. A number of new healthcare professionals had commenced working in the approved centre. These included a psychologist two days per week, a cognitive behavioural nurse therapist two days per week and increased dietetic service to residents in the approved centre.

2. There was a weekly group Individual Recovery Care Plans (IRCP) group. This was facilitated with the aim of residents learning about the individual care planning process and to promote the resident being an active member of their recovery care planning. Additionally, the recovery care plan documentation had been reviewed and updated.

3. A regulatory compliance working group had reviewed and updated documentation pertaining to the transfer of a resident to another facility.

4. A physical health information tool had been developed and introduced into the service. This was used and accessed in part for six monthly physical health assessments required by regulation.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

The Adult Mental Health Unit (AMHU) was located on the campus of Mayo University Hospital (MUH). It served the county of Mayo which had a population of approximately 137,000. The service encompassed five general adult community mental health sector teams, namely: Castlebar, Ballina, Claremorris, Westport/Ballinrobe and Belmullet/Crossmolina/Newport. There were two Psychiatry of Old Age (POA) community teams, one Rehabilitation and Recovery team and one Mental Health Intellectual Disability team that had admitting rights to the approved centre. There was a liaison psychiatry team working directly in MUH. A Memory Assessment and Support Service operated on an outpatient basis. An in-reach model of care was provided for the residents by their respective care team.

The approved centre, which was not purpose built, was a located on the ground floor of what formerly had been a maternity ward. It was subdivided into a main ward and a High Dependency Unit (HDU). The main ward comprised of two single bedrooms and six dormitory style rooms with four or five beds in each. There had been extensive refurbishment and anti-ligature works since the last inspection that included, replacement of fire doors, replacement of windows, upgrading of bathrooms, painting, and renewal of soft finishings. Works were ongoing at the time of inspection and the service was waiting on the replacement of curtains and restoration or renewal of floor coverings. A painting contractor was on site. There was a large dining room, activity rooms that included an activities kitchen, a quiet room that was suitable for visitors, and a courtyard style garden. This garden, which was awaiting painting, had been enhanced to include large planter style boxes.

The HDU had four single bedrooms and a seclusion suite. The fire doors were on order and were due for replacement a month post the inspection date. Painting works, floor covering replacement and plasterworks were outstanding and staff stated these would be attended to immediately when the door works were completed. There was a small courtyard-style garden which was due for painting. The groundwork here had been specially cleaned since the last inspection.

The approved centre facilitated Electroconvulsive Therapy (ECT) and there was an ECT suite on site.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | ***32*** |
| **Total number of residents** | **32** |
| Number of detained patients | 11 |
| Number of wards of court | 0 |
| Number of children | 0 |

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

## 3.2 Governance

The approved centre was part of Community Healthcare West and was governed under the Mayo Mental Health Services (MMHS). The wider Community Healthcare West encompassed Galway and Roscommon. The Adult Mental Health Unit (AMHU) was one of four approved centres under the governance of MMHS and all were located in Castlebar town. The Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee (Q&PSC) meeting were both held monthly.

The approved centre was closely aligned with Mayo University Hospital (MUH) for premises and maintenance, food supplies and pharmaceutical products and services. Residents had access for general health services and emergency healthcare. The maintenance department worked closely with the staff in the approved centre and were involved in the refurbishment programme. Senior management of the approved centre held quarterly meetings with the general manager from MUH to discuss mutual issues. There was a development plan for MUH which included the building of an adult mental health unit.

The Adult Mental Health Unit management meeting was held monthly and attended by medical, nursing, administrative, and health and social care professionals. There was a weekly Clinical Risk and Governance meeting that discussed clinical concerns such as the HDU, one-to-one special nursing or chaperone requirements, restrictive practices, admissions and discharges. Residents who had been in the approved centre over three months were also discussed. At the time of inspection there were a number of residents who were considered to have a delayed discharge, mainly due to the difficulties in sourcing appropriate accommodation. Mayo Mental Health Services had a Tenancy Support Worker, through a Community Living Implementation group.

A named person with responsibility for risk management processes was known throughout the approved centre. It was understood that everyone had a responsibility for risk management through line management structures as appropriate. Risk management was supported by a Quality and Patient Safety (QPS) advisor who worked across the Mayo Mental Health Service. There were clear processes around risk assessments, maintaining a local risk register and escalation to the QPS committee for the Area Management Team (AMT) risk register as applicable. Most risks had been assessed, documented and monitored; however, there was no risk assessment evident for the ongoing nursing staff shortages.

The approved centre operated an in-reach model of care. This required medical and health and social care professionals from the treating teams to visit the approved centre and provide care and treatment to any resident from that sector or specialist team. These teams were supported by staff who worked directly in the approved centre, namely nursing staff and two occupational therapists. Additionally, a senior psychologist had commenced working directly in the approved centre two days per week. While this was generally satisfactory, plans were underway to introduce an inpatient consultant team, where residents would transfer temporarily to that team for care and treatment. In line with best practice for an in-patient service, two consultant teams would be required for the registered numbers of the approved centre.

At the time of the inspection, a review of the nursing rosters indicated that the number of registered psychiatric nurses working both day and night shifts varied considerably. For 146 shifts preceding and up until the days of the inspection, there was evidence that 75, just over half, had the required numbers of registered psychiatric nurses on duty. While there were a number of factors such as constant (or special) nursing observations and holiday leave this was deemed non-compliant with a critical risk rating. There was evidence that staff worked additional hours or time in lieu to help manage the staff shortages. Staff training figures from the previous inspection in July 2021 indicated that there were 44 nurses assigned to the approved centre. Staff training figures at the time of the inspection in October 2022, indicated that there were 30 nurses assigned to the approved centre. Additionally, an occupational therapy assistant position had been vacant for over a year.

Significant refurbishment works were on-going since the previous inspection. Most of these works were completed, and the service had provided assurances that works would be completed as soon as was possible. These included the replacement of doors in the High Dependency Unit, the replacement of a window in the Tribunal room, the replacement of all the curtains and where required the replacement of flooring. Although not finished these quality improvements had made a significant impact in the approved centre.

There was a Judgement Support Framework (JSF) working group. The JSF was a guidance document for the affiliated statutory regulations. This group which included multi-disciplinary team members and patient advocates had completed over a hundred audits. Notwithstanding the staffing issues identified, it was evident that quality improvement initiatives and good service provision was a guiding principle within the approved centre.

A representative from the Peer Advocacy in Mental Health service attended the approved centre on a weekly basis to meet with residents. Separately, representatives from the National Advocacy Service worked with individuals on a case-by-case basis. The latter was by referral, and available to any resident in the approved centre. There was a weekly *Patient Protected Time* meeting, attended by residents and senior staff working in the approved centre. This meeting which addressed general issues and concerns kept documented records with actions identified. The complaints procedure was publicly displayed, naming both the local and regional complaints managers with contact details. There was a Peer Support Worker (PSW) available to the residents. Mayo recovery college provided a range of courses and groups for the residents.

The service continued to operate within the guidelines for a general hospital setting for the management of COVID-19. There had been a number of declared outbreaks in the approved centre since the last inspection. These had impacted on the residents, staff and visitors throughout those identified times. Otherwise visiting was permitted with adherence to infection prevention and control measures. There were single rooms identified for residents who were isolating or awaiting results from COVID-19 testing. The groups sizes had increased since the last inspection and social distancing requirements had relaxed in line with national practices.

## 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 19: General Health | ✗ | Moderate | ✗ | High | ✗ | High | ✓ | | ✗ | Moderate |
| Regulation 22: Premises | ✗ | High | ✗ | Moderate | ✗ | Critical | ✗ | High | ✗ | High |
| Regulation 26: Staffing | ✗ | Critical | ✗ | High | ✓ | | ✓ | | ✗ | Critical |
| Regulation 32: Risk Management Procedures | ✓ | | ✓ | | ✗ | High | ✗ | Critical | ✗ | High |

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

## 4.2 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice | Details |
|---|---|
| Regulation 17: Children's Education | As the approved centre had not admitted any children since the last inspection, this regulation was not applicable. |
| Rules Governing the Use of Electro-Convulsive Therapy | As no involuntary patient had received ECT since the last inspection, this rule was not applicable. |
| Rules Governing the Use of Mechanical Means of Bodily Restraint | As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As no children had been admitted to the approved centre this code of practice was not applicable. |

# 5.0 Service-user Experience

## 5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. As such, service users' experiences were gathered in the following ways:

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

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

The inspectors met with three residents and received ten resident questionnaires. Resident feedback to the inspectors was that the food was good. The unit was described as well run. Residents stated that they saw their treating team twice weekly and had input into their Individual Care Plan (ICP). Each of the residents shared a room and all felt that they had enough individual space. Nursing staff were described as brilliant but very busy.

Feedback from the questionnaires indicated that five residents understood their care plan, and five residents indicated that they did not understand it. Six residents indicated that they knew who the members of their multi-disciplinary team were and four said that they did not know who they were. Seven of the ten residents said that they did not know who their keyworker was. Six residents indicated that they were "sometimes" able to discuss concerns or worries with staff, no one indicated "always" for this question, and four residents indicated "never" to this question. Six residents indicated that there were enough activities during the day, three indicated that there were not enough activities, and one left this question blank. Six residents indicated that they could communicate freely with family/friends/advocates, three said indicated that they couldn't communicate freely, and one left this blank. Five residents indicated that they "always" felt safe in the approved centre, three indicated "sometimes", one indicated "never", and one left this blank.

On a scale of 1-10 with 1 being poor and 10 being excellent, two residents rated 1, one resident rated 3, two residents rated 5 and 8 respectively, one rated 9 and one rated 10 out of 10 for overall experience of care and treatment. One questionnaire was incomplete for this section.

## 5.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the Peer Advocacy in Mental Health representative, who met with residents on weekly basis. The inspectors also spoke with a representative from the National Advocacy Service.

Feedback from the peer advocate on behalf of the residents was that the care was good in the approved centre. Residents praised the food, stated the staff were very helpful and liked the yoga, music, and art groups. The advocate stated that the residents had enjoyed the gardening groups, particularly planting flowers and enjoyed the outdoor space.

Areas in need of improvement as described to the advocate were mainly related to individual care needs. Common themes related to the vending machine being occasionally out of order, although this got resolved quickly. Residents had reported difficulties when group numbers were restricted because of COVID-19 protocols. Residents reported to the advocate that they did not feel free to come and go from the approved centre, but again thought that this might partly be due to COVID-19.

At the time of the inspection, representatives from the Irish Advocacy Service were working with four residents. This was on a one-to-one basis and depending on specific needs of the resident the advocate worked alongside the resident with a formal advocacy plan or worked using a non-instructed advocacy approach. General observations from the National Advocacy Service were that some residents were not in the most appropriate care setting. COVID-19 had reduced the availability of suitable accommodation.

# 6.0 Feedback Meeting

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

- Executive Clinical Director
- Head of Mental Health Service
- Consultant Psychiatrist
- Maintenance Manager (MUH)
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Regulatory Compliance Advisor
- Head of Pharmacy
- Acting Clinical Nurse Manager 2
- Occupational Therapy Manager
- Social Work Manager
- Psychology Manager
- Dietitian Manager
- Nurse Practice Development Coordinator

Apologies were received from the General Manager/ Registered Proprietor Nominee, Business Manager and Quality and Patient Safety Advisor.

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: name, date of birth, address, and the hospital identifier number.

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. The approved centre had a two-weekly menu cycle with seasonal variation and dietitian input. Residents had four choices for meals daily. A source of safe, fresh drinking water was available at all times in the approved centre.

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

**The approved centre was compliant with this regulation.**

## Regulation 6: Food Safety

**COMPLIANT**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

### INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food. Hygiene was maintained to support food safety requirements, and 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 March 2022.

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. There was a ward safe and a property log was maintained and audited.

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. Ward-based activities included board games, books, jigsaws, TV, and library books which were available on request. Exercise equipment was also available for resident use. The approved centre provided access to recreational activities on weekdays and during the weekend.

**The approved centre was compliant with the 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. Multifaith ministers were available through Mayo University Hospital. The hospital chaplain visited the approved centre weekly, or more frequently by request.

**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 June 2020.

Visiting times were appropriate and reasonable, and the justifications for any visiting restrictions were documented in the clinical file. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The quiet room and identified visiting spaces were available for residents to 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 Activities Room and Quiet Room used for visits were both suitable for child visitors.

**The approved centre was compliant with this regulation.**

## Regulation 12: Communication

**COMPLIANT**

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in March 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. There were mobile phones provided on the ward for communication. There was no Wi-Fi in the approved centre, but access to the Internet was available via a computer in the occupational therapy (OT) room.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others. There were no residents with restrictions on communication at the 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, which was last reviewed in March 2022, and a policy on the management of illicit substances and weapons, which was last reviewed in September 2021. Together, these policies 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.

Clinical files were examined on inspection in relation to three searches. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the residents' 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.

**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 June 2021.

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

**The approved centre was complaint with this regulation.**

## Regulation 16: Therapeutic Services and Programmes

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). Therapeutic programmes and services provided by the centre included art therapy, cognitive behavioural therapy (CBT) and anxiety management skills.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. There was a therapeutic services and programmes monitoring group which was attended by health and social care professionals, nursing staff, the physical health nurse, CBT therapist, recovery co-ordinator, and peer support worker.

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 June 2021. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer file included risk assessment, care needs, medication, and all other relevant information.

**The approved centre was compliant with this regulation.**

## Regulation 19: General Health

**NON-COMPLIANT**

**Risk Rating** MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in May 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 four residents who were in the approved centre for over six months were examined on inspection. The six-monthly health assessments documented a physical examination, family or personal history, medication review, and dental health. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

For one resident the six-monthly assessment did not record blood pressure or nutritional status. Adequate arrangements were not in place for one resident to access general health services and for their referral to other health services as required. Referral to the dietetic service where indicated, had not been offered, at the time of inspection.

Residents could access national screening programmes that were available according to age and gender, including but not limited to Breast check, Cervical screening, Retina check (diabetes only) and Bowel screening.

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

**a) The approved centre did not ensure that adequate arrangements were in place for access by residents to general health services and for their referral to other health services as required, as one resident had not received dietetics supports and had not been referred for such supports at the time of inspection, 19 (1)(a).**

**b) The approved centre did not ensure that each resident's general health needs were assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, as one resident did not have blood pressure or nutritional status recorded in their six-monthly general health assessment, 19 (1)(b).**

## Regulation 20: Provision of Information to Residents

**COMPLIANT**

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

### INSPECTION FINDINGS

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

On admission, residents were provided with required information, including care and services. The approved centre provided a Patient's Information leaflet and Relative/Supporter leaflet. The information in the leaflets was clearly and simply written, and available in the required formats to support resident's needs.

The approved centre's information leaflets 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. Notice boards around the approved centre also displayed information on activities, rights, supports, advocacy, and the complaints procedure.

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

**The approved centre was compliant with this regulation.**

## Regulation 21: Privacy

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

**The approved centre was compliant with this regulation.**

## Regulation 22: Premises

**NON-COMPLIANT**

**Risk Rating** HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. A quiet room, activity rooms, and sitting rooms were available to residents. There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points, however, were not minimised to the lowest practicable level, based on risk assessment.

The approved centre was not kept in good a state of repair externally and internally. In the main garden and in the High Dependency Unit (HDU) courtyard, windowsills were dirty and the paint on the walls was peeling off. In one single room paint on the walls and skirting board was peeling off. In a single room in the HDU, the wall was damaged, poorly repaired, and in need of painting. Floor coverings were badly marked and scuffed throughout resident bedrooms, activities rooms, main corridors, and in the tribunal room. Fire doors in HDU bedrooms were damaged, broken, and ineffective. A redundant cooker hood needed to be removed from the occupational therapy (OT) activities room. A ceiling tile in the OT assessment kitchen was badly stained due to water leaking into a vent pipe. The covering of an accordion

door in the OT activity room was damaged. Ligatures had not all been minimised throughout the approved centre.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was 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. All resident dorms and single rooms were en suite and there were male and female toilets on the ward. The assisted bathroom had been renovated and upgraded. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

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

a) **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that the flooring throughout the centre was scuffed, badly marked and in poor condition, 22 (1)(a).**
b) **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that a ceiling tile in the occupational therapy assessment kitchen was badly stained and the accordion door in the occupational therapy activities room was damaged, 22 (1)(a).**
c) **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that a single bedroom was damaged and in need of repair, 22 (1)(a).**
d) **The registered proprietor did not ensure that premises were clean and maintained in good structural and decorative condition, in that the walls and windowsills of the main garden area and the walls and windowsills in the High Dependency Unit courtyard was dirty and the paint was peeling off the walls, 22 (1)(a).**
e) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was 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, in that fire doors in the High Dependency Unit were broken and ineffective, 22 (3).**
f) **Ligature points had not been minimised to the lowest practicable level, based on risk assessment, 22 (3).**

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

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in April 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. No medication was directed to be crushed in the MPARs examined. Six-monthly review of medication was not applicable as none of the MPARs examined were for a resident who had been in the approved centre for over six months.

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.

**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 operational health and safety policy and procedures in place. The policy was last reviewed in July 2020.

**The approved centre was compliant with this regulation.**

## Regulation 25: Use of Closed Circuit Television

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in January 2022.

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

**The approved centre was compliant with this regulation.**

## Regulation 26: Staffing

**NON-COMPLIANT**

**Risk Rating** CRITICAL

(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 June 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 not sufficient to meet resident needs. In December 2021, there were 39 registered nurses on the roster for the approved centre; in September 2022, that number had reduced by almost 25% to 29 named individuals. As some residents in the centre required one-to-one nursing or support, this meant that the number of registered psychiatric nurses in the approved centre was not sufficient and not in line with the centre's registration requirements to meet resident needs, with consideration to the size and layout of the approved centre. A staff training table submitted by the service for the approved centre in July 2021 included 44 nurses, by comparison to the staff training table in October 2022 which included 30 nurses. Additionally, an occupational therapy assistant position had been vacant for over a year.

An appropriately qualified staff member was on duty and in charge 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 Fire Safety and the Mental Health Act 2001. Not all healthcare staff were trained in Basic Life Support and the Management of Violence and Aggression, but there was evidence to indicate that this had been due to COVID-19 outbreaks. All nursing staff were trained in these subjects, and plans were in place to ensure that the remainder would receive their training soon after the inspection. See the following table 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 (30) | 30 | 100% | 30 | 100% | 30 | 100% | 30 | 100% |
| Consultant Psychiatrist (11) | 10 | 91% | 11 | 100% | 10 | 91% | 11 | 100% |
| Medical (17) | 16 | 94% | 17 | 100% | 13 | 76% | 17 | 100% |
| Occupational Therapist (7) | 7 | 100% | 7 | 100% | 7 | 100% | 7 | 100% |
| Social Worker (12) | 10 | 83% | 12 | 100% | 10 | 83% | 12 | 100% |
| Psychologist (9) | 9 | 100% | 9 | 100% | 9 | 100% | 9 | 100% |

**The approved centre was non-compliant with this regulation because the numbers of registered psychiatric nurses were not sufficient and in line with the approved centre's registration staffing details in order to meet resident needs, with consideration to the size and layout of the approved centre, 26 (2).**

## 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 July 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.

**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 September 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. The Complaints Brochure was visibly displayed in the unit information board with contact information and methods of how to make a complaint. The information was also included in the resident's information leaflet.

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: the unit had a minor complaints booklet where all minor complaints were logged with details of the complaint and the resulting response or solution. All were dated and signed by staff members who had received the complaint.

All non-minor complaints were dealt with by the nominated person and were separately logged with clear details, dates, and an updated record of the status of the complaint. 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** HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management, as well as an Emergency Plan and a Prevention and Management of Covid plan. The risk management policy was last reviewed in February 2020, 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 and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Not all health and safety risks were identified, assessed, treated, reported, and monitored. There was no evidence that health and safety risks associated with a reduction in nursing staff had been assessed,

treated, or monitored by the management of the approved centre. This issue had not been documented in the risk register, as appropriate.

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

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

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that its risk management policy was implemented throughout the approved centre, as health and safety risks associated with a reduction in nursing staff were not assessed, treated, or monitored, and were not documented in the risk register as appropriate, 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 displayed prominently in the main entrance foyer.

**The approved centre was compliant with this regulation.**

# 8.0 Inspection Findings – Rules

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

## Section 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 was last reviewed in August 2022, and 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.

Three episodes of seclusion were reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage 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 the residents. 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.

The residents' next of kin or representative were informed of the episode of seclusion with the resident's consent. Where the resident or next of kin was not informed, the reason for this was recorded in the clinical file.

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 the episode of seclusion and reviewed every four hours.

The seclusion episodes were recorded in the clinical files and seclusion register by the person who initiated seclusion. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of each episode. A copy of the seclusion register was placed in the clinical files. Each episode was 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 Consent to Treatment

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The clinical file of a patient who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment and that the patient was unable to consent.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for the patient. It documented:

- The names of the medications proscribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.

- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

# 10.0 Inspection Findings – Codes of Practice

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

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

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

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

## Use of Physical Restraint

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in March 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 resident had capacity and did not consent to the next of kin or representative being informed, this was recorded in the clinical file.

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.**

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

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was last reviewed in August 2022. It contained protocols that were developed in line with best international practice, including:

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

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

**Evidence of Implementation:** The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery room. Material and equipment for ECT, including emergency drugs, were in line with best international practice. ECT machines were regularly maintained and serviced, and this was documented. A named consultant psychiatrist had responsibility for ECT management. A named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one voluntary patient who was receiving ECT was examined. The consultant psychiatrist assessed his or her capacity to consent to receiving treatment, and this was documented in their clinical file. The voluntary patient was deemed capable of consenting to receiving ECT. Appropriate information on ECT was given by the consultant psychiatrist to enable the voluntary patient to make a decision on consent to ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in a clear and simple language that they could understand. The voluntary patient was informed of his or her rights to an advocate and had the opportunity to raise questions at any time. Consent was obtained in writing for each ECT treatment session, including anaesthesia.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin and a current mental state examination. Cognitive assessments were completed before and after each ECT session.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine. The ECT record which was completed after each treatment and placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT was recorded. All cognitive assessments were recorded in the clinical file.

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

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

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

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

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

**Evidence of Implementation:**

**Admission:** The clinical file of one resident who had been admitted to the approved centre was examined. The admission had been on the basis of a mental illness or disorder and an admission assessment had been completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current and historic medications, current mental health state, and risk assessment. 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 medical practitioner. 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 medical practitioner on the day of discharge. A comprehensive discharge summary was also issued on the day of discharge.

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 and carers or advocates were involved in the discharge process, where appropriate. A timely follow-up appointment was made.

**The approved centre was compliant with this code of practice.**

## Appendix 1: Corrective and Preventative Action Plan

| Regulation 19: General Health | | | | | |
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| **Reason ID : 10003751** | | **The approved centre did not ensure that adequate arrangements were in place for access by residents to general health services and for their referral to other health services as required, as one resident had not received dietetics supports and had not been referred for such supports at the time of inspection, 19(1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The identified resident was referred to the Dietitian and did received dietetics supports. | Audit of Reg 19 General Health | yes | 31/10/2022 | Nurse Manager & Dietitian. |
| **Preventative Action** | Quarterly audits of Reg 19 by CNS in Physical Health. | Audits | yes | 30/06/2023 | Physical Health Nurse, Nursing Management & Dietitian. |
| **Reason ID : 10003752** | | **The approved centre did not ensure that each resident's general health needs were assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, as one resident did not have blood pressure or nutritional status recorded in their six-monthly general health assessment, 19(1)(b).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The identified resident did have his Blood Pressure recorded regularly on the INEWS. The nutritional assessment was completed with the identified resident at time of inspection. | 3 monthly audits by CNS Physical Health | yes | 30/06/2023 | Dietitian & Nurse Manager. |
| **Preventative Action** | The six-monthly general health assessment document | 3 monthly audits by CNS Physical Health | yes | 30/06/2023 | Physical Health Nurse, Dietitian & Nurse Manager. |

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| | has been reviewed and updated to prevent duplication and omissions. The six-monthly general health assessment had been added as an agenda item on the weekly Clinical Risk & Governance meeting. A Nutritional screening assessment training video is been update by the Dietitian. | | | | |

| Regulation 22: Premises | | | | | |
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| **Reason ID : 10003730** | | **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that the flooring throughout the centre was scuffed, badly marked and in poor condition, 22 (1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The flooring throughout the centre were deep cleaned & buffed. Plan for replacement of damaged areas. Funding has been identified. Awaiting final quotes. | Annual premises audit | Completed | 30/11/2022 | Business Manager & Maintenance Manager. |
| **Preventative Action** | Cleaning schedule in place. Audit by cleaning management and Infection Prevention Control Nurse (IPCN) monthly. Full unit inspection by IPC & ISS manager to happen on Wednesday 29th | Annual premises audit (31st May) | Yes | 31/05/2023 | Nurse Manager, IPC & Business Manager. |
| **Reason ID : 10003731** | | **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that a ceiling tile in the occupational therapy assessment kitchen was badly stained and the accordion door in the occupational therapy activities room was damaged, 22 (1)(a).** | | | |
| The approved centre did not provide acceptable Corrective and Preventable Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly. | | | | | |
| **Reason ID : 10003732** | | **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that a single bedroom was damaged and in need of repair, 22 (1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |

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| **Corrective Action** | Damaged wall in single bedroom (206) was repaired and re-painted. | Annual premises audit | Completed | 30/11/2022 | Maintenance manager. |
| **Preventative Action** | Annual premises audit & regular walk around by nursing management. Any damage caused reported on PMAC to maintenance department for repair. | Annual premises audit | Completed | 30/11/2022 | Nurse Manager & Maintenance manager. |
| **Reason ID : 10003733** | | **The registered proprietor did not ensure that premises were clean and maintained in good structural and decorative condition, in that the walls and windowsills of the main garden area and the walls and windowsills in the High Dependency Unit courtyard was dirty and the paint was peeling off the walls, 22 (1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | HDU Courtyards power washed & algae removed. Paving re-grouted. Main garden – awaiting painting. | Annual premises audit | Yes | 30/04/2023 | Maintenance Manager. |
| **Preventative Action** | Annual premises audit & regular walk around. | Annual premises audit | Yes | 31/05/2023 | Nurse Manager, Business Manager. |
| **Reason ID : 10003734** | | **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was 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, in that fire doors in the High Dependency Unit were broken and ineffective, 22 (3).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Bedroom fire doors in HDU area replaced as part of phase 2 of VSS contract works. | Annual premises audit | completed | 28/02/2023 | Business manager & Maintenance Manager. |

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| **Preventative Action** | Annual premises audit & regular walk around. | Annual premises audit | Yes | 31/05/2023 | Nurse Manager, Business Manager. |
| **Reason ID : 10003735** | | **Ligature points had not been minimised to the lowest practicable level, based on risk assessment, 22 (3).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Ligature audit completed and action plans developed to reduce ligatures to lowest practicable level. | Annual Ligature audit with quarterly updates | yes | 31/08/2023 | Maintenance manager, Business manager, Nurse manager. |
| **Preventative Action** | A ligature reduction group developed with quarterly meetings (next one 3rd April) to review and update ligature reduction plan. | Annual ligature audit | Yes | 03/04/2023 | Maintenance manager, Business manager, Nurse manager. |

| Regulation 26: Staffing | | | | | |
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| **Reason ID : 10003750** | | **The numbers of registered psychiatric nurses were not sufficient and in line with the approved centre's registration staffing details in order to meet resident needs, with consideration to the size and layout of the approved centre, 26(2).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Additional nursing resources have been implemented via national recruitment processes. Number of registered psychiatric nurses sufficient to meet the resident's needs. Approved Centre Register updated to reflect accurate nursing numbers. | Annual Audit of Reg 26 Staffing. | yes | 30/06/2023 | Area Director of Nursing. |
| **Preventative Action** | Predicted rotas are reviewed one week in advance and any reduction in nursing staff (due to leave/training) is planned for. Unplanned/unexpected leave and changes in demand (nursing specials etc) is managed as per Mayo Mental Health Service Staffing policy. | yes | yes | 30/06/2023 | Area Director of Nursing. |

| Regulation 32: Risk Management Procedures | | | | | |
|---|---|---|---|---|---|
| **Reason ID : 10003748** | | **The registered proprietor did not ensure that its risk management policy was implemented throughout the approved centre, as health and safety risks associated with a reduction in nursing staff were not assessed, treated, or monitored, and were not documented in the risk register as appropriate, 32(1).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Identified risks assessed, treated, documented and continue to be monitored by Nurse Managers on a daily/weekly base. Additional nursing resources have been implemented via national recruitment processes. | Annual Audit of Reg 32 Risk Management Procedures. | yes | 30/06/2023 | Area Director of Nursing, QPS Risk Advisor & Business Manager. |
| **Preventative Action** | Predicted rotas are reviewed one week in advance and any reduction in nursing staff (due to leave/training) is planned for. Unplanned/unexpected leave and changes in demand (nursing specials etc) is managed as per Mayo Mental Health Service Staffing policy. | Annual Audit of Reg 32 Risk Management Procedures. | yes | 30/06/2023 | Area Director of Nursing. |

## 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.

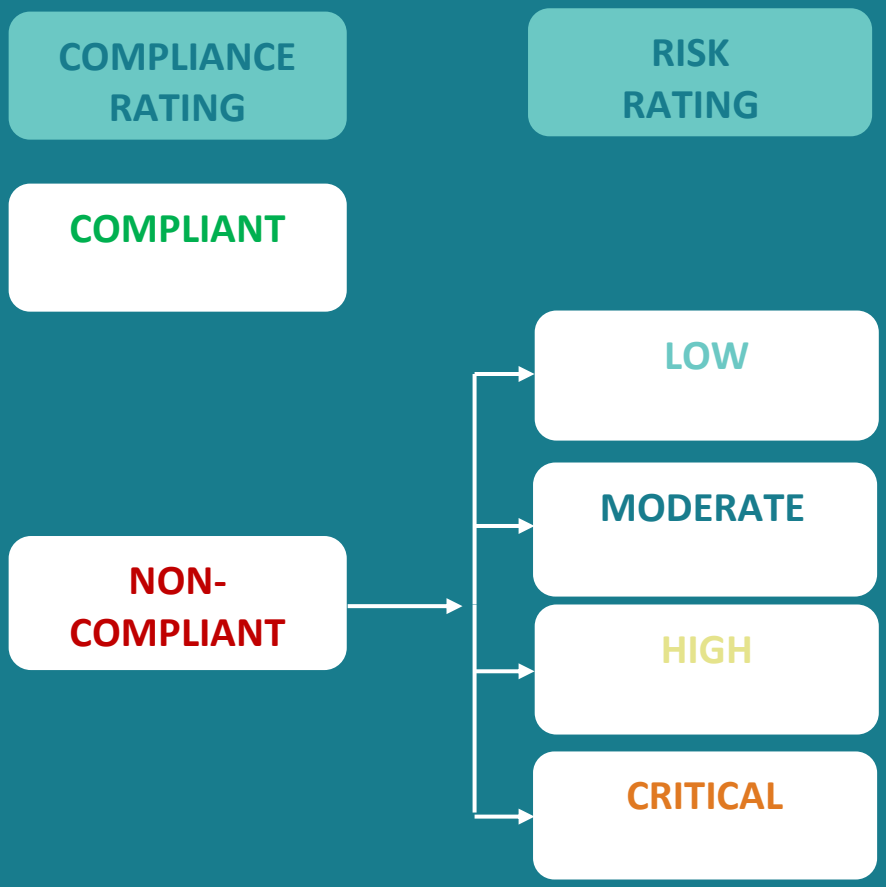
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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