Deer Lodge

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

DEER LODGE

St. Margaret's Road, Killarney, Co. Kerry

Date of Publication:
13 December 2023

ID Number: AC0159

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care/Long Stay Psychiatry of Later Life
Mental Health Rehabilitation
Mental Health Care for People with Intellectual Disability

Conditions Attached:
Yes

Most Recent Registration Date:
11 July 2020

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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Inspection Team:
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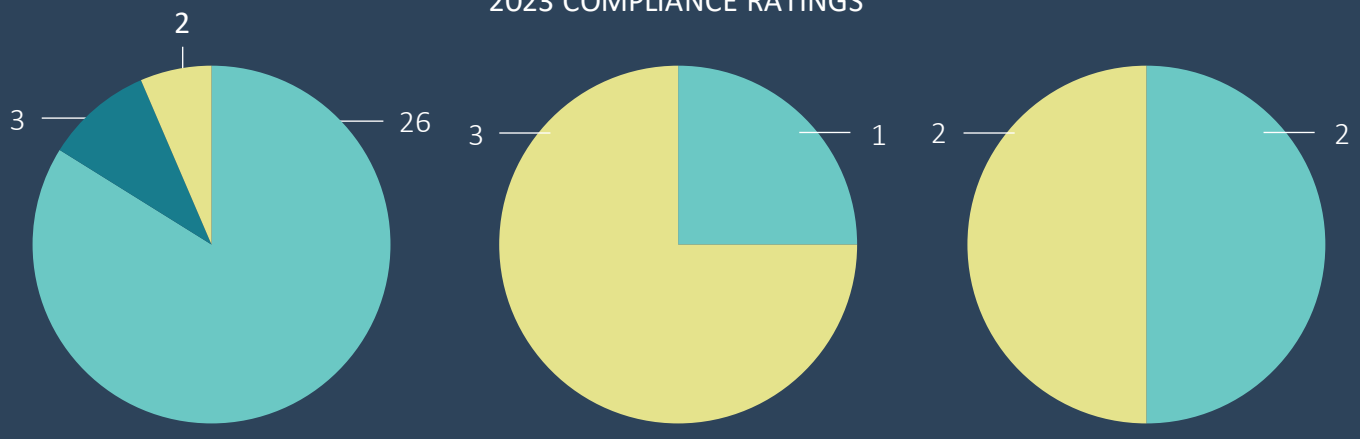
Inspection Date:
13 – 16 March 2023

Previous Inspection date:
22 – 25 February 2022

Inspection Type:
Announced Annual Inspection

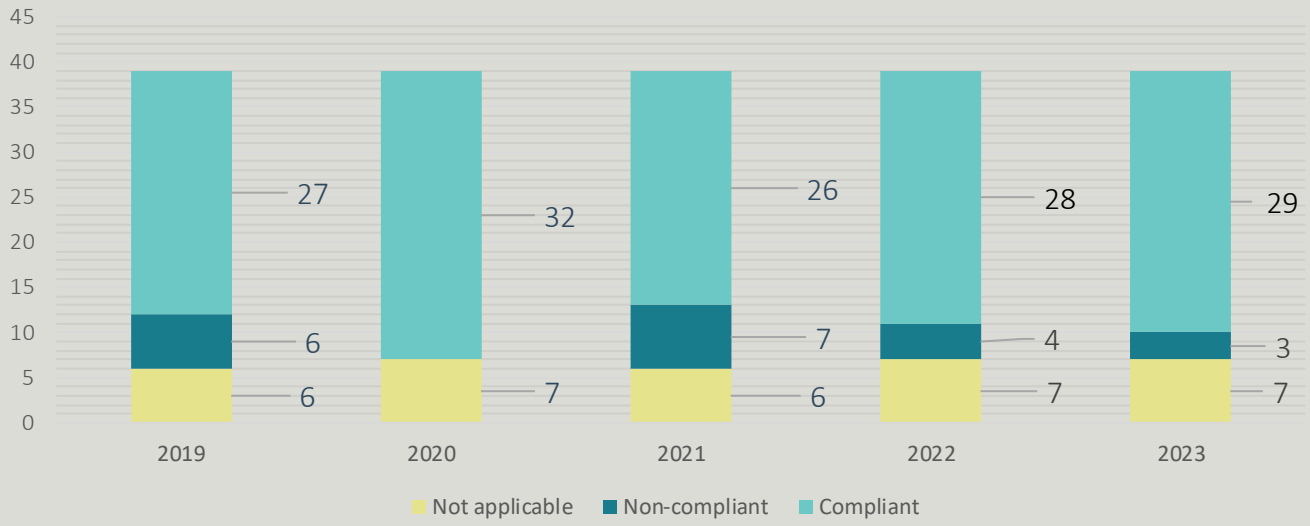
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

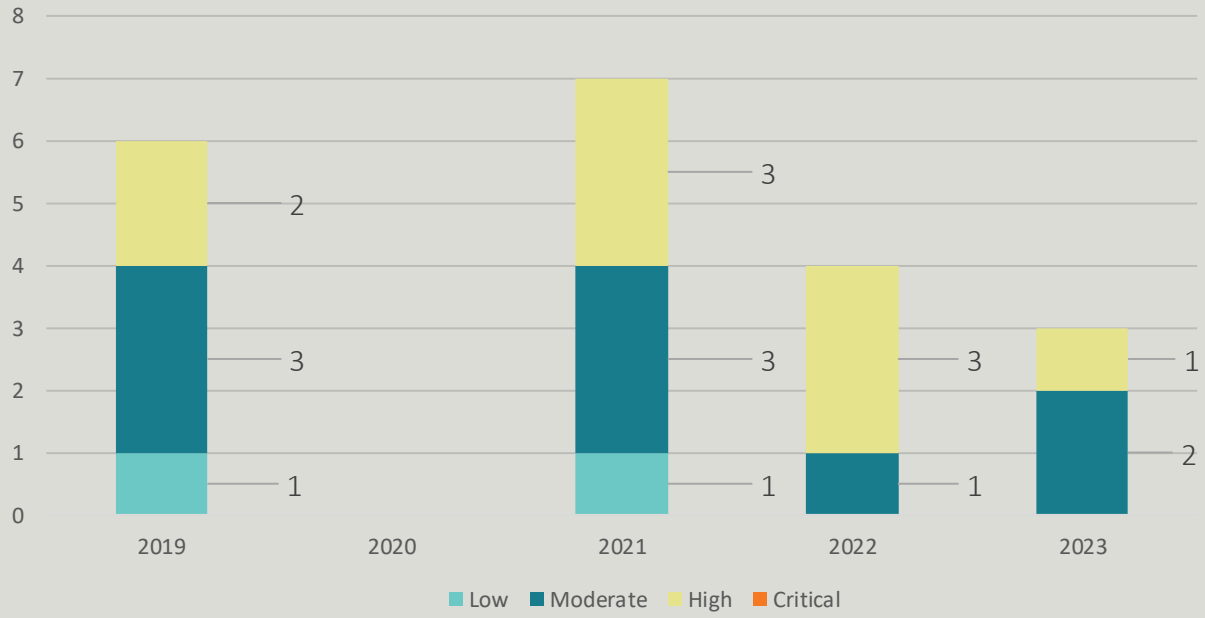
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

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

In brief

The approved centre was a purpose-built, residential Mental Health Recovery Unit. The Unit opened in 2017 and it was located in Killarney in County Kerry. The approved centre was divided into four 'households': Mountain View, River View, Wood View and Lake View. All households were connected through a central thoroughfare that featured an entrance, foyer, communal area, therapy areas, prayer room, activity rooms and other facilities including a hair salon.

The approved centre had two multi-disciplinary teams, specialising in Rehabilitation and Recovery (Mountain View/River View Units), and Psychiatry of Later Life (Wood View/Lake View Units). These two multi-disciplinary teams admitted residents into the approved centre.

The service had a multi-disciplinary review and oversight committee and a senior manager appointed with responsibility for the reduction in restrictive practices within the service.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	82%	100%	79%	88%	91%

Conditions to registration

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

Conditions	Findings
Condition 1: *To ensure adherence to Regulation 26(4) and 26(5): Staffing the approved centre shall develop and implement a plan to ensure all*	The approved centre was not in breach of Condition 1 at the time of inspection.

healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental Health Commission in a form and frequency prescribed by the Commission.	

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.
- ***Safeguarding:*** Staff were aware of safeguarding procedures.
- ***Access to essential information*****:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***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 reason by the medical practitioner to explain why the medication was to be crushed. There was no documented evidence that the pharmacist was consulted about the type of preparation to be used when crushed medications were prescribed. The ordering, storing, and administration of medication was carried out in a safe manner.

- ***Mandatory training:*** Not staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression.

Appropriate care and treatment of residents

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

- **Appropriateness of environment:** The layout and the decoration of Deer Lodge was of high standard and met the needs of the residents.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines. Residents had access to a local visiting General Practitioner (GP) and after hours Care Doc.
- ***Multi-disciplinary team working:*** Two multi-disciplinary teams, specialising in Psychiatry of Old Age (POLL) and Rehabilitation and Recovery were accessible to admitted residents to the approved centre. These teams included nursing, medical, psychologists, social workers and occupational therapists.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan. These included horticulture, art and music, healthy cooking and baking groups, recovery focused therapeutic groups, mindfulness, cognitive therapeutic groups, functional assessments, independent living skills, and vocational, educational and social skills sessions.
- ***Access to other medical services:*** Specialist services were available on a referral basis including dietitians, physiotherapist, speech and language therapist, tissue viability nurse, public health nurse, and palliative care team.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Individual care plans:*** While each resident had an individual care plan that documented the resident's needs, there were deficits in the care planning process in the sample of files (10) inspected. Ten individual care plans (ICPs) were not regularly updated by the resident's multi-disciplinary team (MDT). One ICP was reviewed by medical and nursing staff only, and was not reviewed by the full MDT.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** Each resident had their own single bedroom rooms with en suite bathroom and toilet.
- ***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:*** 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 socialising. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre was compliant with the Code of Practice on Physical Restraint. The approved centre did not use Seclusion or Mechanical Restraint. The approved centre had a reduction of restrictive practices strategy.
- ***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. Each of the four households had access to well maintained and pleasing garden areas. All residents had access to large communal spaces including sitting rooms, dining room and quiet areas.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. A priest visited residents on an individual basis on each unit. Mass was celebrated in the centre and livestreamed to each unit via televisions.
- ***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, where appropriate.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Residents had access to a range of appropriate recreational activities during the weekdays and at the weekend. Activities included TV, DVDs, radio, music, board games, bingo,

pool and soccer tables, art classes, walks, gym, knitting, gardening, and outings which used the approved centre's minibus for transport.

- ***Support groups:*** The approved centre had a peer advocacy service.
- ***Residents' feedback:*** The residents were complimentary about the environment and their overall experience of care and treatment they received; however some residents found the mattresses hard. Residents said that they received information on their treating teams and their individual care plans, and one out of fourteen residents who responded, said that they were unaware of their key worker. Residents said they were able to give feedback about their care to staff. Thirteen of fourteen respondents felt their privacy and dignity were respected during their stay and one did not. Residents said they had private spaces; their dignity was respected and that plenty of activities were provided during the day. Residents were complimentary about staff. Residents said that recovery focused activities on the ward were good and some expressed wanting more recovery focused activities.

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 Cork Kerry Community Healthcare and was governed under the Kerry Mental Health Services. The Cork/Kerry Mental Health Management Team Strategic Meeting convened monthly and was attended by relevant Heads of Discipline and Service.
- ***Leadership:*** Although there was strong leadership within the approved centre on both Psychiatry of Old Age (POLL) and Rehabilitation and Recovery teams, the approved centre had a vacant post for a consultant psychiatrist within Deer Lodge and the Area Lead for Mental Health Engagement post for the service was vacant. The service had a multi-disciplinary review and oversight committee.
- ***Clinical governance:*** Audits of clinical practice were in place. Clinical files showed good documentation of evidence-based clinical processes. A Peer Group Clinical Supervision was implemented in the approved centre for staff. There were systems for performance appraisal for all staff within the approved centre.
- ***Restrictive practices reduction:*** A senior manager appointed with responsibility for the reduction in restrictive practices within the service. The approved centre had a physical restraint and seclusion reduction policy. The service had a reduction of restrictive practices strategy.
- ***Risk:*** Heads discipline had received training in risk management procedures. The person with responsibility for risk was known by staff. Incidents were reported and risk assessed. The approved centre had a local risk register. Relevant risks were escalated to the Kerry Mental Health Service risk register, and reviewed by Cork Kerry Mental Health Management Team Strategic Meeting.
- ***Quality improvement:*** Regular audits had been completed and the approved centre was dedicated to continuously improving service quality. A Quality and Patient Safety Committee for the Kerry region convened every six weeks. A programme of audit was implemented by the multi-disciplinary team throughout the service. A local Compliance Group meeting at Deer Lodge also convened on a regular basis to discuss matters relating to regulatory compliance issues. Nursing Quality Care Metrics (QCM) were introduced in the approved centre as a mechanism to measure and improve the quality of nursing care provided.

- ***Policies:*** All policies were up-to-date. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.
- ***Staff training:*** Staff were trained in safeguarding.
- ***Complaints:*** There was a robust complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** Resident engagement in governance and quality improvement processes was facilitated throughout the service. Within the approved centre, regular resident community meetings, suggestion boxes, service user surveys, annual focus groups and engagement with group planning were utilised to support service improvement.
- ***Advocacy services:*** A designated advocate from the Peer Advocacy in Mental Health contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 89% over the last 4 years. There was one condition at the time of the inspection, and at the time of this inspection the approved centre was not in breach of the condition. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Staff training:*** Not staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Introduction of Nursing Quality Care Metrics (QCM) - The QCM was introduced to Deer Lodge in December 2022. Each month the QCM data collectors collect data and upload to the HSE Test Your Care site. The approved centre then generates a report and discussed it at their monthly committee meeting and devised action plans. Measurement of the quality of care delivered provided an assurance mechanism that captures the contribution and performance of nurses in a way that was transparent and focused on improvement.

2. In February 2023 a Peer Group Clinical Supervision was started at the approved centre. The purpose of peer supervision was to provide a safe and confidential environment for staff to reflect and discuss their personal and professional response to work in order to facilitate personal and professional development in practice.

3. Wall Murals – Since the last inspection a lot of work was done to enhance the therapeutic environment within Deer Lodge. Throughout Deer Lodge (inside and outside) beautiful walls murals have been hand painted of nature scenes which created a soothing environment for both residents and staff.

4. Kickstart Recovery was a soccer programme initiative which was well established in mental health services nationwide. The programme was run in collaboration with the Football Association of Ireland, who provided the soccer coach for the group. It was introduced to the residents of Deer lodge. The programme ran alongside the Occupational Therapist's on the South Kerry Rehabilitation and Recovery Team, the Killarney Community Team and the Castleisland Community Team. The group included male only participants, with varying abilities and at different stages of their recovery journey. This initiative had commenced in March 2023

5. An Art in Hospitals programme was being facilitated in Deer Lodge every Thursday morning in collaboration with the Kerry Education and Training Board. The art tutor along with the Occupational therapist facilitated two consecutive art classes on the day. The therapeutic benefits to art therapy are well documented and it was enjoyed by the residents at Deer Lodge.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was a purpose-built, residential Mental Health Recovery Unit. The Unit opened in 2017, and was located on St. Margaret's Road, Killarney in County Kerry. The approved centre was registered with the Mental Health Commission for the provision of continuing mental health care, psychiatry of later life, mental health rehabilitation and mental health care for people with an intellectual disability. The approved centre consisted of four 'households': Mountain View, River View, Wood View and Lake View. All were connected through a central thoroughfare that featured an entrance, foyer, communal area, therapy areas, prayer room, activity rooms and other facilities including a hair salon. Within each of the four household, each resident had their own en suite bedroom, and additionally, residents had access to a sitting room, dining room, quiet room, kitchenette, and an internal landscaped garden area. The approved centre had two multi-disciplinary teams, specialising in Rehabilitation and Recovery (Mountain View/River View Units) and Psychiatry of Later Life (Wood View/Lake View Units).

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

Resident Profile	
Number of registered beds	***40***
Total number of residents	**39**
Number of detained patients	4
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	38
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of Cork Kerry Community Healthcare and was governed under the Kerry Mental Health Services. The Cork/Kerry Mental Health Management Team Strategic Meeting convened monthly and was attended by relevant Heads of Discipline and Service. The meeting minutes evidenced discussion of key topics such as quality and patient safety, complaints, human resources, staff training, risk issues, regulatory compliance issues, and operational issues. A local business meeting (Deer Lodge Management Meeting) convened on average every two to three months and was attended by heads of discipline or a designated representative. Agenda items included quality initiatives, complaints/compliments, risk issues, incident management, and mandatory training.

In September 2022, the Mental Health Commission (MHC) published revised rules governing the use of seclusion and mechanical restraint, and a revised code of practice relating to the use of physical restraint in

approved centres. The date of commencement of this code of practice and rules was the 1st of January 2023. The service had a multi-disciplinary review and oversight committee and a senior manager appointed with responsibility for the reduction in restrictive practices within the service. The approved centre had a physical restraint and seclusion reduction policy.

Two multi-disciplinary teams, specialising in Psychiatry of Old Age (POLL) and Rehabilitation and Recovery admitted residents to the approved centre. Both teams reflected disciplines required to reflect multi-disciplinary working and included medical, nursing, and health and social care disciplines. However, the approved centre had a vacant post for a consultant psychiatrist within Deer Lodge. The rehabilitation and recovery medical consultant post was vacant since February 2023 with this post being tempora rily covered by the Executive Clinical Director. Recruitment for this position was under way and this issue had been raised at the Cork Kerry Mental Health Management Team Strategic Meeting and entered on the Kerry Mental Health Service risk register. The Area Lead for Mental Health Engagement post for the service was vacant.

Heads of discipline had received training in risk management procedures. A risk register for Deer Lodge was maintained by local management and included corporate, health and safety, and structural risks. The register was kept up-to-date and reviewed regularly at the local Deer Lodge Management Meeting. Relevant risks were escalated to the Kerry Mental Health Service risk register, which in turn, was reviewed at the Cork Kerry Mental Health Management Team Strategic Meeting. Incidents arising in Deer Lodge were reviewed at the local management team meeting.

Resident engagement in governance and quality improvement processes was facilitated throughout the service. Within the approved centre, regular resident community meetings, suggestion boxes, service user surveys, annual focus groups and engagement with group planning were utilised to support service improvement. A designated advocate from the Peer Advocacy in Mental Health contacted the approved centre on a weekly basis and spoke with residents; advocacy contact details were displayed within the approved centre. The approved centre had a complaints process and facilities for residents and their families to make complaints.

The approved centre was dedicated to improving service quality. A Quality and Patient Safety Committee for the Kerry region convened every six weeks. Agenda items indicated active review and planning regarding several areas which underpin service improvement and quality; these included a review of the risk register, serious incident reviews and recommendations, clinical audit results and quality improvement plans. A local Compliance Group meeting at Deer Lodge also convened on a regular basis to discuss matters relating to regulatory compliance issues. A programme of audit was implemented by the multi-disciplinary team throughout the service. There were systems for performance appraisal and clear supervision processes for all staff within the approved centre.

COVID-19 was a standing agenda item for both the Deer Lodge local business meeting and the Cork Kerry Mental Health Management Team Strategic Meeting and issues arising were actively managed. Where relevant, policies and procedures had been updated to reflect the necessary process changes precipitated by the pandemic.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 15: Individual Care Plan	✓		✓		X	High	X	High	X	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	X	Moderate	✓		✓		✓		X	Moderate
Regulation 26: Staffing	X	High	✓		X	High	X	High	X	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Fourteen completed service user experience questionnaires were returned to the inspectors.
Comments made by residents on the questionnaires were that the approved centre was "a home from home", "that the doctors and nurses treat me very well", "that the food is of a poor standard" and "that they would like more activities in the approved centre".

Of the fourteen completed questionnaires, eleven respondents indicated that on arrival to the approved centre, a member of staff had explained what was happening in a way that could be understood, two respondents indicated no to this question, and one could not remember. Eight respondents indicated they had received information on their diagnosis, four indicated sometimes, one indicated never to this question and one resident did not want information on their diagnosis. Thirteen respondents indicated that they understood what their care plan was, one indicated that they did not understand their care plan. Of the thirteen respondents who knew what their care plan was, ten indicated that they were always involved in setting goals for their individual care plans and three indicated that they were involved sometimes. One respondent indicated that they were never involved in their care planning. Fourteen of the respondents indicated that they knew their multi-disciplinary team members and thirteen respondents knew their keyworkers and one respondent did not know their keyworker. Eleven respondents indicated that they were always able to discuss worries or concerns with a member of staff, with two respondents indicating sometimes and one resident indicating never to this question. Thirteen respondents felt there was enough activities in the approved centre and one did not.

Twelve respondents were happy with how staff spoke with them, and two were not happy how staff spoke with them. Twelve respondents felt they had space for privacy, two did not and thirteen respondents felt

their privacy and dignity were respected during their stay, one respondent did not. Thirteen respondents said they could communicate freely with family, friends and the advocate, one expressed they could not communicate freely. Eleven said that they always felt safe with two saying sometimes and one saying never to this question. Twelve respondents indicated that they were always able to give feedback to staff, and to make a complaint when they were not satisfied with any part of their stay. The remaining two respondents indicated sometimes for this question.

On a scale of 1-10, with 1 being poor and 10 being excellent for their overall experience of care and treatment at the approved centre. One resident rated 1 out of 10, one resident rated 6 out of 10, two residents rated 7 out of 10, one resident rated 8 out of 10, three residents rated 9 out of 10 and six residents rated 10 out of 10.

The inspection team also spoke with nine residents during the inspection. Their feedback indicated that their "bedrooms were nice and of a good size" but that some "found the mattresses were hard". Some residents reported that "the food was of poor quality and lacking in flavour and some residents found the food to be very nice". Residents said that "recovery focussed activities on the ward were good and that they wanted more of them". Residents reported "enjoying activities outside of the centre". Residents reported "their attendance at multi-disciplinary care plan meetings and that they knew their team caring for them". Some residents "expressed the wish to go home or move on from the centre". Residents described "some staff as difficult to interact with, while some knew the staff well and got on well with staff and reported that staff were good to them". Residents also reported that "visits wee facilitated when they wanted".

5.2 Advocacy

The approved centre had an advocacy service.

At the time of inspection, the inspectors were not in receipt of a report from the Peer Advocacy in Mental Health representative.

6.0 Feedback Meeting

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

- Executive Clinical Director
- Area Director Of Nursing
- Principal Social Worker
- Principal Psychologist
- Occupational Therapy Manager
- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Clinical Nurse Manager 2

Apologies were offered by.

- The Interim Head of service
- Head Pharmacist

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs. Identifiers included name, address, date of birth and resident identification number.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in September 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary. Each unit of the approved centre had a safe for the storage of residents' monies. Large sums of money were managed by the finance department which was located on the campus. Residents gave written consent to allow their money to be managed by the approved centre.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Each unit had an activities timetable. Residents had access to self-starting activities such as books, TV, DVDs, radio, music, board games, bingo, pool and soccer tables, art classes, walks, gym, knitting, gardening, and outings which utilized the approved centre's minibus for transport.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. The priest visited residents on an individual basis on each unit. The approved centre had a chapel room located on the general corridor. Mass was celebrated in the centre and livestreamed to each unit via televisions. Residents also had access to local mass and access to multi-faith ministers as required.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Visiting times were appropriate and reasonable: visiting was facilitated at any time outside of meals. There were no restrictions on visits for any resident at the time of inspection. Appropriate steps were taken to ensure the safety of residents and visitors during visits. There was a visiting room on the general corridor, and one provided in each unit of the approved centre. The visiting room on the general corridor was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents in the approved centre had access to their own phones where applicable, a landline telephone, postal mail and internet including e-mail. There were no restriction on any resident's communication at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in September 2020, and included all requirements related to:

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

As there had been no searches in the approved centre since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

As there had been no deaths in the approved centre since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

INSPECTION FINDINGS

Each resident had an Individual Care Plan (ICP). Ten ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, and resources required. With regard to allocating space for review of the ICPs, the care plan template used in the Psychiatry of Later Life (POLL) units did not allocate a section for updating the ICP. The care plan template used in the Rehab and Recovery units allocated a section for updating progress in resident goals, but this was inadequate and incomplete on all ICPs examined.

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

ICPs identified appropriate goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ten ICPs examined were reviewed within a six-monthly timeframe. However, one care plan review was attended by nursing and medical staff only rather than the full MDT.

None of the ten ICPs examined were updated to indicate the resident's changing needs, conditions, circumstances and goals.

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

a) **Ten out the ten individual care plans examined were not regularly updated by the resident's multi-disciplinary team.**
b) **One of the ten individual care plans examined was reviewed by medical and nursing staff only.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs).

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Residents had access to the full therapeutic services milieu. There was a dedicated occupational therapist (OT) for the approved centre. There was a social worker based in the approved centre. There was access to a dietitian, physiotherapist, speech and language therapist, tissue viability nurse, public health nurse, and palliative care team on a referral basis. There were three therapeutic groups facilitated by tutors from Kerry Education and Training Board: Horticulture, Art and Music. The OT facilitated healthy cooking and baking groups, recovery focused therapeutic groups, and mindfulness and cognitive therapeutic groups. There were protocols detailing the therapeutic benefits of each group. The OT also provided functional assessments, independent living skills, and vocational, educational and social skills sessions on a one-to-one basis and the POLL psychologist facilitated a social group in the approved centre.

Where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location. Residents could access a dentist and ophthalmologist in Killarney town. A chiropodist visited the approved centre on a regular basis.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in September 2020. The clinical file of one resident who had been transferred from the approved centre was inspected. It was an emergency transfer; a full and complete referral was sent to the relevant medical team after the resident had been triaged and care transferred to a specialist team within the general hospital. The resident was accompanied by two nurses to the emergency department and all relevant information was transferred with the resident. This included the resident transfer form, and the resident's Medication Prescription and Administration Record (MPAR), which included a full list of current medications.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in July 2020. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months.

Five clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessments documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, medication review, and body mass-index, weight, and waist circumference. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram (ECG) heart function.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents had access to a visiting general practitioner three days a week and to Caredoc for out of hours doctor service. Residents also had access to a private dietitian, speech and language therapist, chiropodist and physio (following referral), and a community dentist. Residents could access national screening programmes that were available according to age and gender, including the following: breast check; cervical screening; retina check (diabetics only); and bowel screening.

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

Residents were provided with written and verbal information on diagnosis where appropriate, and 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 side-effects. Residents had access to interpretation and translation as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and 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. Each unit had access to well maintained and pleasing garden areas. The garden beds were well kept and murals of the surrounding countryside and wildlife had been added to the gardens since the last inspection. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

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

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. Resident bedrooms were bright, spacious, and looked on to a garden area. Suitable furnishings were provided 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 **MODERATE**

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

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

INSPECTION FINDINGS

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

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

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

All entries in the MPARs were legible. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file. In one of the MPARs inspected, there was direction for medication to be crushed. The resident's medical practitioner had directed that the medication be crushed. However, the medical practitioner did not document a reason for why the medication was to be crushed. This was rectified by the consultant psychiatrist during the inspection. There was no documented evidence that the pharmacist was consulted about the type of preparation to be used. This was rectified by the pharmacist during the inspection. The medical practitioner documented within the MPAR that the medication was to be crushed.

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

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

a) **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents. In one Medication Prescription and Administration Record, the medical practitioner had not given a reason why the medication was to be crushed, 23 (1).**
b) **The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents. The pharmacist was not consulted about the type of preparation to be used in respect a medication to be crushed, 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 September 2020. The approved centre's site-specific safety statement was last reviewed in January 2023.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

(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 September 2020, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

Two multi-disciplinary teams, specialising in Psychiatry of Old Age (POLL) and Rehabilitation and Recovery admitted residents to the approved centre. These teams included nursing, medical, psychologists, social workers and occupational therapists. Access to other disciplines such as dietitians, physiotherapist, speech and language therapist, tissue viability nurse, public health nurse, and palliative care team were available by referral.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. All healthcare staff were trained in the Mental Health Act 2001. However, not all healthcare staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (43)	35	81%	28	65%	43	100%	43	100%
Consultant Psychiatrist (2)	1	50%	1	50%	2	100%	2	100%
Medical (1)	0	0%	0	0%	0	0%	1	100%

Occupational Therapist (3)	2	66%	2	66%	3	100%	3	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%

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

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in September 2020, and included the following:

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

Resident records were reflective of the resident's current status and the care and treatment being provided. All residents' records were secure and in good order, and were constructed, maintained, and used in accordance with national guidelines and legislative requirements. The records were developed and maintained in logical sequence and kept in good order with no loose pages.

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided a dedicated tribunal room and separate meeting room for consultations to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary. The tribunal room was equipped to access the Mental Health Tribunals remotely if required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. There were no active complaints at the time of inspection; two complaints had been received and processed since the previous inspection. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP). The complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process were made available to them. This was documented.

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

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 policy and procedures in relation to risk management. The policy was last reviewed in September 2020, and included the following:

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

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

Individual risk assessments were completed at admission to identify individual risk factors, including general health risks, risk of absconding, and risk of self-harm. Individual risk assessments were also completed in conjunction with medication requirements or administration, and prior to and during

physical restraint and resident transfer and discharge. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

There was an up-to-date certificate of registration, with one condition to registration attached, prominently displayed in the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical files of three patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

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

Policies and procedures regarding staff training included the following:

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

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

- The prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques).
- Alternatives to physical restraint.
- Trauma informed care.
- Cultural competence.
- Human rights, including the legal principles of restrictive interventions.
- Positive behaviour support, including the identification of causes or triggers of the person's behaviours (social, environmental, cognitive, emotional, or somatic).
- The monitoring of the safety of the person during and after the physical restraint.

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

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. All staff who participate, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures. Mandatory training was delivered every 12 months at a minimum. A record of attendance at training was maintained.

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

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

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

In one of the three episodes, the physical restraint was extended by a renewal order for a period which did not exceed ten minutes, with the continuous period of restraint not exceeding 30 minutes.

The orders for physical restraint lasted for a maximum of 10 minutes. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the consultant psychiatrist within 24 hours.

It was the resident's wish in accordance with their individual care plan (ICP) that their representative was not to be informed of the restraint, and no such communication occurred outside of necessary legal or professional requirement. This was recorded in the resident's clinical file. The Mental Health Commission was notified via Comprehensive Information System (CIS) of the start time and date, and the end time and date, of each episode of physical restraint in the correct format and within three days of each episode. Staff involved in the episodes of physical restraint had taken into account any relevant entries in the person's ICP pertaining to the person's specific requirements or needs in relation to the use of physical restraint. There was documented evidence that the principles of trauma-informed care were used during the episodes of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy.

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

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

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

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

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

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

The multi-disciplinary team 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 a policy in relation to admission, transfer, and discharge. The policy was last reviewed in September 2020, and 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 policy.

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and risks, and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was issued within 14 days.

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

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10004100		**Ten out of ten individual care plans were not regularly updated by the resident's multi-disciplinary team. One of the ten individual care plans examined was reviewed by medical and nursing staff only.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	New template for ICP's have been rolled out within POLL sector and are now live. Any new issues arising are documented in ICP by all MDT members and not just in patient notes	Care Planning is one of the indicators under the Quality Care Metrics and is carried out once a month. Regular Audits are being conducted.	Achievable	01/11/2023	Medical and Nursing Staff
Preventative Action	Monthly Audits	Care Planning is one of the indicators under the Quality Care Metrics and is carried out once a month. Regular Audits are being conducted.	Achievable	01/11/2023	Medical and Nursing Staff

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10004113		**The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents. In one Medication Prescription and Administration Record, the medical practitioner had not given a reason why the medication was to be crushed, 23 (1). The registered proprietor did not ensure that the approved centre had appropriate and suitable practices relating to the prescribing of medicines to residents. The pharmacist was not consulted about the type of preparation to be used in respect a medication to be crushed, 23 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Prescription chart subsequently amended. Updated on Risk Assessment and written in Kardex. Recorded in notes that discussion has taken place with the pharmacist. Staff have been advised to update their training on Medication Management on HSEland.	Completed	Completed	26/10/2023	ECD and Area Director of Nursing
Preventative Action	Ensure Medication Policy reflects best practice around medication. Policy to be reviewed and updated as necessary within 8 week timeframe.	Policy to be reviewed and updated as necessary within 8 week timeframe.	Achievable	31/12/2023	ECD and Area Director of Nursing

	For discussion at next Deerlodge Management Team meeting. December.				

Regulation 26: Staffing					
Reason ID : 10004115		**The registered proprietor did not ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all staff had received up-to-date mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Schedule of Training has been updated and training dates offered to staff earlier than previously. More pro-active plan around mandatory training through early identification of staff whose training is out of date.	Records indicate that training targets are on track to be met.	Achievable	26/10/2023	All Heads of Discipline
Preventative Action	Regular review at Management team meeting	On-Going	Achievable	01/11/2023	All Heads of Discipline

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.

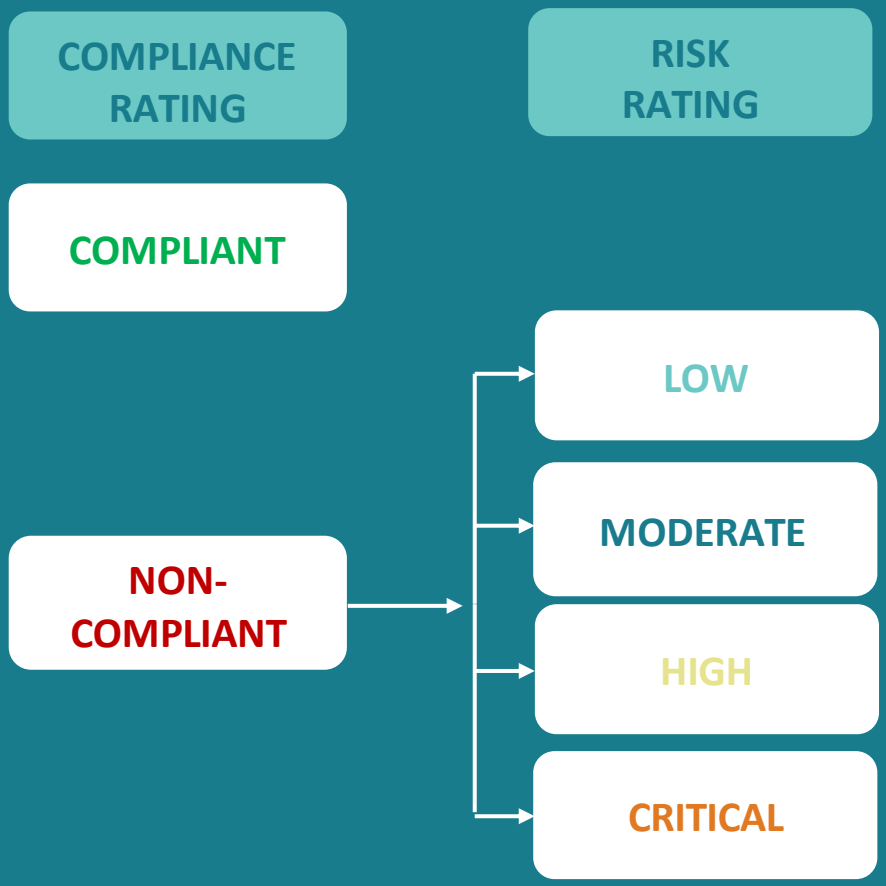
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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