Phoenix Care Centre

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mental health commission

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

PHOENIX CARE CENTRE

Grangegorman, North Circular Road, Dublin 7

Date of Publication:
13 December 2023

ID Number: AC0135

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care / Long Stay
Mental Health Rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
HSE

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

Inspection Team:
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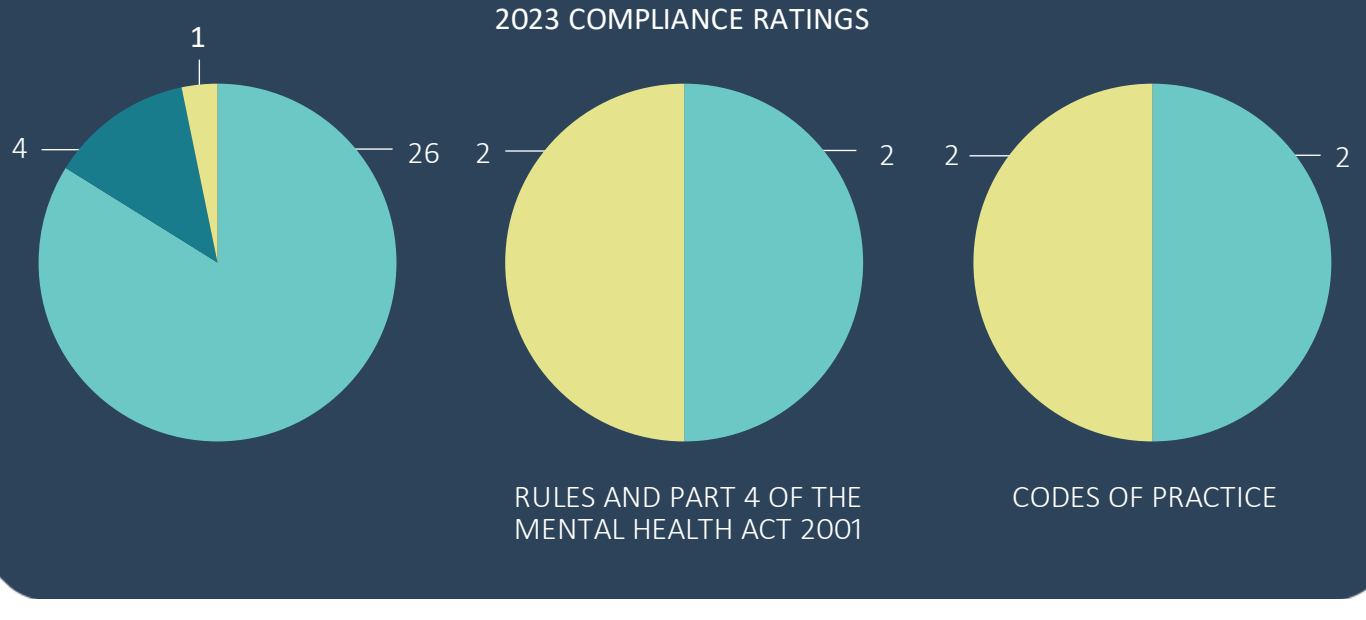
Dr Susan Finnerty MCRN009711

Inspection Date:
3 – 6 April 2023

Previous Inspection date:
26 – 29 July 2022

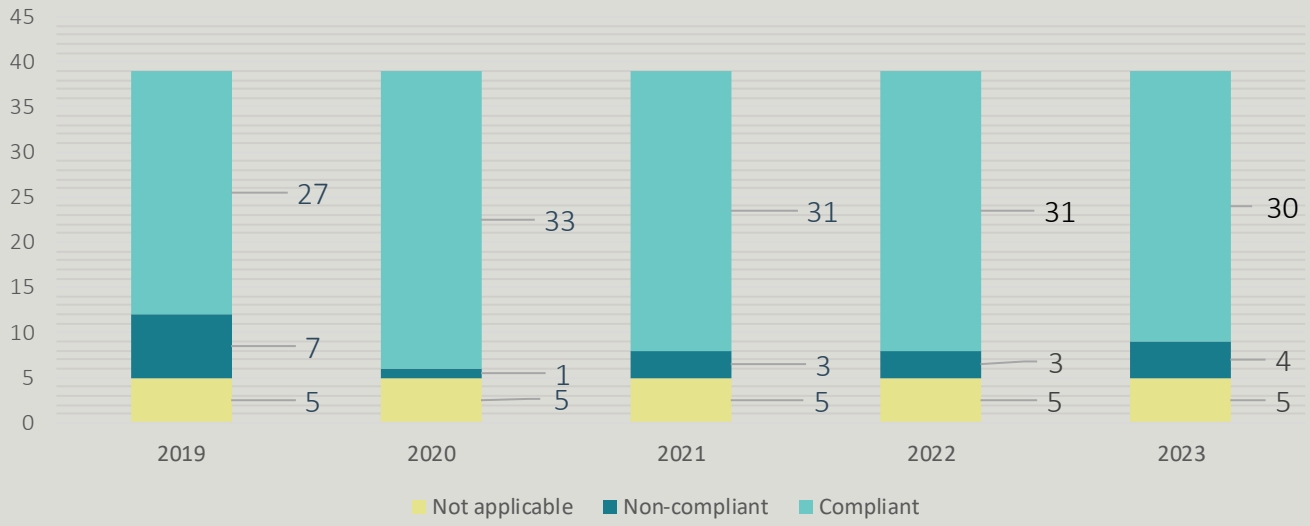
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2019 – 2023

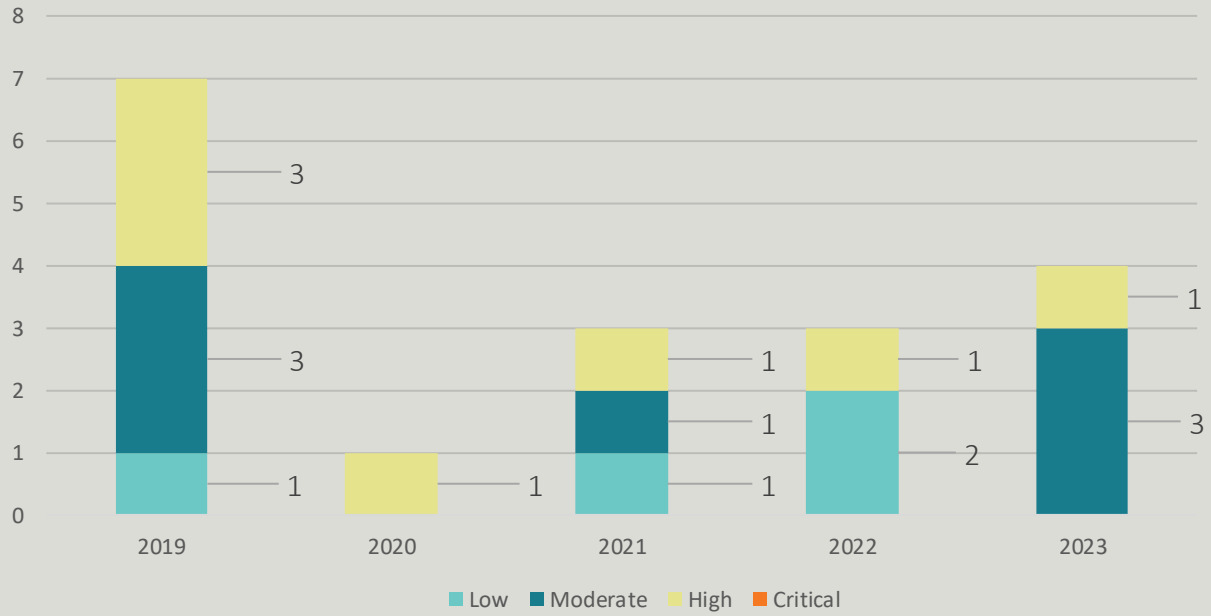
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

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

In brief

Phoenix Care Centre (PCC) was a purpose-built 54 bed facility for specialist tertiary intensive mental health care and treatment for adult patients. It was divided into four wards, on three different levels of the building. The four wards comprised two psychiatric care wards on the ground floor, Birch Ward on the first floor and Hazel ward on the second floor.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	79%	97%	91%	91%	88%

Conditions to registration

There were no conditions attached to the registration of this approved centre at the time of inspection.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety 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.
- ***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.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***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:

- ***Mandatory training:*** While all healthcare staff were trained in the Mental Health Act 2001, not all staff were trained in fire safety, basic life support and in the management of violence and aggression.

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 the Phoenix Care Centre was of a good standard and met the needs of residents.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***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.
- ***Multi-disciplinary team working:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, a registered psychiatric nurse, a psychologist, occupational therapist, and a social worker. There were regular multi-disciplinary team meetings to discuss residents' care plans. Dietitians and pharmacy disciplines had input into resident care plans also.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan and included music and art therapy, and one to one dialectical and cognitive behavioural therapy in relation to issues such as long-term psychosis, bereavement, and low mood.
- ***Access to other medical services:*** Residents had access to external therapeutic services through defined referral pathways to primary care services.

However:

- ***Physical assessments:*** One resident did not have their six-monthly assessment completed within six months, one resident did not have their body mass index recorded as part of their six-month physical assessment, and three residents did not have their waist circumference recorded as part of their six-month physical assessment.

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:*** Each resident had their own single en suite bedroom.
- ***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. 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. It was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre was compliant with the Code of Practice on Physical Restraint, and with the Rule on The Use of Seclusion. The approved centre had a reduction of restrictive practices strategy as well as, a Multidisciplinary 'Therapeutic Interventions and Restrictive Practice' Working Group in place.

However:

- ***Maintenance of records:*** Resident records were found not to be kept in good order. Loose pages were present in six separate clinical files. One clinical file was very bulky and difficult to move.
- ***Rights based care: Searches:*** One resident was not asked to consent before being searched.

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. A priest visited the approved centre, and religious resources were available to residents.
- ***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, when appropriate was provided. Information about 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***: These included the following: books, newspapers, radio, DVDs, board games, puzzles, mindfulness colouring, arts and crafts, knitting, crochet, baking, gardening, table tennis, card games, PlayStation, gym, basketball, POOL, mindfulness, bingo, music and art classes, karaoke, beauty care, community outings, movies, music sessions, and indoor soccer.
- ***Residents' feedback:*** The residents were for the majority 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. All feedback was complimentary toward the staff and service provided. One resident specifically noting that staff were very nice, and that he or she could talk to staff anytime they needed.

However:

- ***Residents' feedback:*** Which reflected a minority view of experiences shared: one resident noted that their mattress was not comfortable, and another resident experienced an unsafe feeling in a ward due to other aggressive residents.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was part of Community Health Organisation 9 which comprised Dublin North, Dublin North City Mental Health Service and Dublin North West. The Dublin North City Mental Health Service were responsible for the overall management and governance of the Phoenix Care Centre (PCC). The DNCMHS Management Team met monthly and included the heads of disciplines.
- ***Leadership:*** The PCC was awaiting confirmation of a new Executive Clinical Director (ECD). There was good leadership in place and the DNCMHS had an established system of governance which included regular meetings, clear reporting structures and oversight of risk management processes. A series of meetings took place at the DNCMHS management level, and the multi-disciplinary management team meetings focused on key service priority areas.
- ***Clinical governance:*** There were areas of good clinical governance: Medication management was good, therapeutic services and programmes provided met the needs of the residents and there was evidence in the files of collaborative multi-disciplinary team working. Audits of clinical practice were in place. There were processes in place to measure staff performance and encourage staff development both formally and informally.

- ***Restrictive practices reduction:*** A senior manager appointed with responsibility for the reduction in restrictive practices within the service. The approved centre had a physical restraint and seclusion reduction policy. The service had a reduction of restrictive practices strategy. Following the introduction of the revised Rules in relation to restrictive practices by the Mental Health Commission, the DNCMHS centre had instigated a Restrictive Practices Committee to ensure compliance with the revised rules governing the use of Seclusion, revised rules governing the use of Mechanical Means of Bodily Restraint and Code of Practice on Physical Restraint published September 2022. A Therapeutic Interventions and Restrictive Practice working group had been established, chaired by the Occupational Therapy Managers, with membership from all disciplines. The group was working to introduce environmental and therapeutic strategies targeted at reducing the use of restrictive practices.'
- ***Risk:*** The service had introduced a new risk management process when a new risk arose or was identified. The person with responsibility for risk was identified and known by all staff. Incidents were reported and risk assessed. The approved centre had a local risk register.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. The approved centre had a number of committees in place to support quality improvement: a Judgement Support Framework (JSF) Compliance Committee, a Quality and Safety Committee, and Staff Health and Well-being Committees.
- ***Policies:*** All policies were up to date.
- ***Staff training:*** Not all staff disciplines had completed mandatory training. The approved centre had introduced trauma informed training and Heads of Service had received this training.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** The approved centre had an advocacy service.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 92% over the last 4 years. It has no conditions on its registration. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Staff training:*** Not all staff disciplines had completed mandatory training.
- ***Clinical governance:*** There were areas where clinical governance were had deficits: general health monitoring was not fully completed, and clinical files of residents were not maintained in good order.
- ***Rights based care: Searches:*** One resident was not asked to consent before being searched.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. In Birch Ward - Residents had been involved in creating an outdoor therapeutic space under the guidance of the nursing staff. This project provided the residents with a social outlet, new experiences and encouraged physical activity.

2. In Birch Ward – a relaxation/quiet room for the clients to listen to music, relax and improve mood was developed.

3. Addition of New Clinical Nurse Manager 3 (CNM3) post-Phoenix Care Centre to support nursing staff in compliance and contribute to governance. The CNM 3's responsibilities include: overseeing the Mental Health Commission requirements and the development and implementation of policy and procedures.

4. Phoenix Care Centre have rolled out an interactive board as a new approach of promoting client-therapist interaction. Each unit is able to link interactive boards to the internet via smart phones. Electronic tablets were also purchased for the units to support social connections in promoting their recovery.

5. A Therapeutic Interventions & Restrictive Practice Working group had been established and developed a work plan regarding training and therapeutic interventions. As part of the new reduction in restrictive practice guidelines, trauma informed care training has been provided to staff directly involved in seclusion and physical restraint. The trauma-informed and person-centred approach also supported staff to recalibrate their responses and mode of communication to provide the type of service required by those with high levels of trauma.

6. Occupational Therapy Managers had undertaken a pilot of the 'just right state' sensory training with staff.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Phoenix Care Centre (PCC) was a purpose built facility located at Grangegorman, North Circular Road adjacent to the new Technical University Dublin. The approved centre has been open since 2013 and consisted of four wards located over three levels. In total, there were 54 beds. The centre was managed by the Health Service Executive (HSE) – Dublin North City Mental Health Services which was part of Community Health Organisation (CHO) 9. PCC provided specialist tertiary intensive mental health care and treatment for adults with a mental disorder for the mental health services of the Dublin North Eastern Region, Dublin South, and Wicklow. At the time of inspection, admissions to the female intensive care unit, Alder ward, were also facilitated on a nationwide basis. Admissions to the Phoenix Care Centre were planned in advance.

Two psychiatric intensive care wards were located on the ground floor: Oak Ward and Alder Ward. Each provided 12 beds for male and female residents respectively. Both Oak Ward and Alder Ward had a seclusion room.

A unit at first floor level (Birch) provided 20 beds for both male and female residents with enduring mental illnesses. On the second floor Hazel unit provided a 10-bedded rehabilitation unit for both men and women. There were adequate therapeutic and recreational facilities throughout the centre. Residents had access to external garden areas which took account of the privacy and dignity of residents.

All bedrooms were single bedrooms with en suite. At the time of inspection, the approved centre was found to be spacious, very clean and bright. The communal areas were comfortable and included colourful furniture and wall art created by the residents. The approved centre had controlled access and had 24-hour security staff at reception. Visits to the approved centre were in-line with the approved centre's COVID-19 procedures. Internally, the wards were well signposted and were wheelchair accessible.

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

Resident Profile	
Number of registered beds	***54***
Total number of residents	**38**
Number of detained patients	9
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	31
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Community Health Care Area 9 – Dublin North, Dublin North Central and Dublin North West. Dublin North City Mental Health Services (DNCMHS) were responsible for the overall management and governance of Phoenix Care Centre (PCC). DNCMHS had an established system of governance in place which included regular meetings, clear reporting structures and oversight of strong risk management processes. A series of meetings took place at the DNCMHS management level, including: a Health and Safety Group, the Drugs and Therapeutic Committee, the Nurse Education Committee and the policy review group. The multidisciplinary DNCMHS Management Team met monthly. Agenda items included: finance, human resources and staff training, service plans and updates, feedback from the service user representative, quality and patient safety, key performance indicators and capital/minor developments. Operational plans for 2023 were progressing, although the service was not yet informed of the National HSE Operational plan for 2023 and its accompanying budget at the time of inspection. PCC did not have any conditions attached to its registration and it had met all of its previous Corrective and Preventative Actions (CAPAs) for 2022.

Copies of the monthly minutes of the DNCMHS management team meetings, Quality and Safety and other supporting committees including the Drugs and Therapeutic Committee and a Policy Review Group were provided to the inspection team. The multi-disciplinary Management Team meetings considered a variety of issues built around key service priority areas. The minutes demonstrated an action-oriented focus with clear time lines. They showed that the management team actively and comprehensively addressed issues such as Mental Health Commission reports and action plans, issues within the risk register, serious incidents, complaints, service development and staff training and development were regularly discussed.

The service had introduced a new risk management process when a new risk arose or was identified. Whilst the numbers and skill mix of staffing was sufficient to meet residents' needs, key risks were identified by the service. These centred around severe staffing challenges across all staff groups in terms of recruitment, backfill of different leave types and vacancies due to retirement. The level of use of agency staff and the difficulty ensuring each staff member was compliant with mandatory training were also risk concerns. The management team had also identified a significant degree of difficulty in sourcing Locum Consultant Psychiatrists. The PCC was awaiting confirmation of a new Executive Clinical Director (ECD) and recruitment of a Service Users Engagement lead was in progress. Risks identified by the heads of discipline had been appropriately escalated to the Dublin North City Mental Health Service risk register where applicable. The approved centre had a comprehensive internal emergency plan and held an Emergency Management Response Meeting as required. Bed occupancy in the month previous to the inspection averaged 70% across all wards.

The approved centre had a number of committees in place to support quality improvement: a Judgement Support Framework (JSF) Compliance Committee, a Quality and Safety Committee, and Staff Health and Well-being Committees. These meetings were attended by members of the multi-disciplinary team. There was a Nurse Practice Development Team, with a newly appointed coordinator in place to support quality improvement and daily Safety Pause meetings. The Fire Safety Advisor and Risk Advisor/Business Manager undertook a Health and safety walk of the PCC and were available for staff to identify or discuss any safety issues within the wards.

Following the introduction of revised Rules in relation to restrictive practices by the MHC, the DNCMHS centre had instigated a Restrictive Practices Committee to ensure compliance with the revised rules governing the use of Seclusion, revised rules governing the use of Mechanical Means of Bodily Restraint and Code of Practice on Physical Restraint published September 2022. A specific Restrictive Practices Committee for PCC had been established. The membership was multi-disciplinary. Meetings had occurred at least fortnightly in two subgroups covering policy and procedures, and training and reduction interventions. It was anticipated that the two subgroups would coalesce into the one restrictive Practice Committee in the very near future. An Assistant Director of Nursing chaired both groups and reported quarterly to an oversight committee which will review all episodes within the approved centre. This oversight committee would in turn feed into the recently bolstered Local Governance and Operations Committee. The Approved centre had engaged in introducing Trauma Informed training. Heads of Service had reported very positive feedback following this recent training.

Completed governance questionnaires were returned to the inspection team by the respective heads of discipline as well as the registered proprietor. All respondents had regular input into the approved centre and met with their clinical staff regularly. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development. A Health and Wellbeing Committee had also been established which reported to the Quality and Patient Safety Committee.

The approved centre had a variety of mechanisms in place in order to capture the service user experience. Regular community meetings took place on each ward and the minutes of these were kept. Issues arising from the community meetings were escalated to the monthly management meeting. Complaints, suggestions and feedback from the advocate were also discussed at management level. The Dublin North City mental health service was also in the process of developing the role of the Mental Health Engagement Area Lead with an appointment pending. The restrictive practices Committee had also identified the need for user representation to be incorporated into the oversight committee.

The approved centre had worked pro-actively in order to minimize the risk posed to residents by the COVID-19 pandemic. An Infection Prevention and Control Committee (IPCC) has been established, which meets quarterly and has replaced the Covid Committee Infection prevention and control strategies but continues to report to the Quality and Safety Committee meetings. The approved centre continued to maintain an 'isolation area' to safely provide care and treatment to any resident who was suspected or confirmed as having COVID-19. Where previously there had been nine beds set aside for isolation in Alder ward, this had been reduced to three at the time of inspection. The 'Work Safety Protocol COVID-19 Update' was addressed at the monthly Health and Safety meetings; this facilitated discussion and communication of updated advice for staff.

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 (X) areas on this inspection are detailed below. Also shown is whether the service was compliant (ü) or non-compliant (X) 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 13: Searches	✓		✓		✓		X	Low	X	Moderate
Regulation 19: General Health	X	Moderate	X	High	✓		✓		X	Moderate
Regulation 26: Staffing	X	High	✓		✓		X	Low	X	Moderate
Regulation 27: Maintenance of Records	✓		✓		✓		✓		X	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
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:

- 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 residents were given the opportunity to speak with the inspection team and to complete feedback questionnaires. Eight residents availed of the opportunity to speak with the inspection team. The verbal feedback included the following quotes:
'food was good, there were good choices , drinks available during the day'.
'bedroom is perfect – access to room when I want and I have enough to do during the day'
'I see my doctor regularly every week and 'I have a good social worker'.
'staff are very nice- I can talk to them anytime I need to'.

Residents interviewed also stated that they were always offered a copy of their care plan. Most stated that they have space and privacy and that they felt safe within the approved centre. Other comments embedded within the feedback reflecting a minority view offered different perspectives including:
'Can find it boring' [on the acute ward]
'food portion sizes could be bigger'
'my mattress isn't that comfortable'
'not sure how to make a complaint [however no reason to make a complaint]
One resident stated that they 'don't feel safe in the unit due to other aggressive residents'

Of the four questionnaires received, key comments included a request for more baking and home skills.

Where any resident brought a matter to the attention of the inspectors during the inspection process, that query or concern was relayed on an anonymised basis to clinical/administrative staff, who undertook to follow it up.

5.2 Advocacy

The approved centre had an advocacy service.

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

6.0 Feedback Meeting

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

- Registered Proprietor
- Clinical Director
- Area Director of Nursing
- Assistant Director Of Nursing X 2
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Occupational Therapy Manager
- Psychologist
- Principal Social Worker
- Social Worker
- Service Manager
- Deputy Business Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident profile. Name, date of birth, and Medical Record Number (MRN) were used on documents in clinical files.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.
(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their n eeds, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in December 2022. A resident's 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 in their ICP or in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Self-starting activities included books, newspapers, radio, music, DVDs, CDs, board games, TV, puzzles, mindfulness colouring, arts and crafts, knitting, crochet, baking, gardening, table tennis, card games, PlayStation, gym, basketball, and pool. A weekly recreational activities timetable was displayed on the wards. One-to-one and groups activities included mindfulness/relaxation, bingo, music and art classes, karaoke, exercise sessions, relaxation exercises, beauty care, community outings, movies, music sessions, and indoor soccer. Seasonal events, including an easter party, were held throughout the year, with resident involvement. Nurse-led activities were held during the weekends.

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 t heir religion.

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. A priest visited the approved centre, and religious resources (including prayer mats and copies of the Bible and Koran), were available to residents.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Visiting times were appropriate and reasonable. A separate visitors' room or visiting area was provided where residents could meet visitors in private, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Suitable steps were taken to ensure the safety of residents and visitors during visits. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents in the approved centre had access to mail, e-mail, Internet, telephone or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. New mobile phones were provided on all wards for resident use, and the phones could be used in conjunction with interactive boards to provide internet access.

It was the approved centre's policy that the clinical director (or senior staff member designated by the clinical director) would only examine incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others. No resident communication was monitored at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

NON-COMPLIANT

Risk Rating **MODERATE**

(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 May 2020, and included all requirements related to:

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to two of the searches, and the request for consent and received consent were documented for those searches. On one search form, however, there was no indication that the residents' consent was sought, as no resident signature was obtained either to consent or not to consent to the search.

The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy. Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched.

The approved centre was non-compliant with this regulation because in one of the clinical files examined, there was no indication that resident consent was sought prior to the search being carried out, 13 (4).

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying, which was last reviewed in October 2020, and a Sudden and Unexpected Death of a Service User Policy, which was last reviewed in December 2022.

The clinical file of one resident who had died suddenly in the approved centre was examined on inspection. The sudden death was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin, and friends. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). Therapeutic groups available in the approved centre included music and art therapy. Therapeutic interventions were primarily on a one-to-one basis to meet needs which had been identified in resident ICPs. These included dialectical and cognitive behavioural therapy in relation to issues such as long-term psychosis, bereavement, and low mood. There was evidence of dietitian and pharmacy input into the ICPs.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. All residents had a comprehensive assessments of needs by health and social care professionals and interventions to meet those needs as part of their recovery journey.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in October 2020. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and a comprehensive transfer form including all relevant details regarding the resident's condition.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a General Health Policy, which was last reviewed in October 2020, and a Medical Emergencies Policy, which was last reviewed in September 2021. The approved centre had two emergency trolleys and staff had access at all times to an Automated External Defibrillator (of which there were also two). Residents received appropriate general health care interventions in line with individual care plans. Five clinical files were examined in relation to the provision of general health services during the inspection. From the files reviewed, it was evident was residents' care was regularly assessed by the multi-disciplinary team (MDT), and residents' general health needs were monitored and assessed. However, in one clinical file, the six-monthly physical assessment was not completed within the six-monthly timeframe and was 20 days overdue.

The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, and medication review for all five residents. However, in one clinical file, there was no record of body mass-index (BMI) or height; and in three clinical files, there was no record of waist circumference.

For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

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

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

a) **In one clinical file, there was no record of body mass-index recorded, 19 (1)(b).**
b) **In three of the clinical files examined, there was no record of waist circumference, 19 (1)(b).**
c) **The six-monthly physical assessment of one resident was not completed within six months, 19 (1)(b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

Residents were provided with written and verbal information on diagnosis where appropriate. The justification for restricting information regarding a resident's diagnosis was documented in the clinical file, and residents would only have restricted access to information where there was a significant risk. Medication information sheets and verbal information were provided in a format appropriate to resident needs. Residents were continuously offered information on their medication as part their individual care plan (ICP) process. Leaflets were provided where required, and information on medication could be accessed online. Medication information sheets included all relevant information on indications for use and any possible side-effects. Medication information was printed and given to residents where appropriate and discussed with residents during their ICP reviews. The approved centre had access to a translation service where required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. All observation panels on doors of treatment rooms and bedrooms were fitted with blinds, curtains, or opaque glass. 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

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided

assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs, and furnished to support resident independence and comfort.

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in November 2020, and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; and the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident.

All entries in the MPARs were legible, and included the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily in respect of medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified, and Scheduled 2 and 3 controlled drugs were secured separately from other medications to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in September 2022. The approved centre's site-specific Safety Statement was last updated in June 2022.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in August 2020.

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating **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 July 2022, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. 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. Not all healthcare staff had received training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (63)	56	89%	56	89%	45	71%	63	100%
Consultant Psychiatrist (6)	4	67%	5	83%	6	100%	6	100%
Medical (8)	5	63%	7	88%	6	75%	8	100%
Occupational Therapist (4)	2	50%	4	100%	4	100%	4	100%

Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	0	0%	1	100%	1	100%	1	100%

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

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in December 2022, and included the following:

- The records required to be created for each resident.
- Those authorised to access and make entries in the residents' records.
- Residents' access to resident records.
- Record retention periods.
- The destruction of records.

Resident records were reflective of the resident's current status and the care and treatment being provided. Not all residents' records were secure and in good order, and constructed, maintained, and used in accordance with national guidelines and legislative requirements. On inspection, loose pages were found in six different clinical files, including progress notes, risk assessments, and recording charts. One file examined was very bulky and unwieldly.

The records were developed and maintained in logical sequence. Throughout the approved centre, records were appropriately secured from loss, destruction, tampering, or unauthorized access. Documentation of food safety, health and safety, and fire inspections were maintained in the approved centre.

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

a) The registered proprietor did not ensure that records and reports were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, as loose pages were noted in six different clinical files on inspection, 27 (1).

b) **The registered proprietor did not ensure that records and reports were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, as one file was found to be very bulky and unwieldy, 27 (1).**

Regulation 28: Register of Residents

COMPLIANT

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

INSPECTION FINDINGS

All operating policies and procedures were reviewed within the required three-year time frame, having due regard to any recommendations made by the Inspector or the Commission.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre will co-operate fully with Mental Health Tribunals.

(2) In circumstances where a patient's condition is such that he or she requires assistance from staff of the approved centre to attend, or during, a sitting of a mental health tribunal of which he or she is the subject, the registered proprietor shall ensure that appropriate assistance is provided by the staff of the approved centre.

INSPECTION FINDINGS

The approved centre provided a large dedicated tribunal room with private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary. The approved centre provided resources and facilities to access the Mental Health Tribunals remotely where required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in August 2020, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all complaints that were not deemed to be minor were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a Clinical Risk Assessment and Management Policy, which was last reviewed in September 2021, and an Additional Risk Management Policy, which was also reviewed in September 2021. Together, these addressed all the policy-related requirements for this regulation, including the following:

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

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

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also

completed in conjunction with medication requirements or administration, and prior to and during resident seclusion, physical restraint, 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 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

There was an up-to-date certificate of registration displayed prominently in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was last reviewed in March 2023.

The policy addressed the following:

- Who may initiate, and who may carry out seclusion.
- The provision of information to the resident, including information about the resident's rights, presented in accessible language and format.
- The safety, safeguarding and risk management arrangements that must be followed during any episode of seclusion.

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

- Clear documentation of how the approved centre aims to reduce or, where possible eliminate, the use of seclusion.
- The role of leadership and the use of data to inform practice, the specific reduction tools in use, the development of the workforce, and the use of post incident reviews to inform practice.
- How the approved centre planned to provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion.

The policy and procedures for training all staff involved in seclusion documented who would receive training (based on the identified needs of persons who are secluded and staff), and the identification of appropriately qualified persons to give the training.

The areas addressed in the training included the following:

- Trauma Informed Care.
- Cultural Competence.

- Human rights, including the legal principles of restrictive practices.
- Positive Behaviour support, including the identification of causes or triggers of the resident's behaviours).
- Alternatives to seclusion or restraint.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy. All staff who participate, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

Monitoring: An annual report on the use of seclusion in the approved centre was published on the registered proprietor's website.

A multi-disciplinary review and oversight committee was established to analyse every episode of seclusion in detail.

Evidence of Implementation: The seclusion facilities were furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's privacy was respected. The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There was an anti-barricade door. There were no ligature points or electrical fixtures. The room allowed for staff to clearly observe the resident in the seclusion room. The seclusion room had externally controlled heating and air conditioning which enabled those observing the resident to monitor the room temperature.

The seclusion room had limited furnishings, which included a pillow, mattress, and a blanket or covering, all of which met current safety requirements. The room was large enough to support the resident and staff who may be required to use physical interventions during transition to seclusion. The resident in seclusion had sight of a clock displaying the time, day and date. The seclusion room was in an area away from communal sitting rooms and sleeping accommodation.

The resident who was secluded had ready access to sanitary facilities. Seclusion facilities were not used as bedrooms.

Orders for Seclusion: Two episodes of seclusion were reviewed on inspection. Seclusion was only initiated following a comprehensive assessment of the resident. This included a risk assessment, the outcome of which was recorded in the clinical file. Seclusion was initiated by a registered medical practitioner (RMP) or the most senior registered nurse (RN) on duty. The RMP or RN recorded the seclusion orders in the clinical files and on the seclusion register. Where seclusion was initiated by a RN, a RMP was informed of the seclusion episode as soon as practicable, no less than 30 minutes following the commencement of the seclusion episode.

Upon commencement of each episode of seclusion, a Seclusion Care Plan for the resident was developed by a RN. This included:

- How de-escalation strategies would continue to be used.

- The person's preferences in relation to seclusion, taking into account any previous debrief with the resident.
- Recognition of signs where the resident's behaviour was no longer to be deemed a risk to themselves or others.
- How potential risks might be managed.
- Reference to specific support plans for the resident and details of how the resident's mental health needs would continue to be met while in seclusion.
- Meeting of all needs relating to food, hydration, personal hygiene, and dressing.

There was a medical examination of the resident by a RMP as soon as practicable, and no later than two hours after the commencement of each episode. The examination included an assessment and record of any physical, psychological and/or emotional trauma caused to the resident as a result of the seclusion. The RMP recorded this consultation in the clinical files and indicated on the seclusion register that the consultant psychiatrist (CP) ordered or did not order the continued use of seclusion. Where the CP ordered the continued use of seclusion, they advised the duration of each order. This information was recorded by the RMP on the seclusion register. Seclusion orders were not made for any period of time longer than four hours from the commencement of each seclusion episode. The orders of the CP confirmed that there were no other less restrictive ways available to manage the residents' presentation.

The CP undertook a medical examination of the residents and signed the seclusion register within 24 hours of the commencement of each episode. As soon as practicable, and at the residents' wishes in accordance with their individual care plans (ICPs), the residents' representatives were informed of the seclusion and a record of this communication was entered in the clinical files.

Where close confinement was contraindicated, seclusion was only used when all other options had proven unsuccessful and following risk assessment. The clothing worn in seclusion respected the right of the residents to dignity, bodily integrity and privacy. Bodily searches were only undertaken in exceptional circumstances, following risk assessment. Bodily searches were undertaken in the presence of more than one staff member, and respected the right of the resident to dignity, bodily integrity and privacy. Gender and cultural sensitivity and the preferences of the residents were respected.

The residents placed in seclusion were kept under direct observation by an RN for the first hour following the initiation of seclusion. After the first hour, an RN kept the residents under continuous observation and remained within sight and sound of the seclusion room throughout the episode. A written record of the resident was made by the RN every 15 minutes. This included:

- The resident's level of distress.
- The resident's behaviour.
- The resident's level of awareness.
- The resident's physical health, especially with regard to breathing, pallor, or cyanosis.
- Whether hydration/nutrition needs were met.

Following risk assessment, a nursing review of the residents took place every two hours. During this review, a minimum of two staff members entered the seclusion room and assessed the resident to

determine whether the episode could be ended. This assessment and decision were recorded. A medical examination was carried out by a RMP every four hours. For each review, the decision to end or continue seclusion was recorded.

The two seclusion orders were renewed by a RMP under the supervision of the CP (or the duty CP) following a medical examination, for periods of eight hours and 48 hours respectively. In the second case where the seclusion order was renewed beyond the initial 24 hours of continuous seclusion, the CP or duty CP undertook a medical examination and this was recorded in the clinical file.

Ending of Seclusion: The residents were informed of the ending of each episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date the seclusion was ended. An in-person debrief followed both episodes. This occurred within two working days of the episode, unless it was the preference of the resident to have the debrief outside of this timeframe. The debrief was person-centred, facilitated residents to discuss the seclusion with members of the multi-disciplinary team (MDT) involved with their care and treatment, and included a discussion regarding alternative de-escalation strategies that could be used to avoid future use of restrictive interventions. The residents were given the opportunity of having their representative or nominated person present at the debrief with them; if this person did not attend, a record of the reasons why, were recorded in the clinical file. The residents' ICPs were updated to reflect the outcome of the debrief, taking particular note of the residents' preferences in relation to restrictive interventions going forward.

Appropriate emotional support was provided to the residents in the direct aftermath of each episode. Staff also offered support, if appropriate, to other residents who may have witnessed the seclusion.

Clinical Governance: Each episode of seclusion was reviewed by the members of the MDT involved in the resident's care and treatment and documented in the clinical file as soon as practicable and, in any event, no later than five working days after each episode. The MDT review, including recorded actions decided upon and follow-up plans to eliminate or reduce interventions for the resident, was documented.

The registered proprietor had appointed a named senior manager with responsibility for the approved centre's reduction of seclusion.

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 four patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment of each of the four patients and that all were unable to consent.

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

- 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.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.

- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy been reviewed annually and was last reviewed in March 2023. It addressed the following:

- The provision of information to the person which should include information about the person's rights presented in accessible language and format.
- Information regarding who can initiate and who may carry out physical restraint.
- Information regarding the safety, safeguarding and risk managements that should be followed during an any episode of physical restraint.

Policies and procedures regarding staff training included the following:

- Who will receive training based on the identified needs of persons who are restrained and staff.
- The identification of appropriately qualified person(s) to give the training.
- The mandatory nature of training for those involved in physical restraint.

The areas to be addressed within the training programme were specified, and they included the following:

- The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
- Alternatives to physical restraint.
- 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 (social, environmental, cognitive, emotional, or somatic).
- The monitoring of the safety of the person during and after the physical restraint.

The approved centre had a written policy on the reduction of physical restraint. The policy was last reviewed in April 2023, and addressed the following:

- Clear documentation of how the approved centre aims to reduce, or where possible eliminate, the use of physical restraint.
- The role of leadership and the use of data to inform practice, specific reduction tools in use, 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 physical restraint.

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. A record of attendance at training was maintained.

Monitoring: The approved centre had a multi-disciplinary review and oversight committee, responsible for the following:

- To determine if there was compliance with the code of practice on the use of physical restraint for each episode reviewed.
- To determine if there was compliance with the approved centre's own policies and procedures relating to physical restraint.
- To identify and document any areas for improvement.
- To identity the actions, the persons responsible, and the timeframes for completion of any actions.
- To produce a report following each meeting of the review and oversight committee which should be available to the Mental Health Commission upon request.

Evidence of Implementation: Three separate episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed that there were no other less restrictive methods available to manage the person's presentation. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the resident had been completed no later than two hours after the start of each episode of restraint.

The orders for physical restraint did not exceed 10 minutes, lasting five minutes, two minutes, and two minutes respectively. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the CP (or duty DP) within 24 hours.

Where it was the resident's wish in accordance with their individual care plan (ICP), the resident's representative was informed of the use of physical restraint as soon was practicable. Where the resident's representative was not informed, there was record explaining why this did not occur in the clinical file. Where it was the resident's wish that their representative was not to be informed of the restraint, no such communication occurred outside of necessary legal or professional requirement. This was recorded in the resident's clinical file.

The Mental Health Commission was notified via Comprehensive Information System (CIS) of the start time and date, and the end time and date, of each episode of physical restraint in the correct format and within three days of each episode. Staff involved in the episodes of physical restraint had taken into account any relevant entries in the residents' ICPs pertaining to their specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy.

The residents' were continuously assessed throughout the uses of restraint to insure their safety, and there was documented evidence that:

- The resident's head and neck were protected and supported where necessary.
- The resident's airway and breathing was not compromised.
- Effective communication was maintained with the resident, and the resident's physical and psychological health was monitored for as long as clinically necessary after using physical restraint.

Observations were conducted, including vital clinical indicators such as the monitoring of pulse, respiration, and complexion, and these observations were recorded.

The physical restraint in each instance was ended by the person who had lead it. The time, date, and reason for ending the physical restraint was recorded in the clinical file on the date that each episode ended. The residents were given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. This occurred within two working days of each episode of physical restraint, unless it was the preference of the resident who was restrained to have the debrief outside of this timeframe. The decision of the resident not to participate in the debrief, if that was their wish, was respected. A record of this was maintained and recorded in the person's clinical file. The residents' ICPs were updated to reflect the outcome of the debrief, taking particular note of the residents' preferences in relation to restrictive interventions in the future. There was a record of all attendees who were present at the debrief and this was included in the clinical file. Appropriate emotional support was provided to the person following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

Recording of the Use of Physical Restraint: The episodes of restraint were recorded in the clinical files. The episodes of restraint were clearly recorded in the clinical practice forms in accordance with Provision 3.7. There was a copy of the clinical practice forms in the clinical files and it was available to the Mental Health Commission on request.

Clinical Governance: The episodes of physical restrain were reviewed by members of the multi-disciplinary team within five working days from the date of each episode. The review included the following:

- The identification of the trigger events which contributed to the restraint episode.
- A review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support.
- The identification of alternative de-escalation strategies to be used in future.
- The duration of the restraint episodes and whether this was for the shortest possible duration.
- Consideration of the outcomes of the person-centred debrief, if available.
- An assessment of the factors in the physical environment that may have contributed to the uses of restraint.

The multi-disciplinary team recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the residents. 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 May 2022, included all of the policy-related criteria for this code of practice.

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

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

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

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

Evidence of Implementation:

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

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

There had been no discharges in the approved centre since the last inspection.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 13: Searches					
Reason ID : 10004121		In one of the clinical files examined, there was no indication that resident consent was sought prior to the search being carried out, 13 (4).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	All staff have been informed of the importance of ensuring consent is sought and documented should a search be required.	Audit	Achievable & realistic	29/02/2024	DON-A, CNM3, CNM2 & Staff Nurses
Preventative Action	Reminder to complete search form included on Nursing assessment document	Audit	Achievable & Realistic	29/02/2024	CNM2 & Staff Nurses

Regulation 19: General Health					
Reason ID : 10004125		**In one clinical file, there was no record of body mass-index recorded, 19 (1)(b). In three of the clinical files there was no record of waist circumference, 19 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Body Mass Index for this service user is now recorded and is documented on this clinical file. Measuring tapes have been provided on each ward. All staff have been informed & reminded to complete BMI & Waist circumference and record when service user declines this option.	Physical Health Audit are completed every 6 months. Audit results are presented to the Medical Audit Committee.	Achievable & Realistic	29/03/2024	Nursing & Medical Staff
Preventative Action	All staff have been informed & reminded to complete all areas of the General Health documentation as part of Admission assessment.	Physical Health Audit are completed every 6 months. Audit results are presented to the Medical Audit Committee.	Achievable & Realistic	08/03/2024	Staff Nurses & Medical Staff
Reason ID : 10004127		**The six monthly physical assessment of one resident was not completed within six months, 19 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	This six month physical assessment is now complete and recorded on clinical file.	Staff confirmed Physical assessment has taken place.	Achieved	20/10/2023	Medical and Ward CNM 2
Preventative Action	Ongoing 6 monthly audits of medical examination of all patients. All charts to be audited for 6 monthly medical examinations and dates for upcoming medical examinations to be entered on patient information boards	6 monthly Audit of physical examinations already commenced. Audit results to to the Medical Audit Committee. Quarterly Quality and Safety Walkarounds will focus on this.	Achievable	08/03/2024	Medical and ward CNM 2s

Regulation 26: Staffing					
Reason ID : 10004124		**The registered proprietor did not ensure that all staff had received education and training to enable then to provide care and treatment in accordance with best contemporary practice, as not all staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26 (4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff to be reminded of the mandatory training requirements	Update of register of training for all Disciplines and individual training requirements to be forwarded to all staff.	Achievable	08/03/2024	Heads of all Disciplines
Preventative Action	Additional training places to be made available to all staff where required and prioritisation of training to be emphasised for all staff	Audits of all training registers to be circulated to Quality and Patient Safety Committee on a Quarterly basis. Any areas of concern will be addressed by the DNC Management team.	Achievable	08/03/2024	Heads of All Disciplines

Regulation 27: Maintenance of Records					
Reason ID : 10004122		**The registered proprietor did not ensure that records and reports were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, as loose pages were noted in six different clinical files on inspection, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All staff have been informed through local Governance and Operations meeting about the importance of the appropriate maintenance of records. All staff have been instructed to rectify and file back any loose pages in the appropriate place immediately if discovered. All wards now have a supply of reinforcers for charts. PCC Maintenance of Records Policy will be circulated to all staff	Audit will take place on 8th December 2023	Achievable & Realistic	08/03/2024	All MDT Members
Preventative Action	Quarterly records maintenance audit will take place and findings will be brought to	Maintenance of Record Audit	Achievable & Realistic	31/03/2024	MDT team members on each ward Governance and Operations Committee

	Governance and Operations Committee Quality and Safety Walkarounds will ensure focus in this area.				
Reason ID : 10004123		**The registered proprietor did not ensure that records and reports were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval, as one file was found to be very bulky and unwieldy, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The file was urgently reviewed was reinforced and filed back in the appropriate place, a second volume has been opened.	Visual check of bulky chart which has been reduced	Achievable	20/10/2023	CNM2
Preventative Action	Quarterly maintenance of records audit will take place Quality and safety walk around every 3 months will visually assess the size of charts. All staff assigned responsibility for appropriate management of loose pages.	Maintenance of records audit will be brought to Governance and Operations Committee	Achievable	08/03/2024	MDT on each ward

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.

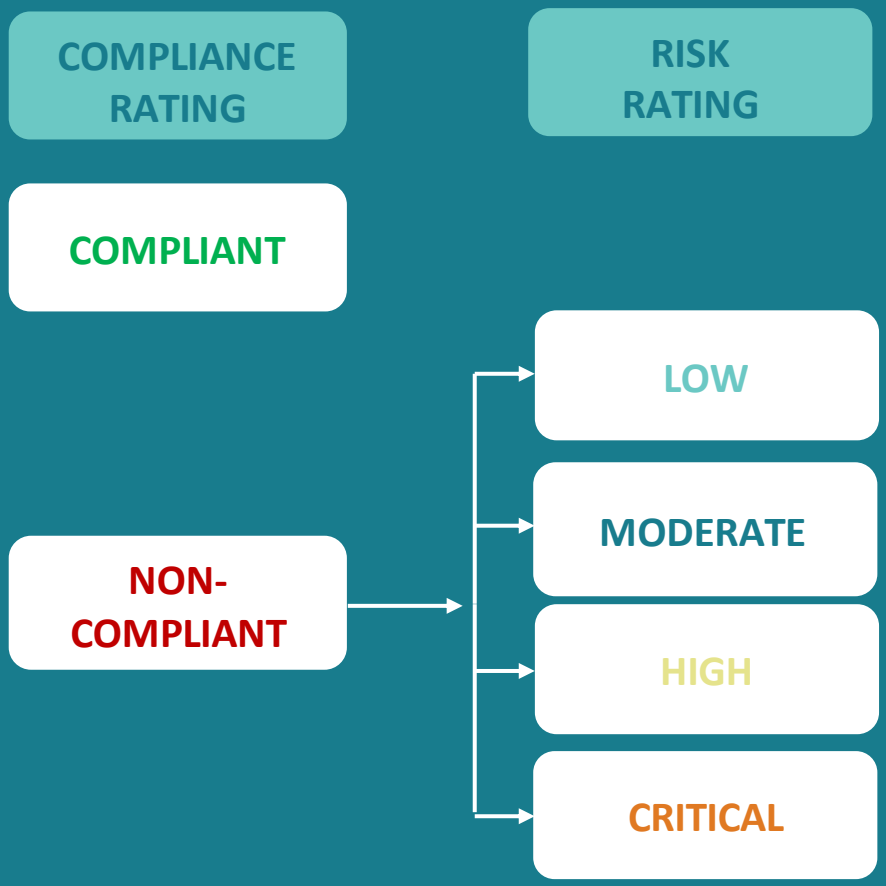
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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