St Gabriel's Ward, St Canice's Hospital

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ST GABRIEL'S WARD, ST CANICE'S HOSPITAL

Dublin Road, Kilkenny, R95P231.

Date of Publication:
13 December 2023

ID Number: AC0156

2023 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
None

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Anne Donaghey, Head of Services, CHO 5 Mental Health Services

Inspection Team:
Siobhán Dinan, Lead Inspector
Fergal Duffy
Barbara Murphy

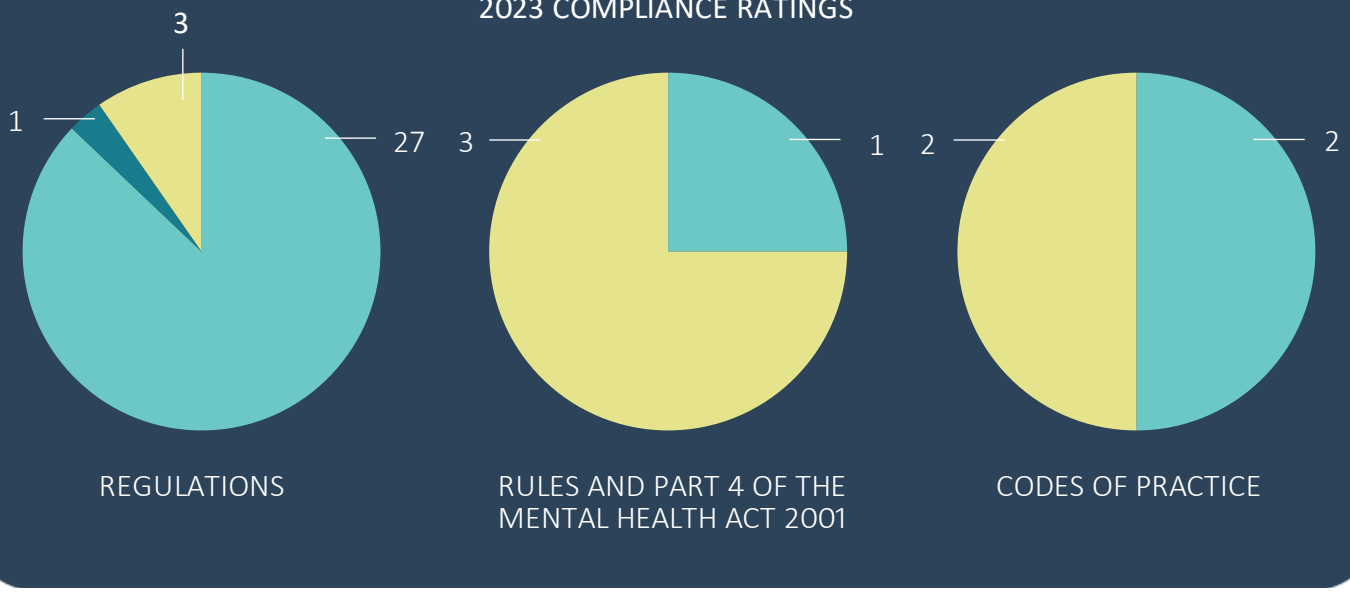
Inspection Date:
3 – 6 July 2023

Previous Inspection date:
24 – 27 May 2022

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Type:
Announced Annual Inspection

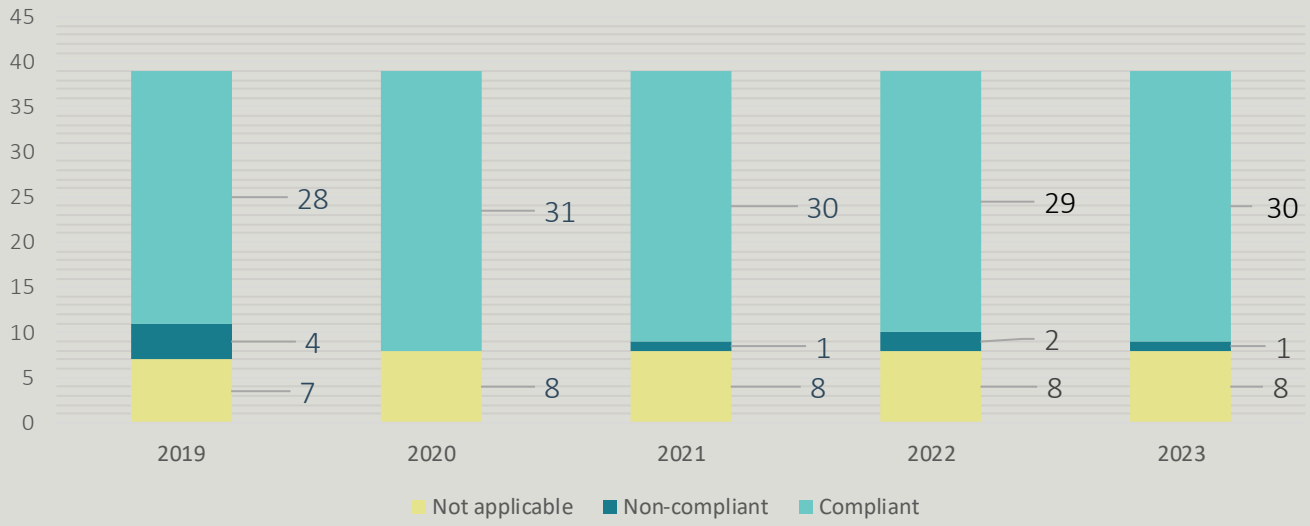
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

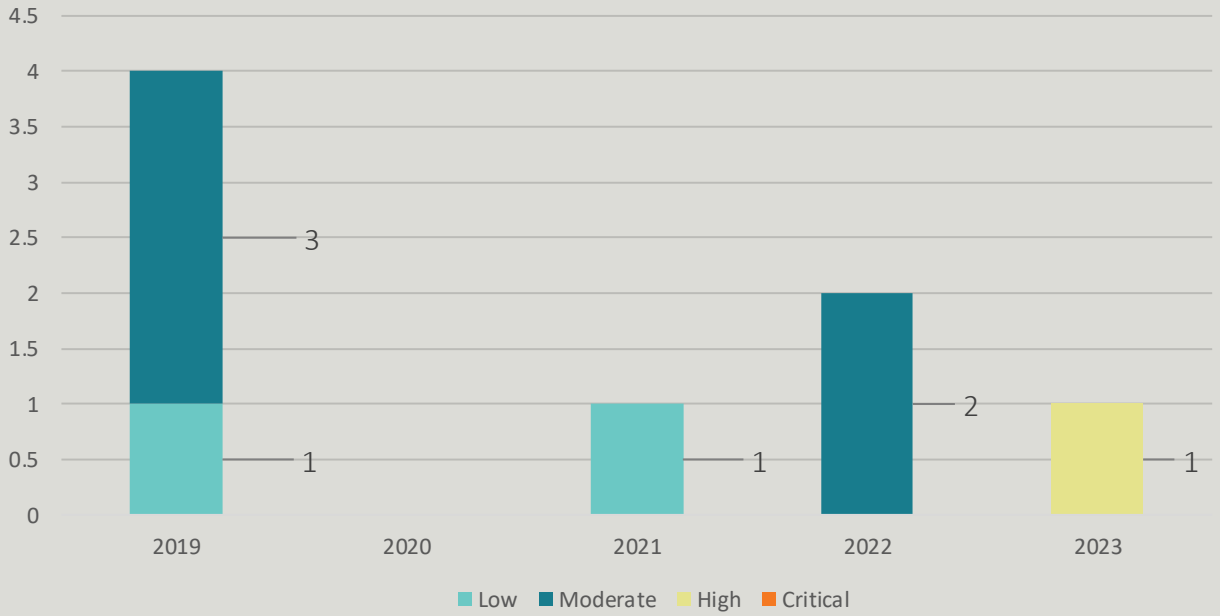
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

The approved centre was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey, building erected in the 1980s with a brick façade. The community mental health teams had moved to a new premises and were no longer located in separate facilities within the approved centre's building. The move of the community mental health teams to a new premises freed up space for the approved centre to incorporate a new occupational therapy area and a resident's day room; these plans were subject to financial approval.

The approved centre was registered to accommodate residents for Continuing Mental Health Care or Long Stay and Psychiatry of Later Life.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	88%	100%	97%	94%	97%

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.
- ***Ligature anchor points:*** Ligature points were minimised to the lowest level, based on individual risk assessment.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Access to essential information*****:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***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:

- ***Medication safety:*** While direction to crush the medication was only accepted from the resident's medical practitioner, there was no documented evidence that the pharmacist was consulted about the type of preparation to be used when crushed medications were prescribed. Secondly, although 'taken as required' medication was dated and timed for administration, there was no documented evidence of the signature by the administering nurse.

  The ordering and storing, of medication was carried out in a safe manner.

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 St Gabriel's Ward was of a good standard and met the needs of the 16 residents accommodated for Continuing Mental Health Care and Psychiatry of Later Life needs. The approved centre was bright and clean and had a calm, dementia-friendly focus.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines. Residents had access to a local General Practitioner (GP) and local hospital for assessment and any treatment required.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) 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 two multi-disciplinary teams (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, occupational therapist, social work and psychology staff. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan. Activities included: relaxation, exercise groups, music groups, pet therapy, reminiscence therapy, and chair yoga. Although group therapeutic activities could be facilitated, there was a focus on one to one therapeutic activities due to the cohort of residents.
- ***Access to other medical services:*** Residents had access to specialist therapeutic interventions, including dietetics, speech and language therapy, and physiotherapy , when required.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

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:*** Sleeping accommodation was in single, two, three and four-bed rooms. Toilet and shower facilities were a mix of both en suite and communal.
- ***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 were privacy screens on bedroom doors. All bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialisation. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Mechanical restraint was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained by mechanical means, including information on attempts to reduce or eliminate the use of restraint for that person. The approved centre was compliant with the Rule on Mechanical Restraint. The approved centre was compliant with the Code of Practice on Physical Restraint. The approved centre did not use Seclusion.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs. Residents had access to a large, secure, and well-maintained garden area. Extensive works had been completed to provide residents and their families with a dementia-friendly garden space.
- ***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 a day room, quiet room, sun room, visiting spaces and large garden. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options for both vegetarians and non-vegetarians which were nicely presented.
- ***Recreational activities***: Residents had access to a diverse range of appropriate recreational activities during the weekdays and at the weekend. Activities included jigsaws, word search, movies, tv, music, arts and crafts, flower arrangement, board games, massage, a relaxation group, a music group, chair yoga, walks, day trips, baking, garden activities, pet therapy, live music, and dance.
- ***Support groups:*** The approved centre had a Peer Advocacy Service.
- ***Residents' feedback:*** No residents availed of the opportunity to meet with the inspection team. No completed questionnaires were received from 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 South-East Community Healthcare Organisation which was divided into two executive management teams (EMT), namely Carlow/Kilkenny/South Tipperary and Waterford/Wexford. St. Gabriel's ward was governed by both executive management teams.
- ***Leadership:*** Both EMTs met together monthly and comprised of heads of disciplines, the head of service, the area lead for mental health engagement, the finance manager, and the general manager. Governance was strengthened by a Quality and Safety Executive committee (QSEC) which was held monthly and a Quality Patient Safety Committee (QPSC) which also met monthly. Clinical heads of discipline outlined clear strategic goals for the service and systems to monitor goal progression. All

disciplines had formal structures and processes in place for measuring and encouraging staff performance and personal development.

- ***Clinical governance:*** Audits of clinical practice were in place and clinical audits were spread out among the disciplines. Quality and Patient Safety Committee (QPSC) meetings were held bi-monthly, and a robust risk management structure was in place. All disciplines which comprised nursing, medical, occupational therapy, social work, and psychology disciplines, had formal and informal clinical supervision arrangements in place where appropriate.
- ***Restrictive practices reduction:*** There was a named senior manager who was chair of a newly established multi-disciplinary review and oversight committee for restrictive practices. This committee met quarterly, and an identified action plan had been devised. The service had a reduction of restrictive practices strategy.
- ***Risk:*** The person in the approved centre with responsibility for risk management was identified and known by staff. Applicable risks had been escalated to the corporate risk register as appropriate. Senior management formally reviewed the risk register every quarter and updated the register's content and control measures as necessary.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. Governance was strengthened by a Quality and Safety Executive committee (QSEC) which was held monthly and a Quality Patient Safety Committee (QPSC) which also met monthly. The QPSC was a sub-group of the Quality and Safety Executive committee. This working group managed the completion of regulatory compliance actions and also managed the implementation of quality improvement actions.
- ***Policies:*** The approved centre's policies were developed by the Policy Development Committee and were regularly reviewed. In addition, in line with the Mental Health Commissions updated Rules on Mechanical Restraint and the Code of Practice on Physical Restraint, the approved centre had updated their policies and procedures.
- ***Staff training:*** All staff had received mandatory training. All disciplines which comprised nursing, medical, occupational therapy, social work, and psychology had formal and informal clinical supervision arrangements in place where appropriate.
- ***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. Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, regular family engagement and support, suggestion boxes, and engagement with the complaints process were utilised to support service improvement***.***
- ***Advocacy services:*** The approved centre had an advocacy service. A designated advocate from the Peer Advocacy in Mental Health organisation was available to the approved centre by referral. Advocacy contact details were displayed within the approved centre. Referrals could be made by residents, their family or friends or staff of the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 97% over the last 4 years. There were no conditions attached to the registration of this approved centre at the time of inspection. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Social/Information Safekeeping Folders had been provided for residents. This facilitated residents to safekeep any private information received.

2. The Tovertafel (magic table), initiative had been implemented for residents. The Magic Table was an award-winning innovation from the Netherlands which used specially designed technology to help people with mid-to-late-stage dementia. It consisted of a series of colourful and fun interactive light games projected onto the surface of a table which respond to hand and arm movements, and which stimulates physical and cognitive activity as well as encouraging social interaction.

3. Two new beds specifically designed to prevent pressure sores had been purchased. Both beds were designed to be at floor level for falls prevention. One of the beds was designed to enable residents to move from a lying down position to a seated position, facilitating assessments such as speech and language therapy (SALT) if the resident is bedbound.

4. A compliance care folder had been introduced to the approved centre. This folder was developed to facilitate recordings and reviews of compliance with the new rules on mechanical restraint.

5. Each resident had been provided with an individualised personal emergency evacuation plan (PEEP) which were reviewed on a monthly basis. Each residents PEEP plan weas displayed at their bed-sides.

6. A tissue viability nurse was newly introduced to the approved centre and available for assessments and reviews of residents.

7. A new 14-seater motor vehicle was purchased for residents to facilitate outings.

8. Hair salon equipment had been purchased to install a small hair salon for residents. This promoted health and relaxation by giving residents access to hair washing and styling.

9. A new welcome and information pack was developed for families. This pack included the approved centres introductory booklet, a therapeutic activities leaflet, social worker availability, and advocacy services information.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was a 20-bed facility, located on the grounds of St. Canice's Hospital in Kilkenny. St. Gabriel's Ward was a single-storey, brick façade building erected in the 1980s. The community mental health teams were no longer located in separate facilities within the building; they had moved to a new premises which freed up space for the approved centre to incorporate a new occupational therapy area and a resident's day room. These plans had not yet received financial approval.

The approved centre was comprised of a central nurses' office, sitting room, and day area with bedroom accommodation located on an adjacent corridor. Sleeping accommodation was in single, two, three and four-bedded rooms. Toilet and shower facilities were a mix of both en suite and communal. The approved centre was registered to accommodate residents for Continuing Mental Health Care/Long Stay and Psychiatry of Later Life.

Residents had access to a large, secure, and well-maintained garden area. Extensive works had been completed to provide residents and their families with a dementia-friendly garden space. Since the last inspection, additional garden furniture including seating, a water feature, and garden mirrors were purchased, the lawn was re-seeded, and paths were power washed. The approved centre had been newly painted, and plans were in place for dementia friendly décor for the walls. The radiators and associated piping had been covered. New curtains were fitted in bedrooms and to the day areas and new duvet covers had been purchased to match the curtains. Overall, the approved centre was bright and clean and had a calm, dementia-friendly focus.

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

Resident Profile	
Number of registered beds	***20***
Total number of residents	**16**
Number of detained patients	0
Number of wards of court	1
Number of children	0
Number of residents in the approved centre for more than 6 months	8
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of South-East Community Healthcare Organisation which was divided into two executive management teams (EMT), namely Carlow/Kilkenny/South Tipperary and Waterford/Wexford. St. Gabriel's ward was governed by both executive management teams. Both EMTs met together monthly and

comprised of heads of disciplines, the head of service, the area lead for mental health engagement, the finance manager, and the general manager. Agenda items such as service development and strategy, mental health engagement, finance/resources, recruitment and retention, performance, quality/service improvement, compliance, and items escalated from the Quality and Safety Executive committee (QSEC) were discussed at these meetings.

Governance was strengthened by a Quality and Safety Executive committee (QSEC) which was held monthly and a Quality Patient Safety Committee (QPSC) which also met monthly. The QSEC discussed regulation and compliance, staff training, clinical audit and quality improvements, mental health service user engagement and recovery, health and safety, policies and procedures, compliments and complaints, incidents/near misses, and risk management processes and review. The members completed an overview of the serious incidents reported within the approved centre and reviewed any issues identified as part of their risk management processes.

The QPSC was a sub-group of the Quality and Safety Executive committee. This working group managed the completion of regulatory compliance actions by monitoring compliance requirements, assigning action responsibility and monitoring completion dates to ensure actions were completed in a timely manner and compliance was maintained. The working group also managed the implementation of quality improvement actions arising from incident reviews, audits, and other inspection findings.

The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded using a standardized template and risk rated and uploaded to the National Incident Management System (NIMS) system. The person in the approved centre with responsibility for risk management was identified and known by staff. The approved centre had a local risk register that was maintained and overseen by Clinical Managers and the Head of Quality, Risk and Compliance. Applicable risks had been escalated to the corporate risk register as appropriate. Senior management formally reviewed the risk register every quarter and updated the register's content and control measures as necessary. Risk management procedures actively reduced identified risks to the lowest practicable level of risk. Training in risk management had been provided to staff. The approved centre had an Emergency Plan and a COVID-19 Prevention and Outbreak Plan.

An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of clinical staff was sufficient to meet the residents' needs. The approved centre had two multi-disciplinary teams. They included psychiatry, nursing, occupational therapy, social work, and psychology staff. Health care professionals, including physiotherapy, dietetics and speech and language therapy were also accessible to residents. All healthcare staff were up to date with mandatory training in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001.

All heads of discipline completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included: nursing, medical, occupational therapy, social work, and psychology. Clinical heads of discipline outlined clear strategic goals for the service and systems to monitor goal progression. All disciplines reported having formal structures and processes in place for measuring and encouraging staff performance and personal development. All disciplines had formal and informal clinical supervision

arrangements in place where appropriate. Annual staff training plans were completed to identify and address training needs.

Operational risks identified by staff included: ongoing poor investment at national level in psychiatric services, increased administrative workload due to regulatory and good practice guidance, recruitment and retention of staff, COVID-19 impacts such as increased pressure on all staff to keep patients and staff safe, difficulty attending mandatory training and Continuing Professional Development (CPD) due to work pressures. The identified risks were effectively mitigated by escalating potential issues to senior management meetings and via the risk management process.

Resident and family engagement in governance and quality improvement processes were facilitated throughout the service. Within the approved centre, regular family engagement and support, suggestion boxes, and engagement with the complaints process were utilised to support service improvement. A designated advocate from the Peer Advocacy in Mental Health organisation was available to the approved centre if requested; advocacy contact details were displayed within the approved centre. There were clear processes in place to follow up on any issues identified by service users or family members.

The progression and development of various quality initiatives in the approved centre was a standing agenda item at the Quality Patient Safety Committee (QPSC). A programme of audit was implemented by the multi-disciplinary team throughout the service. The QSEC provided a multi-disciplinary approach to policy development, review, approval and dissemination and all policies were up to date at the time of inspection. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre.

In line with the Mental Health Commissions updated Rules on Seclusion and Mechanical Restraint and the Code of Practice on Physical Restraint, the approved centre had updated their policies and procedures. There was a named senior manager who was chair of a newly established multi-disciplinary review and oversight committee for restrictive practices. This committee met quarterly, and an identified action plan had been devised. The seclusion and physical restraint documentation had been updated.

The approved centre followed all public health advice in regard to a COVID-19 outbreak. Contingency planning included the potential risks posed by the COVID-19 virus. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✓		✓		✓		✓		✗	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.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, 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 Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. To that end, the inspection team engage with residents in a number of different ways:

- The inspection team informally approached residents and sought their views on 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.
- Set times and a private room were available to talk to residents.
- The Peer Advocacy in Mental Health representative was contacted to obtain residents' feedback about the approved centre.

No residents availed of the opportunity to meet with the inspection team. No completed questionnaires were received from residents.

5.2 Advocacy

The approved centre had an advocacy service. The inspection team spoke with the Peer Advocacy in Mental Health representative. The advocate said they had not received a referral from St. Gabriel's Ward since the last inspection. The advocate said referrals could be made by residents, their family or friends or staff of the approved centre. The advocate stated that they had not visited the approved centre.

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:

- Clinical Director
- Executive Clinical Director
- Acting Area Director of Nursing
- Acting Head of Service
- Deputy Services Manager
- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Occupational Therapy Manager
- Principal Social Worker
- Support Services Manager
- Complaints Officer
- Risk Manager/Advisor
- Compliance Officer/Assistant Director of Nursing

Apologies were received on behalf of the Head of Services and the Principal Psychologist.

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two appropriate resident identifiers before administering medications, undertaking medical investigations, and providing other healthcare services. Identifiers included resident home address, identification number, name, and date of birth. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.
(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their 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. The approved centre used a three week menu cycle. Residents had at least two choices for meals, and meal options included meat, fish and vegetarian.

A source of safe, fresh drinking water was available at all times in the approved centre from water dispensers located in the day room and residents were offered drinks at regular intervals throughout the day.

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2021.

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

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

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

An activities nurse organised the timetable and facilitated activities in the approved centre on weekdays, and nursing staff and health care assistants facilitated activities also during the week, and on weekends. Activities included jigsaws, word search, movies, tv, music, arts and crafts, flower arrangement, board games, massage, a relaxation group, a music group, chair yoga, walks, day trips, baking, garden activities, pet therapy, live music, and dance.

An outside agency called Siel Bleu visited the approved centre to provide an exercise group once a week. One-on-one activities were also provided for the residents. Each resident had a Get to Know Me template in their clinical file and an activity report template which was reviewed weekly by the activities nurse.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had written policies and procedures in relation to visits. The policy was last reviewed in July 2022. At the time of inspection, visiting times were flexible, appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Residents could meet visitors in a private visiting area unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. The visiting area was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had written policies and procedures in relation to communication. The policy was last reviewed in February 2021. Residents in the approved centre had access to postal mail and Wi-fi enabled internet access including e-mail, and the approved centre's telephones, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was a reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in June 2021, and included all requirements related to:

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

The resident search policy and procedure was communicated to all the residents, and relevant staff could articulate the searching processes as set out by the policy.

No searches had occurred in the approved centre since the last inspection. Compliance was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. This policy was last reviewed in September 2020. The clinical file of one resident was reviewed on inspection.

The clinical file of a resident who had died was inspected. The 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's family, and next of kin.

The end-of-life care provided was appropriate to residents' physical, emotional, social, psychological, and spiritual needs. Religious and cultural practices were respected. The privacy and dignity of the resident was respected, and the resident was given a single bedroom while in receipt of end-of-life care. Representatives, family, next of kin, and friends were involved, supported, and accommodated during end-of-life care.

All deaths of residents, including a resident transferred to a general hospital for care and treatment, were notified to the Mental Health Commission as soon as is 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

Five individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes. ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment. The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

The ICPs identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. They also identified the resources required to provide the care and treatment identified. The ICPs were reviewed by the MDT at least six-monthly, in consultation with the resident and their family representative. ICPs were updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre had a combined recreational and therapeutic group programmes timetable. Group therapies were facilitated by the occupational therapist, activity nurse and external providers such as Siel Bleu: a physiotherapy-lead exercise programme. Therapeutic activities included: relaxation, exercise groups, music groups, pet therapy, reminiscence therapy, and chair yoga. Therapeutic activities were provided on a one-to-one and group basis, and at the time of inspection due to the cohort of residents there was a focus on one-to-one therapeutic activities.

At the time of inspection, the community occupational therapist was providing services to the approved centre and was based there two days a week and was available for additional days, when required. The social worker was based in the approve centre on a part-time basis and provided one to one work with residents and worked with residents' families, when required.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health and medical emergency policy. The policy was last reviewed in April 2021.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Registered medical practitioners assessed residents' general health needs at admission and on an ongoing basis as part of the approved centre's provision of care. Residents received appropriate general health care interventions in line with individual care plans and general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

The clinical files of five residents who had been in the approved centre over six months were reviewed. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, a medication review, body mass-index and weight. For residents on anti-psychotic medication, the six-monthly form documented that there had been an annual assessment of their glucose regulation, blood lipids, prolactin levels, and an electrocardiogram (ECG).

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

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents. The policy was last reviewed in March 2021.

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Staff appearance and dress were appropriate. Staff showed discretion when discussing the resident's condition or treatment needs.

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

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 in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards 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 good a state of repair externally and internally. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. The centre was clean, hygienic, and free from offensive odours. Current national infection control guidelines were followed.

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

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in October 2021. The policy included:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, six of which were examined on inspection. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies; the administration route for the medication; and a clear record of the date of discontinuation for each medication. The MPARs also contained the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

There was not a complete record of all medications administered to the resident in one MPAR. One 'taken as required' medication for one resident that was dated and timed for administration was not signed by the administering nurse.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently where there was a significant change in the resident's care or condition; this was documented in the clinical file.

Directions to crush medication were only accepted from the resident's medical practitioner with a documented reason as to why. In one resident's MPAR there was no documented evidence to suggest that there had been consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed.

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

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

a) **On one resident's medication, prescription, administration record there was no documented evidence to suggest that there had been consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed, 23 (1).**
b) **One 'taken as required' medication for one resident that was dated and timed for administration was not signed by the administering nurse, 23 (1).**

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 March 2022.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in February 2023, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre were sufficient to meet resident needs. The approved centre had two multi-disciplinary teams. They included psychiatry, nursing, occupational therapy, social work, and psychology staff.

An appropriately qualified staff member was on duty and in charge at all times. All healthcare staff were up to date with mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre.

See the table below for a breakdown of the numbers and percentages of staff trained in each of the four mandatory training topics:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (15)	15	100%	15	100%	15	100%	15	100%
Medical (4)	4	100%	4	100%	4	100%	4	100%

Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in June 2021. Resident records were secure, up-to-date, and in good order, and were physically stored together in a secure office. All resident records were reflective of the residents' current status and the care and treatment being provided.

Resident records were developed and maintained in a good order and logical sequence. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. Documentation of inspections relating to food safety, health and safety, and fire inspections were maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All policies and procedures requiring a three-yearly review had been reviewed and updated

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

There was a nominated person responsible and available for dealing with all complaints who was based in the approved centre. Information was provided about the complaint's procedure to residents and their representatives at admission or soon after. This information was available within the resident information booklet and on noticeboards in the approved centre. The complaints procedure, including how to contact the nominated person, was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

There were no minor or major complaints lodged to the approved centre since the last inspection.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint (PR). The policy had been reviewed annually and was dated January 2023. It addressed the following:

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

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

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. All staff who participated or may participate in the use of physical restraint had received appropriate training in the use of physical restraint and in the related policies and procedures regarding staff training. All staff who participated or may participate in the use of physical restraint had received training in cultural competence, and in the positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic. A record of attendance at physical restraint training was maintained by the approved centre.

Monitoring: There was a multi-disciplinary review and oversight committee in the approved centre which met at least quarterly, and it determined if there was compliance with the code of practice on the use of physical restraint for each episode of physical restraint reviewed.

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

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

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

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

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

An in-person debrief with the person who was restrained followed the episode of PR. This debrief was person-centred and gave the person the opportunity to discuss the PR with members of the multi-disciplinary team (MDT) involved in the person's care and treatment as part of a structured debrief process.

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

The episode of PR was recorded on the clinical practice form located in the clinical file. The episode of PR was reviewed by members of the MDT within five working days from the date of the restraint. The review covered everything required to be covered. The MDT recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

There was a named senior manager responsible for the approved centre's reduction of physical restraint.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

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

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

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

Evidence of Implementation:

Admission: The clinical file of one resident who was admitted to the approved centre was reviewed on inspection. A key worker system was in place, and admission was on the basis of mental illness or mental disorder. An admission assessment was completed. This assessment included the following: presenting problem; past psychiatric history, family history, medical history, current and historic medication, where relevant, social and housing circumstances, current mental health state, risk assessment, full physical examination, and other relevant information. The resident's family member, carer, or advocate was involved in the admission process, with the resident's consent.

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

Discharge: The clinical file of one resident who was discharged from the approved centre was reviewed on inspection. The discharge plan included the following: estimated date of discharge, documented communication with the relevant general practitioner or primary care team or community mental health team (CMHT); a follow-up plan; and a reference to early warning signs of relapse and risks. The discharge

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

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

The comprehensive discharge summary was issued within 14 days. The discharge summary included details of diagnosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, names and contact details of key people for follow-up, and risk issues such as signs of relapse.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10004116		**On one resident's medication, prescription, administration record there was no documented evidence to suggest that there had been consultation with a pharmacist about the type of preparation to be used when crushed medications were prescribed, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Documented evidence with the pharmacist will be maintained about the type of preparation to be used when crushed medications are prescribed.	Audit	Achievable + realistic	09/10/2023	Pharmacist, NCHD + CNM2
Preventative Action	Documented evidence with the pharmacist will be maintained about the type of preparation to be used when crushed medications are prescribed.	Audit	Achievable + realistic	09/10/2023	Pharmacist, NCHD + CNM2
Reason ID : 10004117		**One 'taken as required' medication for one resident that was dated and timed for administration was not signed by the administering nurse, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	To ensure safe practice, all 'taken as required' medication will be signed by the administering nurse.	Audit.	Achievable + realistic	09/10/2023	Nurse
Preventative Action	All staff are reminded of the importance to adhering to the	Audit	Achievable + Realistic	09/10/2023	Nurses

	Medication policy and to complete refresher training on medication management.				

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.

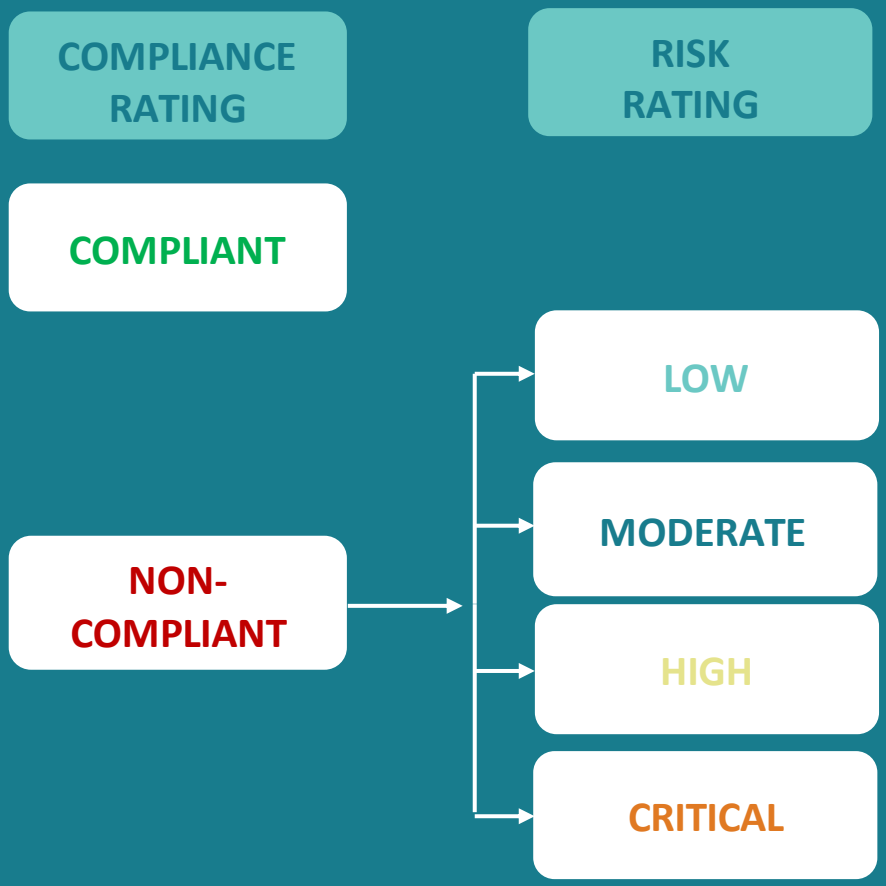
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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