Bloomfield Hospital

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

BLOOMFIELD HOSPITAL

Stocking Lane, Rathfarnham, Dublin 16

Date of Publication:
13 December 2023

ID Number: AC0131

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care / Long stay
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
Yes

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
Bloomfield Hospital CLG

Registered Proprietor Nominee:
Mr Joe Kelly, Chief Executive Officer

Inspection Team:
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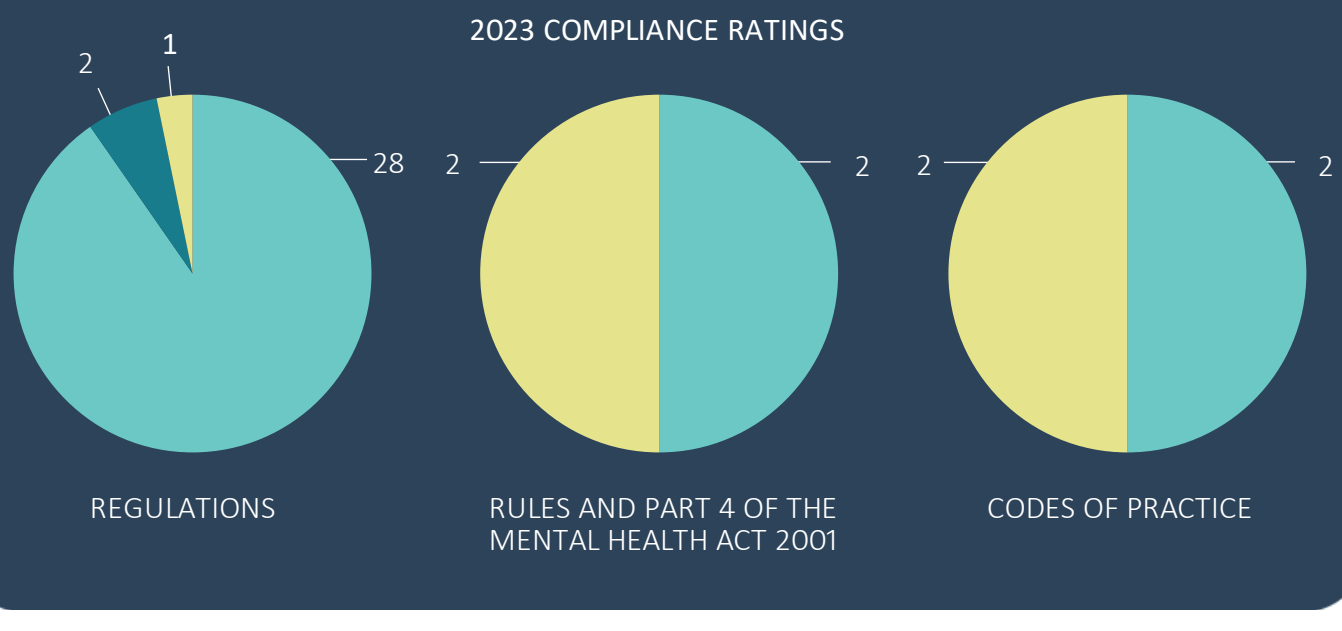
Dr Susan Finnerty MCRN009711

Inspection Date:
28 February to 3 March 2023

Previous Inspection date:
20 -23 September 2022

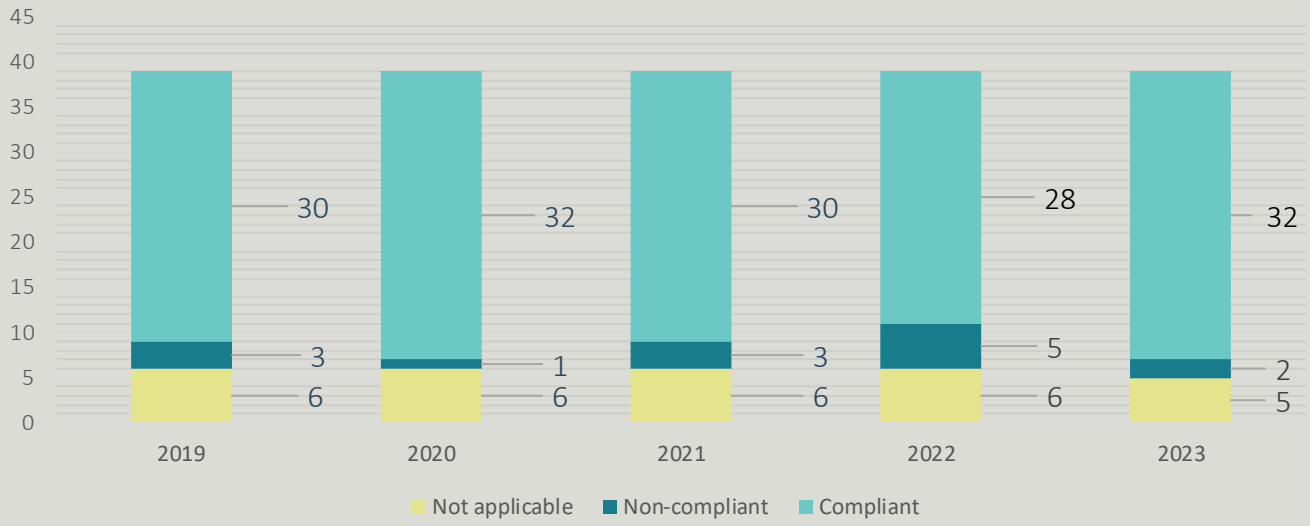
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2019 – 2023

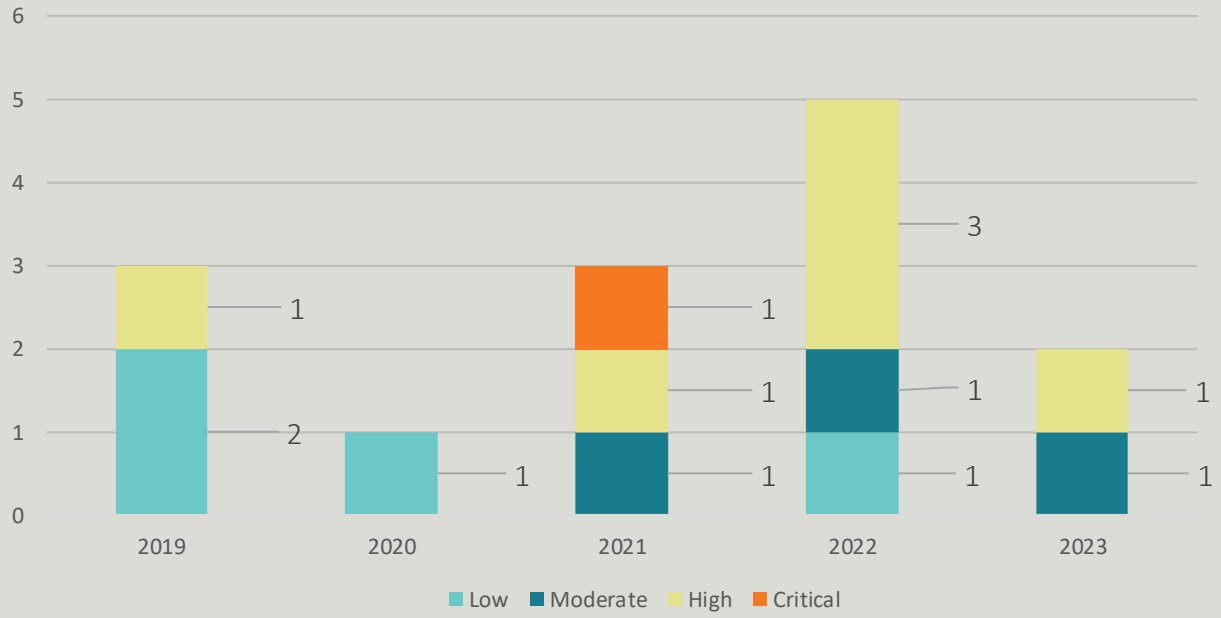
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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 2019 – 2023



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

In brief

Bloomfield Hospital was a 123-bed voluntary hospital in Rathfarnham, South Dublin. It provided treatment for residents with a range of severe and enduring mental health issues and neuropsychiatric disorders and was the national facility for the care of residents with Huntington's Disease. Bloomfield has a Specialist Rehabilitation Unit (SRU), with a specialised rehabilitation team. The approved centre provided residential and outpatient specialist mental health assessment, treatment, and support services to adults throughout Ireland. Admissions to the approved centre were pre-planned and by referral. The approved centre had three consultant psychiatrist led multi-disciplinary teams.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	91%	97%	91%	85%	94%

Conditions to registration

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

Conditions	Findings
Condition 1: *The approved centre must implement the Compliance Plan submitted to the Mental Health Commission by the service on 08 April 2022. The approved centre shall submit updates in a form and frequency specified by the Commission.*	The approved centre was in not in breach of Condition 1.

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Propose Condition 10000220	*14/04/2022*	*Condition proposed re 8 April 2022 compliance plan. Ongoing escalation at the time of the Inspection.*	*In response to an MHC programme of regulatory activities, the registered proprietor has implemented a quality improvement programme (which was attached as a condition of registration) which has resulted in a range of measures and initiatives to improve compliance and ensure resident safety.*

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

The approved centre demonstrated that they provided safe care in the following areas:

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** Not all staff had completed their mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Safeguarding:*** Staff were aware of safeguarding procedures.
- ***Access to essential information*****:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Alarms*****:** Staff were provided with alarms that were in working order.
- ***Infection control*****:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Ligature anchor points:*** The approved centre did not minimise ligature points to the lowest practicable level, based on risk assessment.
- ***Maintenance:*** Hazards were not minimised as there were two trip hazards in Donnybrook and Laurel Hill Units. The bathroom floors in Swanbrook Unit were very stained and in need of replacing. There were two water leak marks in the ceiling in Laurel Hill Unit.

Appropriate care and treatment of residents

The approved centre demonstrated that they provided appropriate care and treatment in the following areas:

- **Appropriateness of environment:** The layout and the decoration of Bloomfield was of good standard and residents. Renovations were ongoing to meet the needs of the population.
- ***Initial assessments:*** All residents had a comprehensive initial assessment on admission.
- ***Physical assessment:*** Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines. Residents had access to a local General Practitioner (GP) and local hospital for assessment and any treatment required.
- ***Multi-disciplinary Team:*** Psychology, social work, physiotherapy, dietetics, and speech and language therapy were accessible to all residents.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. There was evidence of significant engagement with residents in respect of their ICP. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed on a regular basis.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan.
- ***Access to other medical services:*** Specialist medical interventions were available if required.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Multi-disciplinary team :*** The numbers and skill mix of staff were not sufficient to meet the residents' needs. At the time of inspection, two occupational therapy posts were vacant. These services were being provided to residents through cross care cover. Recruitment was underway at the time of inspection to fill these roles.

Respect for residents' privacy, dignity and autonomy

The approved centre demonstrated that they respected people's privacy, dignity and autonomy in the following areas:

- ***Sleeping accommodation:*** While some bedrooms were multioccupancy the approved centre had plans to move to single en suite occupancy.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialisation. Clinical files were securely stored.
- ***Use of restrictive practices:*** At the time of the inspection, mechanical means of bodily restraint and physical restraint were used. The approved centre demonstrated compliance with the relevant Rule and Code of Practice.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

Responsiveness to residents' needs

The approved centre demonstrated that they were responsive to people's needs in the following areas:

- ***Environment:*** 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.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Residents were supported to attend religious services locally and other faiths could be accommodated on an individual needs basis.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.

- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: There was a wide range of recreational activities.
- ***Residents' feedback:*** All feedback was complimentary toward the staff and service provided. The residents were very complimentary about the environment and the care they received. They said that they received information on their treating teams and their individual care plans, were aware of their key workers and were able to give feedback about their care to staff. They said they had private spaces, their dignity was respected and that plenty of activities were provided during the day.

Governance, Leadership and Accountability

The approved centre had the following governance structures and processes in place:

- ***Structure in place:*** The approved centre was under the overall governance of a Board of Directors who met monthly. The Senior Management Team at the time of inspection met weekly and comprised the Chief Executive Officer (CEO), Clinical Director, Director of Nursing, Head of Human Resources, Head of Facilities and Technical Services, Financial Controller, and Head of Quality and Risk Management. Governance was strengthened by a Quality and Risk Executive Committee (QREC) which was held monthly and a Quality, Risk and Compliance working group (QRCWG) which met weekly.
- ***Leadership:*** There was strong leadership in place with a focus on improving quality.
- ***Clinical governance:*** Good clinical governance was in place which was evidenced in the documentation in residents clinical files. Regular clinical audits took place.
- ***Restrictive practices reduction:*** The service had developed and implemented a policy on the reduction of mechanical restraint and physical restraint, which included the training of all staff on the use of mechanical means of bodily restraint and physical restraint. The registered proprietor had appointed a senior manager responsible for the approved centre's reduction in mechanical means of bodily restraint and physical restraint.
- ***Risk:*** The approved centre had local unit risk registers that were maintained and overseen by Clinical Managers and the Head of Quality, Risk and Compliance. Applicable risks had been escalated to the executive risk register. Senior management formally reviewed the risk register every quarter and updated the register's content and control measures as necessary. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Training in risk management had been provided to staff.
- ***Quality improvement:*** The approved centre had an established culture of quality improvement. This was evident in the ongoing refurbishment of the approved centre. The progression and development of various quality initiatives in the approved centre were also a standing agenda item at the Quality, Risk and Compliance Working Group (QRCWG). A programme of audit was implemented by the multi-disciplinary team throughout the service.
- ***Policies:*** There was a multi-disciplinary approach to policy development, review, approval and dissemination and all policies were up to date at the time of inspection.
- ***Staff training:*** All staff had received mandatory training. Clinical supervision was provided for medical staff and the health and social care professional groups.

- ***Complaints:*** There was a robust complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, weekly resident community meetings, suggestion boxes, service user surveys, and engagement with the complaints process were utilised to support service improvement. There were clear processes in place to follow up on any issues identified by service users.
- ***Advocacy services:*** A designated advocate from the Peer Advocacy in Mental Health organisation contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last 5 years over 92%. It has a condition on its registration regarding implementation the Compliance Plan and is not in breach of this condition. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A wellbeing programme for staff was introduced. Staff recognition events, such as 'long service recognition' to celebrate staff who had reached significant career milestones, were also introduced.

2. A Nurse Practice Training Manager role was introduced to enable higher nurse standards of practice.

3. Influenza vaccines were provided to all staff and service-users in Bloomfield Hospital.

4. A Q-Pulse online quality and risk management system was implemented in the approved centre. This system electronically manage documentation for incidents, complaints, audits, risk registers, staff training, and staff performance reviews.

5. A Bloomfield Green Campus Committee was established as an initiative to reduce the approved centres carbon footprint by integrating efficient energy use, reducing waste, and increasing recycling.

6. The approved centre achieved a Gold Award from the Irish Heart Foundation for the Happy Heart Healthy Eating Programme.

7. A nutrition newsletter for staff and residents was developed and distributed on a monthly basis.

8. An end-of-life care booklet for families was developed.

9. A new medication prescription and administration record (MPAR) was developed to facilitate better management of anticipatory prescribing of palliative care medications.

10. A new risk assessment tool for the Specialised Rehabilitation Unit (SRU) was developed.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Bloomfield Hospital was a 123-bed voluntary hospital located on Stocking Lane in Rathfarnham, South Dublin. It was originally founded in 1812 by the Quakers in Ireland. It provided treatment for residents with a range of severe and enduring mental health issues and neuropsychiatric disorders. The approved centre provided residential and outpatient specialist mental health assessment, treatment, and support services to adults throughout Ireland. It also provided a national facility for the care of residents with Huntington's disease.

The approved centre was comprised of six distinct units:

- Kylemore Unit was a 15-bed unit that was the Specialist Rehabilitation Unit (SRU).
- Swanbrook was a 24-bed unit that catered for residents with Huntington's disease and those with other neuropsychiatric disorders.
- Owendoher was a 26-bed unit that catered for residents with enduring mental illness and challenging behaviour.
- Donnybrook was a 37-bed unit that catered for residents with dementia.
- Laurel Hill was a 12-bed unit that provided care for residents with high dependency needs.
- Pearson was a 9-bed unit used to provide relief beds for other units during renovations.

Bloomfield Hospital was an independent non-profit organisation. The hospital had a modern dining facility for both staff and residents. There was a well-equipped occupational therapy room, library, hairdressing services, and visiting room. These were all situated off a link corridor known as 'Wicklow way'. The approved centre had extensive grounds which were accessible to residents and visitors. Residents also had access to a sensory garden, courtyards, and landscaped gardens.

The approved centre had three consultant psychiatrist led multi-disciplinary teams (MDTs), which included a general practitioner (GP), social workers, occupational therapists, a pharmacist, physiotherapists, psychologists, nursing staff, health care assistants, and mental health support workers. Admissions to the approved centre were pre-planned and by referral.

The approved centre had commenced a programme of remedial works and while works where underway 14 beds had been decommissioned in Donnybrook unit. The approved centre had plans to expand the scope of the remedial works to include improved dining facilities, a move to single occupancy rooms and refurbishment. The water supply system was repaired, and fire doors were upgraded/replaced as necessary. The approved centre installed mirrored privacy coating to all residents' rooms on the ground floor which had previously been overlooked by public areas. All garden furniture was sanded down, treated, and repainted.

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

Resident Profile	
Number of registered beds	***123***
Total number of residents	**103**
Number of detained patients	9
Number of wards of court	12
Number of children	0
Number of residents in the approved centre for more than 6 months	94
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the overall governance of a Board of Directors who met monthly. The Senior Management Team at the time of inspection met weekly and comprised the Chairman of the Board, Chief Executive Officer (CEO), Clinical Director, Director of Nursing, Head of Human Resources, Head of Facilities and Technical Services, Financial Controller, and Head of Quality and Risk Management. Issues such as service development and strategy, recruitment, serious incidents, occupational health, safety, safeguarding, quality improvement, facilities, finance, risk management, and data protection, were discussed at these meetings.

Governance was strengthened by a Quality and Risk Executive Committee (QREC) which was held monthly and a Quality, Risk and Compliance working group (QRCWG) which met weekly. The QREC discussed quality indicators and outcome measures, policies and procedures, clinical audit and quality improvements, compliments and complaints, incidents/near misses, regulation and compliance, and risk management processes and review. The members completed an overview of the serious incidents reported within the approved centre and reviewed any issues identified as part of their risk management processes.

The QRCWG was a sub-group of the Quality and Risk Executive Committee. This working group managed the completion of regulatory compliance actions by monitoring compliance requirements, assigning action responsibility, and monitoring completion dates to ensure targets were achieved and compliance was maintained. The working group also managed the implementation of quality improvement actions arising from incident reviews, audits, and other inspection findings.

Subordinate committees included an infection control committee, a clozapine committee, a health and safety committee, a food and nutrition committee, a prevention and management of violence and aggression committee, a falls committee, and a drugs and therapeutics committee. All subordinate committees provided reports to the Quality and Risk Executive committee.

The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded using a standardised template and risk-rated and uploaded to the National Incident Management System (NIMS). The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had local unit risk registers that were maintained and overseen by Clinical Managers and the Head of Quality, Risk and Compliance. Applicable risks had been escalated to the

executive risk register. Senior management formally reviewed the risk register every quarter and updated the register's content and control measures as necessary. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Training in risk management had been provided to staff.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. The numbers and skill mix of staff were not sufficient to meet the residents' needs. At the time of inspection, two occupational therapy posts were vacant. These services were being provided to residents through cross care cover. Plans were in place to recruit and fill these roles. Health and social care professionals, including occupational therapy, psychology, social work, physiotherapy, dietetics, and speech and language therapy were accessible to all residents.

On 28 September 2022, the Mental Health Commission (MHC) published revised rules governing the use of mechanical restraint, and a revised code of practice relating to the use of physical restraint in approved centres. 01 January 2023, the new rule on the use of mechanical means of bodily restraint and code of practice on physical restraint came into effect. At the time of inspection, the approved centre used mechanical restraint and physical restraint and had commenced integrating the revised rule and code of practice. New policies, accounting for changes to the rule and code of practice, were available at the time of inspection. The service had developed and implemented a policy on the reduction of mechanical restraint and physical restraint, which included the training of all staff on the use of mechanical means of bodily restraint and physical restraint. The registered proprietor had appointed a senior manager responsible for the approved centre's reduction in mechanical means of bodily restraint and physical restraint.

At the time of the inspection, mechanical means of bodily restraint and physical restraint were applicable. Staff had carefully considered the use of physical restraint in the episodes inspected and that there were no other less restrictive ways available to manage the person's presentation. Mechanical restraint was only used when less restrictive alternatives were not deemed suitable. All the elements required by the new rule and code of practice were evident within the relevant clinical files inspected.

All Heads of Discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, and psychology. The inspector spoke with each head of discipline. Respondents outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. All disciplines had formal and informal clinical supervision arrangements in place where appropriate. Annual staff training plans were completed to identify and address training needs. Operational risks highlighted within these questionnaires included recruitment and retention of staff, and COVID-19 impacts such as staff absences and maintaining adherence with mandatory training requirements. The identified risks were effectively mitigated, with potential issues escalated to senior management meetings and via the risk management process.

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

the approved centre. There were clear processes in place to follow up on any issues identified by service users.

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

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

3.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

4.0 Compliance

4.1 Non-compliant areas on this inspection

Non-compliant (✗) areas on this inspection are detailed below. Also shown is whether the service was compliant (✓) or non-compliant (✗) in these areas between 2019 and 2023 and the relevant risk rating when the service was non-compliant:

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 22: Premises	✗	Low	✓		✗	Critical	✗	High	✗	High
Regulation 26: Staffing	✗	Low	✓		✓		✗	High	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The Inspectors spoke with five residents directly during the inspection and the inspection team received two completed service-user questionnaires.

Of the two completed questionnaires, both respondents indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood. Both respondents indicated that they had often received information on their diagnosis and care and treatment. Both respondents indicated that they understood what their care plan was, one indicated that they were 'always' involved in setting goals for their individual care plan, while one indicated that they were 'sometimes' involved.

Both respondents indicated that they knew their multi-disciplinary team members, and both indicated that they knew who their keyworker was. One respondent indicated that they were 'always' able to discuss worries or concerns with a member of staff, while one respondent indicated 'sometimes' to this question. Both respondents felt there were enough activities in the unit and were happy with how staff spoke with them.

Both respondents felt their privacy and dignity were respected during their stay and all respondents said they could communicate freely with family, friends, or advocates. Both said that they 'always' felt safe in the approved centre. One respondent indicated that they were 'always' able to give feedback to staff and to make a complaint when they were not satisfied with any part of their stay, while one respondent indicated 'sometimes' to this question.

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

The inspection team spoke with four residents in person and one resident over the phone. This feedback indicated that:

- Residents commented that the approved centre was comfortable, a nice place to be in, and they felt well-looked after and happy there.
- Residents commented that staff were very helpful, respectful, approachable, and helped to give them confidence.
- Residents commented that there were a lot of activities to take part in, and described them as 'tremendous.'
- Residents commented that the food was very nice and that they had a choice of meals.
- Residents commented that their care plan provided great support and that the team involved their family which they found helpful.
- Residents commented that it was nice to have their own room and bathroom, that it was lovely and comfortable, and noted that they had access to the garden.

5.2 Advocacy

The approved centre had an advocacy service. The advocate visited the approved centre on a weekly basis and offered face-to-face individual and group consultations to residents.

The inspection team spoke with a representative from the advocacy service who furnished the inspectors with a report detailing advocacy activity within the approved centre. Residents expressed to the advocate that nursing staff were available to discuss any issues that they had, and that they appreciated the outings that were organised by the staff. Residents expressed that the range of activities in the occupational therapy suite were greatly appreciated, for example art, pottery, relaxation, mindfulness, walks, and the men's shed groups. Residents expressed that the choice of food was very good and special dietary needs were catered for.

Some residents in the Specialised Rehabilitation Unit (SRU) expressed that they would like more time out on their own.

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:

- Chief Executive Officer (CEO)
- Clinical Director
- Head of Quality Risk & Compliance
- Director of Nursing
- Head of Facilities & Technical Services
- Assistant Director of Nursing x 2
- Chief Financial Officer
- Head of Human Resources
- Senior Occupational Therapist
- Pharmacist
- Executive Assistant to CEO
- Nurse Practice Development Manager
- IPC Clinical Nurse Manager
- Clinical Nurse Manager 3
- Consultant Neuro-Psychiatrist
- Senior Clinical Psychologist
- Principal Social Worker

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 appropriate resident identifiers before administering medications, undertaking medical investigations, and providing other healthcare services. Identifiers included resident photograph, name, and date of birth. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. Residents had the option of three hot options including meat, fish and vegetarian. There were additional options available to residents, such as salads, wraps, sandwiches, and paninis.

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 and serving of food. The approved centre had a main kitchen and smaller kitchenette units on the wards. Hygiene was maintained to support food safety requirements. 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 practises. 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 operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in September 2022.

Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to a wide range of recreational activities appropriate to the resident group profile on weekdays and weekends.

The approved centre had a full-time activities coordinator. Each unit had a weekly activities timetable which was developed for the cohort of residents which included both recreational and therapeutic activities. Residents had access to a recreational room on the wards and also access to the day centre activities room, kitchen, library room, art room, group room, and garden.

At the time of inspection, the sensory garden was being upgraded. There was a wide range of recreational activities including activities, such as books, jigsaws, board games, TV and DVDs. A mobile library visited the approved centre once a month and a hairdresser visited weekly. Some residents took part in aerobic exercises and walking. Activities were available to residents on a one-to-one and group basis, including: movie nights, music, table tennis, pool table, bowls, exercise, mindfulness colouring, quizzes, bingo, karaoke, storytelling, newspapers, word search, hand massage, sing-along, prayers, knitting club, book club, drama club, history club, movie club, outings, cookery, and gardening.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written policies and procedures in relation to visits. The policy was last reviewed in February 2023. At the time of inspection, visiting times were flexible, appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits . Residents could meet visitors in a private visiting area unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting area was suitable for visiting children.

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 written policies and procedures in relation to communication. The policy was last reviewed in April 2022. Residents in the approved centre had access to postal mail and internet including e-mail and telephone, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was a reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in April 2022, and included all requirements related to:

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

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

Residents were informed by the those implementing the search of what was happening during the search, and why. A minimum of two clinical staff attended all times during the searches, and due regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search was 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. This policy was last reviewed in August 2022. The clinical files of two residents were reviewed on inspection.

The end of life care provided was appropriate to the resident's physical, emotional, social, psychological, and spiritual needs. This was documented in the resident's individual care plan. Religious and cultural practices were respected, insofar as practicable. The privacy and dignity of the resident was protected, and the resident was given a single room within the approved centre during the provision of end of life care. Representatives, family, next of kin, and friends were involved, supported and accommodated during end of life care.

The sudden death was managed in accordance with the resident's religious and cultural practises, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends. All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment. 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 identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT at least six-monthly, in consultation with the resident and their family representative. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans, and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Occupational therapy (OT), social work and psychology provided therapeutic group programme input, and one-to-one sessions for the residents when identified on the resident's individual care plan. Each unit had a weekly combined therapeutic and recreational activities programme. Therapeutic activities included: reminiscence therapy, sensory programmes, music therapy, gardening groups, exercise groups, art therapy groups, social skills groups, cooking and nutritional groups, healthy eating groups, decider skills and emotional regulation groups. Social work provided the resident's with one on one sessions, examples included: family work, financial management and discharge planning. The therapeutic programme was reviewed every eight weeks with multi-disciplinary team (MDT) involvement to ensure the programme was meeting individual needs.

Where a resident required a therapeutic service or programme that was not provided internally such as dietetics, speech and language therapy, and physiotherapy; the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in September 2022. The clinical file of one resident who had been transferred from the approved centre to a different approved centre was inspected. Full and complete written information for the resident was transferred when they were moved from the approved centre. Information accompanied the resident upon transfer, to a named individual, including a letter of referral that contained a list of current medications and a resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy. The policy was last reviewed in February 2023.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans and 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 five residents who had been in the approved centre over six months were reviewed. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, body mass-index and weight. For residents on anti-psychotic medication the six-monthly form documented that there had been an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG).

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

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in May 2022.

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

Residents were provided with written and verbal information on diagnosis where appropriate, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication 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. Staff appearance and dress were appropriate, and staff showed discretion when discussing the resident's condition or treatment needs.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains or opaque glass. Where residents shared a room, the bed screening ensured their privacy was not compromised. 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 personal space, and appropriately sized communal rooms were provided. Rooms were ventilated. There was suitable and sufficient heating throughout the approved centre. 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 residents in finding their way around the approved centre. Sufficient spaces were provided for residents to move about, including outdoor spaces.

Hazards were not minimized as there were two trip hazards identified in Donnybrook and Laurel Hill Units. In Lauren Unit, the trip hazard was a floor lifting/raised up in the doorway between the sitting room and veranda area. In Donnybrook Unit, the trip hazard comprised eroded cement in a doorway which was located between the sitting room and small outdoor area where residents potted plants. Both trip hazards were rectified during the inspection.

Numerous ligature points were not minimised to the lowest practicable level, based on risk assessment.

The approved centre had a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Current national infection control guidelines were followed. The centre was clean and hygienic. The approved centre, however, was not kept in a good state of repair internally. The bathroom floors in Swanbrook Unit were very stained and in need of replacing. There were two water leak marks in the ceiling in Laurel Hill Unit.

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

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

a) **The registered proprietor did not ensure that the premises were maintained in good structural and decorative condition. The bathroom floors in Swanbrook Unit were very stained and in need of replacing. There were two water leak marks in the ceiling in Laurel Hill Unit, 22 (1)(a).**
b) **Hazards were not minimised as there were two trip hazards in Donnybrook and Laurel Hill Units, 22 (3).**
c) **The approved centre did not minimise ligature points 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 on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in September 2022. The policy included:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing resident medication.
- The process for the 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. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; a record of all medications administered to the resident, and a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition; this was documented in the clinical file. Directions to crush medication were only accepted from the resident's medical practitioner with a documented reason as to why.

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere, such as the refrigerator. Schedule 2 controlled drugs were locked in a separate cupboard from other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in February 2023.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

(a) it shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in February 2023.

There were clear sings in prominent positions where CCTV cameras were located throughout the approved centre. Residents were monitored solely for the purpose of ensuring their health, safety and welfare, and any monitoring systems were viewed only 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. All monitoring systems in the approved centre were incapable of recording or storing a resident's image on tape, disc, hard drive, or any other form. The Mental Health Commission had been informed about the approved centre's use of CCTV.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating **MODERATE**

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

An appropriately qualified staff member was on duty and in charge at all times. The numbers and skill mix of staffing were not sufficient to meet resident needs. At the time of inspection there were two occupational therapists (OT) posts vacant in the approved centre: the senior OT post was vacant since December 2022, and the basic grade OT was vacant since January 2023. A recruitment campaign for the two vacant posts in the OT Department had commenced in December 2022 and was on going at the time of inspection. This included a campaign launched by the approved centre and a campaign launched by five healthcare recruitment agencies.

Not all healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression.

All healthcare staff were trained in the Mental Health Act 2001. 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. The following is a table of staff showing the numbers and percentages of staff trained in the four mandatory training topics:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (77)	64	83%	65	84%	71	92%	77	100%

Consultant Psychiatrist (2)	2	100%	1	50%	0	0%	2	100%
Occupational Therapist (3)	3	100%	3	100%	3	100%	3	100%
Social Worker (2)	2	100%	2	100%	1	50%	2	100%
Psychologist (3)	1	33%	2	67%	0	0%	3	100%
Physiotherapist (2)	2	100%	1	50%	2	100%	2	100%
Senior Management (7)	0	0%	5	71%	4	57%	7	100%
Other MDT (107)	98	92%	99	93%	101	94%	107	100%

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

a) **The numbers and skill mix of staffing were not sufficient to meet residents' needs, 26 (2).**
b) **The registered proprietor did not ensure that all staff had access to training to enable them to provide care and treatment in accordance with best contemporary practice, as not all staff had completed their mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26 (4).**

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in September 2022. Resident records were secure, up-to-date, and in good order, and were physically stored together in a secure office. All resident records were reflective of the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence and maintained in good order. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of inspections relating to 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 policies and procedures requiring a three-yearly review had been reviewed and updated as required.

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 operational policy and procedures on the complaints process. The policy was last reviewed in June 2021 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible and available for dealing with all complaints who was based in the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed.

Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly, and handled appropriately and sensitively. The registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of the complaint being made. Minor complaints were documented and actioned appropriately. All complaints that were not minor were dealt with by the nominated person; however, no complaints had been made since the previous inspection.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management. The policy was last reviewed in April 2022. The risk management policy and associated safety statement addressed all policy requirements, including:

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

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

Individual risk assessments were completed prior to and during physical restraint and mechanical restraint. Individual risk assessments were also completed in conjunction with medication requirements or administration; at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm; resident transfer and resident discharge. 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 and the risk advisor reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymous at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently at the reception area of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

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 Mechanical Restraint which was last reviewed in February 2023. The policy addressed the following:

- Who may initiate and carry out mechanical restraint.
- The provision of information to the person, including the person's rights, presented in accessible language and format.
- The safety, safeguarding, and risk management arrangements followed during any episode of mechanical restraint.

The approved centre had a policy on the reduction of mechanical restraint. The policy was dated February 2023. The policy addressed the following:

- How the approved centre aimed to reduce, or where possible eliminate, the use of mechanical restraint within the approved centre.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.
- How the approved centre will provide positive behaviour support as a means of reducing, or where possible eliminating, the use of mechanical restraint within the approved centre.

The policy and procedures for training all staff involved in mechanical restraint addressed the following:

- Who will receive training.
- The areas to be addressed within the training programme.
- An assertion that staff applying mechanical restraint devices must have appropriate training in their use.
- The identification of appropriately qualified individuals to give the training.

Training and Education: There was a written record to indicate that all staff involved in mechanical restraint had read and understood the policy relating to the use of mechanical restraint. All staff who participated or may participate in the use of mechanical restraint had received appropriate training in its

use, and in the related policies and procedures, and the training was in accordance with the relevant policy.

There was a record of training attendance.

Monitoring: The annual report on the use of mechanical restraint in the approved centre was published on the registered proprietors website. The multi-disciplinary team (MDT) review and oversight committee had undertaken a detailed analysis of every episode of mechanical restraint.

Evidence of Implementation: Three episodes of mechanical restraint was reviewed during the inspection process. Mechanical restraint was only used to address an identified clinical need and/or risk. Mechanical restraint was only used when less restrictive alternatives were deemed unsuitable. Each episode was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist on their behalf. A risk assessment of the safety and suitability of mechanical restraint was undertaken, and it specified the monitoring arrangements and frequency to be implemented during its use. The MDT developed a plan of care for each person restrained by mechanical means, including information on attempts to reduce or eliminate the use of restraint for that person.

Each clinical file contained a contemporaneous record that specified the following: that there was an enduring risk of harm to the self or others; that less restrictive alternatives were implemented without success; the type of mechanical restraint; the situation in which mechanical restraint was being applied; the duration of the restraint; the duration of the order; and the review date. The approved centre notified the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the correct format, and within the timeframes set by the Mental Health Commission.

Clinical Governance: The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of mechanical restraint.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of nine patients who had been in the approved centre for more than three months and who had been in continuous receipt of mediation were examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment on each of the nine patients and that eight of the nine patients were unable to consent. One of the nine patients was able to consent and the approved centre met all of the stipulated requirements.

In relation to the eight patients who were unable to consent to treatment, a Form 17 *Administration of Medicine for More than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for each of the eight patients. It documented: the names of the medications prescribed, a confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications, as well as details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits, as well as any supports provided to the

patient in relation to the discussion and their decision-making. The form also included approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

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 (PR). The policy had been reviewed annually and was dated February 2023. It addressed the following:

- The provision of information to the person which included information about the person's rights, presented in accessible language and format; information regarding who can initiate and who may carry out PR; information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of PR.
- Policies and procedures regarding staff training including the following:
- Who will receive training based on the identified needs of persons who are restrained and staff
- The areas to be addressed within the training programme, which included training in:
  The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques); alternatives to PR; trauma-informed care; cultural competence, human rights, including the legal principles of restrictive interventions; positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic, and the monitoring of the safety of the person during and after the PR.
  The identification of appropriately qualified person (s) to give the training.
- The mandatory nature of training for those involved in PR.

The approved centre had a policy on the reduction of physical restraint. It addressed the following:

- Details of how the approved centre aimed to reduce, or where possible eliminate, the use of PR within the approved centre, including its use of positive behaviour support.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.

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. All staff who participated or may participate in the use of physical restraint had received appropriate training in the use of physical restraint and in the related policies and procedures regarding staff training. All staff who participated or may participate in the use of physical restraint had received training in cultural competence, and in the positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic. A record of attendance at physical restraint training was maintained by the approved centre.

Monitoring: Was not applicable nor inspected at the time of the inspection as the first quarter of 2023 was not yet over at the time of the inspection.

Evidence of Implementation: The clinical file of one resident who was physically restrained three times since the last inspection, was examined on inspection. PR was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy on physical restraint. The physical restraint order confirmed that there were no other less restrictive ways available to manage the person's presentation. The consultant psychiatrist (CP) or the duty consultant was notified as soon as was practicable and this was recorded in the clinical files. The RMP completed a medical examination of each of the residents (a physical examination) no later than two hours after the episodes of PR. The orders for PR lasted a maximum of 10 minutes.

The Clinical Practice Form (CPF) was signed by the CP within 24 hours. The residents were informed of reasons for, likely duration of, and circumstances leading to discontinuation of PR unless the information may have been prejudicial to the residents' mental health, well-being, or emotional condition.

In all episodes of physical restraint, as soon as was practicable, and as it was the person's wish in accordance with their individual care plan, the person's representative was informed of the person's restraint and a record of this communication was placed in the clinical file. The Mental Health Commission (MHC) was notified through the Comprehensive Information System (CIS) of the start time and date, and the end time and date of each episode of PR in the format specified by the MHC, within three days of the restraint.

A same sex staff member was present at all times during the episodes of PR. In the three episodes of physical restraint the person was continuously assessed throughout the use of restraint to ensure the person's safety and this was documented. In all three episodes of physical restraint the person's head and neck were supported where necessary. In all three episodes of physical restraint the person's airway and breathing were not compromised.

The person who lead the physical restraint ended it. The time, date, and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended.

An in-person debrief with the person who was restrained followed two of the three episodes of PR. The person refused to engage in the de-brief in one episode of physical restraint. This debrief was person-centred and gave each person the opportunity to discuss the PR with members of the multi-disciplinary team (MDT) involved in the person's care and treatment as part of a structured debrief process.

The debrief included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. The debrief included a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future, such as preferences in relation to which restrictive intervention they would not like to be used. The person's individual care plan was updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward. There was a record of all attendees who were present at the debrief, this was recorded in the clinical files.

The episodes of PR were recorded on the clinical practice forms located in the clinical file. The episodes of PR were reviewed by members of the MDT within five working days from the date of the restraint. The review covered everything required to be covered. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

Transfer: The transfer policy, which was last reviewed in September 2022, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in September 2022, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who was admitted to the approved centre was reviewed on inspection. A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the following: presenting problem; past psychiatric history, family history, medical history, current and historic medication, where relevant, social and housing circumstances, current mental health state, risk assessment, full physical examination, and other relevant information. The resident's family member, carer, or advocate 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 was discharged from the approved centre was reviewed on inspection. The discharge plan included the following: estimated date of discharge, documented communication with the relevant general practitioner or primary care team or community mental health team (CMHT); a follow-up plan; and a reference to early warning signs of relapse and risks. The discharge

meeting was attended by residents, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate, where appropriate and with the consent of the resident.

The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs. Discharge was coordinated by a key worker. The preliminary discharge summary was sent to the relevant general practitioner, or primary care team or community mental health team within three days.

The comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, 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.

The approved centre was compliant with this code of practice

Appendix 1: Corrective and Preventative Action Plan

Regulation 22: Premises					
Reason ID : 10003940		Hazards were not minimised as there were two trip hazards in Donnybrook and Laurel Hill Units, 22 (3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The trip hazard identified in Donnybrook Unit at the time of inspection was rectified at the time of inspection. The minor uneven surface noted on the floor in a small area of Laurel Hill is scheduled for repair in October 2023.	Floors will be monitored via the following methods to ensure hazards do not arise again: Facilities audits Premises audit Quality walk-abouts Senior Management Team (SMT) walk-abouts Daily environmental checks on units Any items of concern will be recorded and actioned appropriately.	No barriers identified	31/10/2023	Head of Facilities supported by the Senior Management Team
Preventative Action	The replacement flooring in Swanbrook Unit will ensure the stains are removed. Following the renovation works, Swanbrook premises will continue to be monitored via: Facilities audits	Any non-compliances noted in audits or walk-abouts will automatically be entered Bloomfield's new Quality Management System QPulse as a non-conformance which automatically raises a Quality Improvement	No barriers identified	31/10/2023	Head of Facilities supported by the Senior Management Team

	Premises audit Quality walk-abouts Senior Management Team (SMT) walk-abouts Daily environmental checks on units The Laurel Hill ceiling will also be monitored via: Facilities audits Premises audit Quality walk-abouts Senior Management Team (SMT) walk-abouts Daily environmental checks on units Any items of concern will be recorded, actioned and reviewed utilising the tracking capabilities of QPulse Quality Improvement Project management module.	Project (QIP) with an assigned owner and timeline. These QIPs are reviewed each week at SMT meetings to ensure target completion dates are adhered to and that the actions are appropriate and effective.			
Reason ID : 10003941		**The approved centre did not minimise ligature points to the lowest practicable level, based on risk assessment, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is an ongoing programme of ligature works in Bloomfield Hospital. The attached 2023 - 2026 Bloomfield	Ligature point audits are conducted annually on each ward with findings risk assessed (utilising the Queensland Tool)	Completion of all ligature works is dependable on funding from the HSE.	31/12/2026	Senior Management Team

	Hospital Ligature Minimisation Plan outlines the risk assessed plan to be implemented by the Senior Management Team. Clinical risk assessments and clinical observations are in place for each resident to ensure the risk of ligature points is at the lowest possible level.	and entered onto the appropriate risk register. Ligature points are also incorporated into the 6 monthly Premises Audit.			
Preventative Action	There is an ongoing programme of ligature works in Bloomfield Hospital. The attached 2023 - 2026 Bloomfield Hospital Ligature Minimisation Plan outlines the risk assessed plan to be implemented by the Senior Management Team. Clinical risk assessments and clinical observations are in place for each resident to ensure the risk of ligature points is at the lowest possible level.	Ligature point audits are conducted annually on each ward with findings risk assessed (utilising the Queensland Tool) and entered onto the appropriate risk register. Ligature points are also incorporated into the 6 monthly Premises Audit.	Completion of all ligature works is dependable on funding from the HSE.	31/12/2026	Senior Management Team

Reason ID : 10003942		The registered proprietor did not ensure that the premises were maintained in good structural and decorative condition. The bathroom floors in Swanbrook Unit were very stained and in need of replacing. There were two water leak marks in the ceiling in Laurel Hill Unit, 22 (1)(a).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The water leak marks in Laurel Hill were rectified in the days following inspection. Fire remedial works are due to commence in Swanbrook Unit next month (October 2023), this will include a full renovation of the unit including floor replacement throughout which will rectify the staining on bathroom floors.	The Head of Facilities will oversee the renovation of Swanbrook Unit ensuring the renovation works are of a compliant and acceptable standard for residents and staff. All ceilings will be monitored via: Facilities audits Premises audit Quality walk-abouts Senior Management Team (SMT) walk-abouts Daily environmental checks on units	No barriers identified	31/05/2024	Head of Facilities supported by the Senior Management Team
Preventative Action	The replacement flooring in Swanbrook Unit will ensure the stains are removed. Following the renovation works, Swanbrook premises will continue to be monitored via:	Any non-compliances noted in audits or walk-abouts will automatically be entered Bloomfield's new Quality Management System QPulse as a non-conformance which automatically raises a	No barriers identified	31/05/2024	Head of Facilities supported by the Senior Management Team

	Facilities audits Premises audit Quality walk-abouts Senior Management Team (SMT) walk-abouts Daily environmental checks on units The Laurel Hill ceiling will also be monitored via: Facilities audits Premises audit Quality walk-abouts Senior Management Team (SMT) walk-abouts Daily environmental checks on units Any items of concern will be recorded and actioned appropriately.	Quality Improvement Project (QIP) with an assigned owner and timeline. These QIPs are reviewed each week at SMT meetings to ensure target completion dates are adhered to and that the actions are appropriate and effective.			

Regulation 26: Staffing					
Reason ID : 10003943		**The registered proprietor did not ensure that all staff had access to training to enable them to provide care and treatment in accordance with best contemporary practice, as not all staff had completed their mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26 (4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A comprehensive schedule of mandatory and non-mandatory training is currently in place at Bloomfield Hospital. The maximum number of training sessions are always offered to staff to attend. An increased effort has been made by Heads of Departments to release staff from day duties to attend mandatory trainings and refresher trainings. Compliance with mandatory trainings has greatly increased since the time of inspection.	Regular auditing of training needs within all departments is conducted by the HR Team. Gaps identified are communicated to Heads of Department and staff are scheduled for training.	No barriers identified	31/12/2023	Head of Human Resources supported by the Senior Management Team
Preventative Action	Bloomfield recently implemented My Training Portal on	Regular auditing of training needs within all departments is	No barriers identified	31/12/2023	Head of Human Resources supported

	QPulse which enables staff to view all available training sessions and book themselves into suitable sessions. It also enables staff to view their training record and keep it up to date. This new electronic system will also assist with 100% accurate statistic analysing which will assist the HR Team in easily identifying staff who are almost due their refresher training and therefore book these staff into refresher sessions prior to their expiration date.	conducted by the HR Team. Gaps identified are communicated to Heads of Department and staff are scheduled for training.			by the Senior Management Team
Reason ID : 10003944		**The numbers and skill mix of staffing were not sufficient to meet residents' needs, 26 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Recruitment for vacant posts is continuously underway. Recruitment for posts is commenced as soon as resignation notifications are received.	Continuous monitoring of staffing levels by the HR Team & Heads of Departments.	Inadequate funding from the HSE preventing Bloomfield from offering staff market rates & benefits, therefore, potential candidates seek employment in alternative hospitals and Bloomfield posts remain vacant. This inadequate funding also	31/12/2023	Head of Human Resources supported by the Senior Management Team

			inhibits talent retention as staff seek market rates & benefits elsewhere.		
Preventative Action	Re-deployment for adjustments to service is pre-planned to ensure minimal disruption to service and the maintenance of an appropriate skill mix. The Chief Executive is continuously lobbying for increased funding for Bloomfield.	Continuous monitoring staffing levels by the HR Team & Heads of Departments.	Inadequate funding from the HSE preventing Bloomfield from offering staff market rates & benefits, therefore, potential candidates seek employment in alternative hospitals and Bloomfield posts remain vacant. This inadequate funding also inhibits talent retention as staff seek market rates & benefits elsewhere.	31/12/2023	Head of Human Resources supported by the Senior Management Team

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.

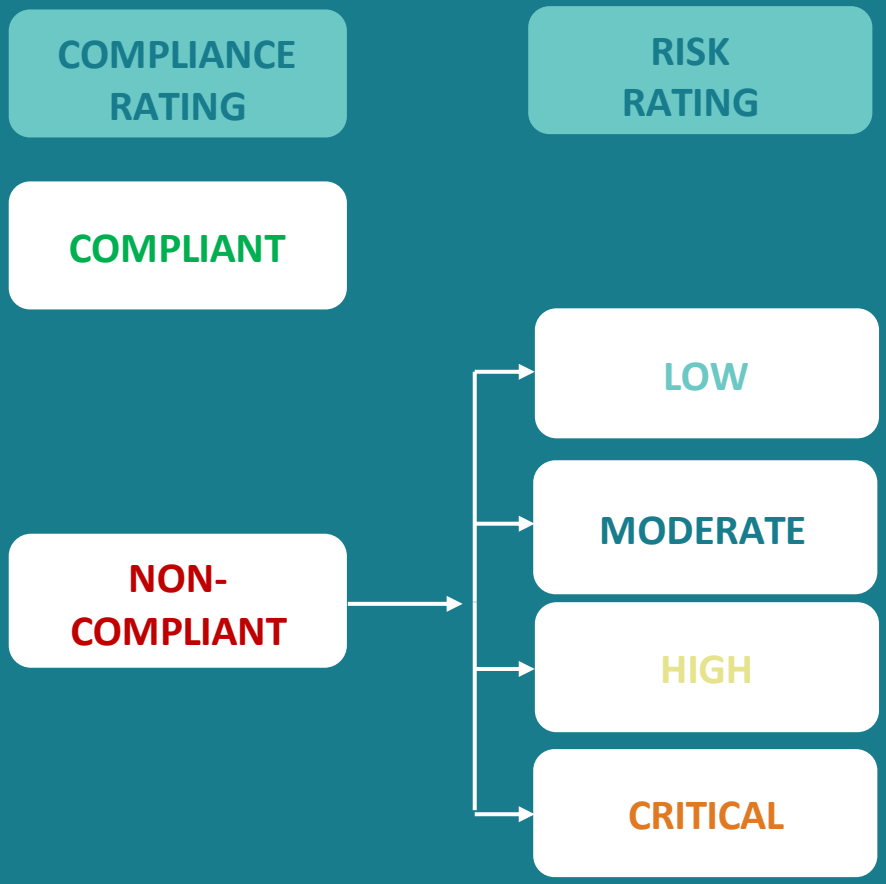
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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