St Aloysius Ward, Mater Misericordiae University Hospital

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mental health commission

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ST ALOYSIUS WARD, MATER MISERICORDIAE UNIVERSITY HOSPITAL

Eccles Street, Dublin 7

Date of Publication: 11th March 2024

ID Number: AC0136

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
Yes

Most Recent Registration Date:
1 September 2022

Registered Proprietor:
Mater Misericordiae University Hospital DAC

Registered Proprietor Nominee:
Mr Alan Sharp, Chief Executive Officer

Inspection Team:
Marianne Griffiths, Lead Inspector
Karen McCrohan
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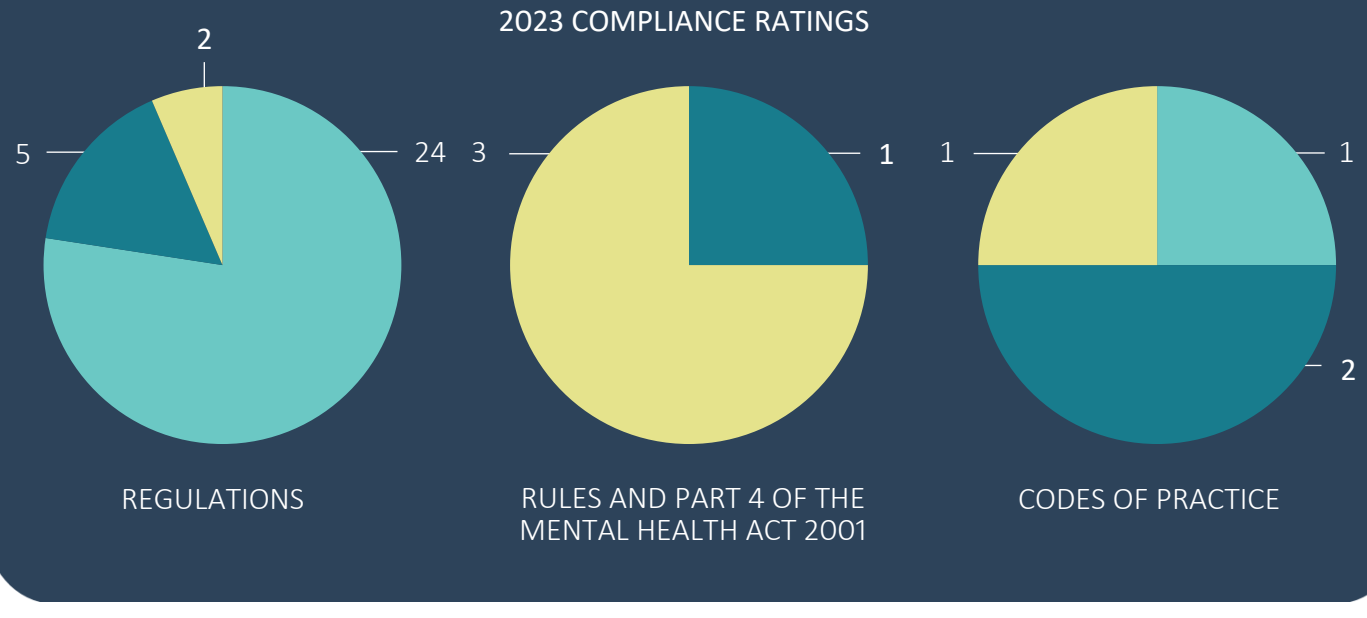
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
9 – 12 May 2023

Previous Inspection date:
22 – 25 February 2022

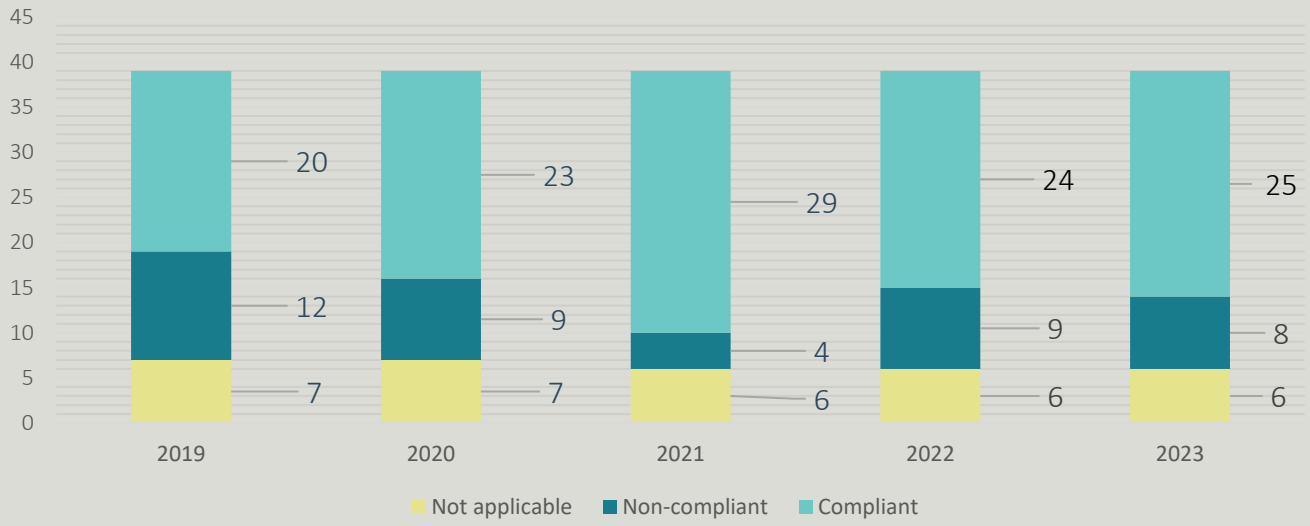
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2019 – 2023

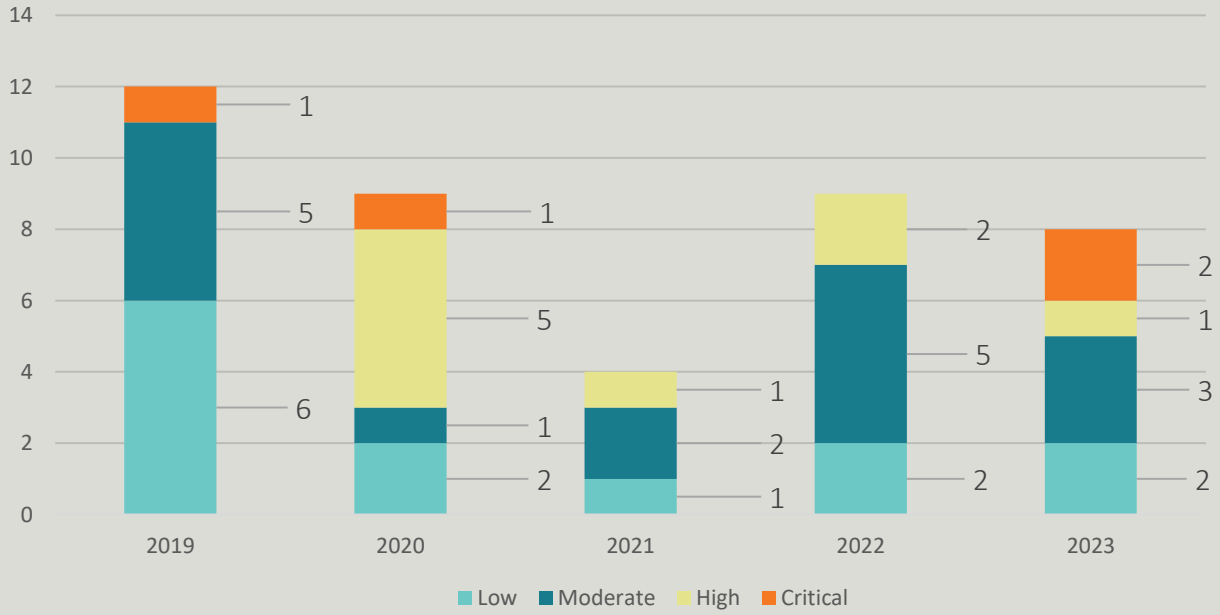
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

St. Aloysius Ward was a 13 bed approved centre for adult in-patient services. It was located on the grounds of the Mater Misericordiae University Hospital (MMUH). The registered proprietor of St. Aloysius Ward is the CEO of the MMUH. Two Health Service Executive (HSE) community mental health teams, including a newly established team specifically focused on the needs of homeless service users, had admitting rights to St. Aloysius Ward. The Mater Misericordiae liaison psychiatry team also admitted service users to the approved centre.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	63%	72%	88%	73%	76%

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 22(3): Premises the approved centre shall develop and implement a costed, funded and time-bound plan to minimise ligatures and hazards and to ensure the approved centre is maintained in a good structural and physical condition. This plan shall be developed by a date specified by the Mental Health Commission. The approved centre shall provide a progress update on implementation of this plan to the Mental Health Commission in a form and frequency prescribed by the Commission.*	The approved centre was not in breach of Condition 1. The approved centre was non-compliant with Regulation 22: Premises at the time of inspection.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action 10000273	*26/05/2023*	*Breach of Regulation. Non-compliant with the Code of Practice: Physical Restraint, and Rules: Governing the Use of Seclusion.*	*In response to the immediate action notice, the registered proprietor nominee submitted an action plan, which the MHC continues to monitor closely.*

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment which was completed prior to and during the following: resident admission, resident transfer, resident discharge, seclusion and physical restraint.
- ***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:

- ***Ligature anchor points:*** Were not minimised to the lowest practicable level, based on individual risk assessment.
- ***Mandatory training:*** Not all staff disciplines were trained in fire safety, basic life support, and the management of violence and aggression.
- ***Access to essential information: Maintenance of records:*** Resident records were found not to be kept in a complete and accurate format. Some documentation within a clinical file did not contain resident identifiers as required. While some clinical notes were corrected retrospectively by the

writer for accuracy reasons, the notes written into the clinical file were not always altered using national guidelines for correcting errors.

Appropriate care and treatment of residents

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

- ***Initial assessments**:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment**:* Each resident had a physical examination on admission. No resident was in the approved centre for more than six months at the time of the inspection.
- ***Multi-disciplinary team working:*** There was a social worker, occupational therapist, and psychologist on the team.
- ***Therapeutic interventions:*** There was a range of recovery focused therapeutic interventions for residents which were evidence-based and in line with their individual care plans. There was a relaxation room, a recently refurbished visitors room, a library, a day room, an exercise room and a clinical room.
- ***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 Plan**:* There were a significant number of deficits in the care planning process in the sample of files (5) inspected:
  a) Three out of five individual care plans examined were not developed by the multi-disciplinary team following a comprehensive assessment.
  b) One individual care plan did not identify the appropriate care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.
  c) One individual care plan did not identify the resources required to provide the care and treatment identified.
  d) Two individual care plans were not reviewed by the multi-disciplinary team.

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:*** At the time of inspection, residents were accommodated in one two-bed, and two four-bed shared bedrooms, and in two en suite single occupancy bedrooms on the ward.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed

discretion and respect for confidentiality when discussing the resident's condition or treatment needs.

- ***Privacy and dignity:*** There were privacy screens on bedroom doors, noticeboards did not show residents' names, clinical files were securely stored, and it was not possible for the public to see into the approved centre. All bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls.

However:

- ***Privacy and Dignity: Searches:*** The outcome of the search was not documented for one resident within their clinical file.
- ***Use of restrictive practices: Rights based Care: Seclusion:*** Seclusion was used in the approved centre only when less restrictive alternatives were deemed unsuitable. There were a significant number of deficits in the seclusion handling and management process in the sample (3) of seclusion episodes inspected: an in person debrief did not follow every episode of seclusion inspected, each episode of seclusion was not reviewed by members of the relevant multi-disciplinary team within five working days following the seclusion episode, and one clinical file indicated that the clinician involved in initiating seclusion did not demonstrate a clear understanding of the circumstances under which seclusion is permitted when documenting the seclusion episode.
- ***Use of restrictive practices: Rights based Care: Physical Restraint:*** There were a significant number of deficits in the physical restraint process in the sample (3) of physical restraint episodes inspected:
  a. In two of three episodes, the order did not confirm that there were no other less restrictive ways available to manage the person's presentation.
  b. In one of three episodes, the registered medical practitioner did not complete a medical examination of the person no later than two hours after the start of the episode of physical restraint.
  c. None of the three physical restraint episodes examined contained documentation indicating that the person was informed of the reasons for and the circumstances which lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition.
  d. In one of three episodes, it was not documented that the person's representative was informed of the person's restraint.
  e. In three of three episodes, the person was not continuously assessed, throughout the use of restraint to ensure the person's safety.
  f. In two of three episodes, the person was restrained in the prone position and this was not recorded in the clinical file.
  g. It was not documented in the three files examined that the person who led the physical restraint ended the restraint.
  h. In three of three episodes, there was no in person debrief with the resident to give an opportunity to discuss the episode of physical restraint with members of the multi-disciplinary team involved in the person's care and treatment.
  i. None of the three episodes of physical restraint were reviewed by the multi-disciplinary team involved in the person's care and treatment.

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 lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements.
- ***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 residents could access.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Residents had access to Mass in the main hospital if they wanted to attend. There was a chaplaincy department, chapels, and multi-faith prayer room.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: These included the following: magic table, interactive light games, jigsaws, music, television, mindfulness, colouring, movies, relaxation, and beauty therapy.
- ***Residents' feedback:*** From resident interviews, residents were for the majority positive about their experience of care and treatment, especially about the patience and approachability of nursing staff, the quality of food and cleanliness of the premises. One resident expressed a preference for a single room as communal toilets for shared bedrooms were too far away at night. Residents interviewed were aware of their individual care plan (ICP) documents and chose to attend their weekly multi-disciplinary team (MDT) meeting. From the advocacy report, feedback given on the availability of activities was mixed, with some residents really enjoying those on offer and others expressing preferences for alternative options.

However:

- **Environment:** The approved centre was not in good structural and decorative condition, instead it was in a poor state of repair with evidence of wear and tear in the bedrooms. This included chipped paint, there was writing on the wall in one bedroom and another bedroom had a small hole in the wall. The ceiling in one of the renovated toilets needed to be painted, as well as the wall outside of the tribunal room.
- **Environment:** While provisions were in place to ensure the safety of the children and respond to the children's special needs as young people in an adult setting, a sample of three files of three children admitted to the adult approved centre, showed the children did not receive a programme of activities appropriate to age and ability.

Governance, Leadership and Accountability

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

- ***Structure in place:*** St. Aloysius Ward came under the overall governance of the Mater Misericordiae University Hospital (MMUH), and also had input from North Dublin Mental Health Services (NDMHS). The executive governance team was known as the Psychiatry Governance Committee. This committee had representation from both MMUH (including MUH's CEO) and NDMHS.
- ***Leadership:*** The executive governance team, the Psychiatry Governance Committee – met every two months. The approved centre had several smaller committees, which informed the Psychiatry Governance Committee. Clear lines of reporting and responsibility were evident within each of the disciplines. There was no Area Lead for Mental Health Engagement involvement in the governance of the approved center at the time of the inspection.
- ***Clinical governance:*** There were aspects of good clinical governance: General health needs of residents were met, medication management was good, recreational services and therapeutic services and programmes provided met the needs of the residents. The multi-disciplinary teams operated well within the approved centre and the therapeutic services programme met the needs of residents; it was directed towards the restoration and maintenance of optimal levels of physical and psychosocial functioning of each resident.
- ***Restrictive practices reduction:*** There was a multi-disciplinary and oversight committee for restrictive practices which met quarterly. At the time of the inspection the Restrictive Practice Oversight Committee was in the process of drafting a policy detailing the therapeutic interventions to be put in place as part of the approved centre's restraint reduction plan.
  - **Physical Restraint:** At the time of inspection the approved centre used physical restraint and had commenced integrating the revised code of practice. The Use of Physical Restraint Policy had been updated and included all the criteria required for this code of practice. A Reduction of Physical Restraint Policy, which was also required was in use and included all the criteria required for this code of practice. The approved centre was not compliant with the Code of Practice on physical restraint for eight different reasons.
  - **Seclusion:** At the time of inspection the approved centre used seclusion and had commenced integrating the revised rule governing the use of seclusion. A Reduction of Restrictive Practices Policy, which was also required was in use and the policy contents included all the criteria required for this code of practice. The approved centre was not compliant with the Rule Governing Seclusion for three different reasons.
- ***Risk:*** Heads of Discipline had each received training in the area of risk management. Persons with responsibility for risk working for the approved centre were known by staff. Risk assessments had been completed for identified risks and included on the local risk register which was reviewed regularly and escalated where appropriate. Incidents were reported electronically and reviewed and escalated appropriately. Where required, incidents were reviewed by the Quality and Safety Committee.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. The visitors room had been renovated and refurbished. The walls in the day room had been painted and new floors and seating had been procured. The family room had been renovated and artwork selected by the residents had been selected for the family room.
- ***Policies:*** The approved centre Policy and Audit Committee provided a multi-disciplinary approach to policy development, review, approval, and dissemination. There was collaboration with the wider MMUH in terms of policy development.

- ***Staff training:*** Not all staff disciplines had completed mandatory training. Healthcare staff were fully trained in the Mental Health Act 2001. Goals identified by the various disciplines included continued reduction of restrictive practice by promoting alternative therapeutic interventions. These included training in the use of sensory attachment approach (OT) and the provision of the RAID course (positive approach to working with disturbed and challenging behaviour) by the psychology department. Staff supervision was well established for all disciplines.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible, residents were involved in their own care. The feedback from family members to the inspection team was for the majority very complimentary towards staff and the care their family member received. They were involved with the care planning process and knew staff by name. They reported that they could contact staff at any time.
- ***Resident feedback:*** There was service user involvement in the Restrictive Practice Oversight Committee. Feedback was provided via the HSE *Your Service Your Say* complaints process or the Mater Hospital Patient Liaison Services feedback process.
- ***Advocacy services:*** A representative from Peer Advocacy in Mental Health visited the approved centre each week.
- ***Regulatory compliance and engagement:*** The approved centre had an average compliance rate of 77% over the past four years, and continues to engage positively with the Mental Health Commission.

However:

- ***Risks:*** Ligature anchor points were not minimised to the lowest practicable level based on risk assessment.
- ***Regulatory compliance and engagement:*** The approved centre had eight non-compliances including with five regulations, the Code of Practice on Admission of Children, the Code of Practice on the Use of Physical Restraint, and the Rules Governing the use of Seclusion. Two areas of the inspection were risk rated as critical: the Code of Practice on Physical Restraint and the Rules Governing the use of Seclusion.
- ***Clinical governance:*** There were some areas where clinical governance was not functioning: the poor documentation of care plans, aspects of the search processes were not adequately implemented, and restrictive practices in the areas of physical restraint and seclusion processes had significant deficits.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The visitors room had been renovated and refurbished. The walls in the day room had been painted and new floors and seating had been procured. The family room had been renovated and artwork selected by the residents had been selected for the family room.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. Aloysius Ward in the Mater Misericordiae University Hospital (MMUH) provided adult in-patient psychiatric services for the Dublin North Central catchment area. The approved centre was located at the back of the MMUH site with access from the North Circular Road.

The approved centre had recently been repainted and refurbished with new furniture acquired and some lino replaced. At the time of inspection, bedrooms were configured with one two bedded and two four-bed shared bedrooms. Residents in these rooms utilised the communal facilities located on the corridor. There were two en suite bedrooms on the ward. These were maintained as single rooms where possible; however, when there were 13 residents to be accommodated one of the two rooms became a double room. In the event of the en suite bedroom accommodating two residents, the appearance of this room would have been small and cramped. The approved centre also has a large therapy room with an OT run kitchenette.

The approved centre contained a seclusion facility, a relaxation room, a recently refurbished visitors room, a library, a day room which incorporated dining facilities, an exercise room, and a clinical room. There was a private outdoor garden area accessible from the day room. The seclusion room had been refurbished since the 2022 inspection.

Two HSE community mental health teams, including a newly established team specifically focused on the needs of homeless service users, had admitting rights to St. Aloysius Ward. The Mater Misericordiae liaison psychiatry team also admitted service users to the approved centre.

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

Resident Profile	
Number of registered beds	***13***
Total number of residents	**12**
Number of detained patients	1
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

St. Aloysius Ward came under the overall governance of the Mater Misericordiae University Hospital (MMUH) and also had input from North Dublin Mental Health Services (NDMHS). The executive governance team was known as the Psychiatry Governance Committee. This committee had representation from both

MMUH and NDMHS in terms of finance, estates, some clinical heads of discipline (nursing, psychology and medicine), as well as the MMUH CEO. This committee convened every two months. The agenda for this meeting consistently addressed: risk management issues emerging from St. Aloysius Ward (including any incidents that had been escalated to the senior level), the outcomes of inspection report, and audits and updates from the various disciplines working in the approved centre.

The approved centre had several smaller committees, which fed into the Psychiatry Governance Committee. These included the Policy and Audit Committee and the Restrictive Practice Oversight Committee. The minutes reflected an established culture of audit, a responsive strategy for the update of polices to reflect good practice and ongoing evidence-based research. The Restrictive Practice Oversight Committee was in the process of drafting a policy detailing the therapeutic interventions to be put in place as part of the approved centre's restraint reduction plan. The approved centre Policy and Audit Committee provided a multi-disciplinary approach to policy development, review, approval, and dissemination. There was collaboration with the wider MMUH in terms of policy development. There was an established culture of implementing quality improvement audit tools to monitor and evaluate standards of care. Audit findings were discussed within this committee and the findings were shared with the relevant management.

The approved centre had a robust process in place for the management of risk. Incidents were submitted electronically and reviewed and escalated appropriately. The DATIX system assisted in ensuring that the risk management process functioned correctly, informing those responsible for reviewing a specific risk in a timely manner. Where required, incidents were reviewed by the Quality and Safety Committee. Risks were documented on the risk register which was also reviewed regularly. Heads of Discipline had each received training in the area of risk management.

The recruitment and retention of staff was identified by the approved centre management team as an ongoing concern. The team had responded to the challenges presented and a fully functional multi-disciplinary team was in place within the approved centre. Clear lines of reporting and responsibility were evident within each of the disciplines. Goals identified by the various disciplines included continued reduction of restrictive practice by promoting alternative therapeutic interventions. These included training in the use of sensory attachment approach (OT) and the provision of the RAID course (positive approach to working with disturbed and challenging behaviour) by the psychology department. Staff supervision was well established for all disciplines.

A representative from Peer Advocacy in Mental Health visited the approved centre each week. There was service user involvement in the Restrictive Practice Oversight Committee. Feedback was provided via the HSE *Your Service Your Say* complaints process or the Mater Hospital Patient Liaison Services feedback process. There was no Area Lead for Mental Health Engagement involvement in the governance of the approved centre at the time of the inspection.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 13: Searches	✗	Moderate	✓		✓		✓		✗	Low
Regulation 15: Individual Care Plans	✓		✗	High	✓		✓		✗	High
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	High	✗	Moderate
Regulation 26: Staffing	✓		✓		✗	Moderate	✗	Moderate	✗	Low
Regulation 27: Maintenance of Records	✗	Moderate	✗	High	✓		✓		✗	Moderate
Rules Governing the Use of Seclusion	✗	High	✗	Critical	✓		✗	Low	✗	Critical
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	High	✓		✓		✗	Moderate	✗	Critical
Code of Practice on the Admission of Children		N/A		N/A	✗	Low	✗	Moderate	✗	Moderate

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

4.2 Areas that were not applicable on this inspection.

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, 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 Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The inspection team met with six residents. Feedback from the residents was positive, praising the nursing staff for the respect that they provided to residents who were unwell and welcoming their patience and approachability. Residents interviewed were aware of their individual care plan (ICP) documents and chose to attend their weekly multi-disciplinary team (MDT) meeting. Residents spoke in positive terms about the quality of the food and the cleanliness of the premises. Residents felt that the choice and frequency of activities was adequate.

One resident stated that they would have a preference of single room accommodation as opposed to sharing and that the toilets were a distance to walk when needed in the night time.

No resident chose to complete the questionnaire.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the Peer Advocacy in Mental Health representative. This report indicated that residents were appreciative of the quality of the food provided and the unit refurbishments. Some residents enjoyed the availability of library books, the existence of the relaxation room, and the fact that the garden was a calming space. Several residents reported high levels of satisfaction with the care that they received from staff. Feedback on the availability of activities was mixed, with some residents really enjoying those on offer and others expressing preferences for alternative options.

Some residents reported witnessing a distressed patient act in a way that they found frightening. The Peer Advocate reported that more accessible charging facilities for electronic devices would be welcomed, as would increase support coping with residents' addictions as well as the mental health issues that caused their admission; a number had specifically asked for more help around accessing rehabilitation programmes. Residents reported a lack of awareness with regard to the availability of a social worker to help them with financial and housing issues that they faced during their stay and post-discharge. Some residents informed the Peer Advocate that they were not familiar with their wider care team or their care plan.

6.0 Feedback Meeting

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

- Clinical Director
- Acting Director of Nursing
- Senior Occupational Therapist
- Principal Psychologist
- Principal Social Worker
- Acting Drug Safety Facilitator
- Clinical Nurse Manager 1
- Interim Directorate Nurse Manager MMUH
- Clinical Nurse Manager 2
- Psychologist
- Assistant Director of Nursing
- Operations Manager MMUH

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

There was a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs; this included medical record number (MRN) and date of birth. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

Nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans; referral occurred as required to dietetics in the general hospital.

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

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 August 2020. Resident 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. The approved centre maintained a signed property checklist detailing each residents' personal property and possessions. The property checklist was kept separate from the resident's individual care plan (ICP).

Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP.

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. Activities included the following: gym; gardening; newspaper; library; reading room; arts and crafts; games; TV; cards; mindfulness colouring; music equipment; internet; and, the ward laptop and electronic tablet.

The approved centre provided access to recreational activities on weekdays and during the weekend.

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 was practicable. There was a chaplaincy department, chapels, multi-faith prayer room, and mass and communion were also available in the main hospital.

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

There was a written policy and procedures in relation to visits. The policy was last reviewed in July 2022. Visiting times were appropriate and reasonable. There was a designated visitor's room available where private visits could take place, unless there was an identified risk to the resident, an identified risk to others, or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during these visits. The visiting rooms were 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 resident communication. The communication policy was last reviewed in July 2022. Residents had access to mail, fax, e-mail, Internet, telephone or any device for the sending and receiving of messages or goods, unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health. There were no restrictions on residents' communication at the time of the inspection. A senior staff member only examined incoming and outgoing resident communication based on risk assessment - if there was reasonable cause to believe the communication may result in harm to the resident or to others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

NON-COMPLIANT

Risk Rating LOW

(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 operational policy in relation to the implementation of resident searches. The policy was last reviewed in February 2022. The policy addressed all of the requirements of the regulation, including the following:

- 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 and the process for carrying out searches in the absence of consent.
- The process in relation to the findings of illicit substances.

Three clinical files were reviewed on inspection in relation to searches. Risk was assessed prior to a search of a resident, their property, or the environment, appropriate to the type of search being undertaken. Resident consent was sought prior to all searches; the request for consent and the received consent were documented for every search of a resident and every property search. General written consent was sought for routine environmental searches. The resident search policy and procedure was communicated to all residents. Relevant staff could articulate the searching processes as set out in the policy.

Residents were informed by those implementing the search of what was happening during a search and why. A minimum of two clinical staff were in attendance at all times when searches were being conducted. Searches were implemented with due regard to the resident's dignity, privacy and gender, with at least one of the staff members conducting the search being the same gender as the resident being searched. In two of the three searches examined, there was no written record of the search contained within the clinical file; however these searches were documented in the ward Search Log. The outcome of the search

was not documented for one of the residents being searched. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

The approved centre was non-compliant with this regulation because in one case the outcome of the search was not documented, 13(9).

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 operational policy and procedures in relation to caring for residents who are dying. The policy was last reviewed in February 2023. As no resident had died in the approved centre premises since the last inspection, compliance for this regulation was assessed on the basis of policy only.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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). Five ICPs were inspected. All ICPs were a composite set of documentation, with allocated space and sections for goals, treatment, care, resources required, and reviews. ICPs were stored within the clinical file, were identifiable and were not interrupted. ICPs were not integrated with progress notes.

However, three out of five care plans inspected were not developed by the multi-disciplinary team (MDT). 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. ICPs identified goals for the resident. One care plan did not identify the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. Similarly, one care plan inspected did not identify the resources required to provide the care and treatment identified. Two out of five care plans inspected were not reviewed by the MDT. All ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

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

a) **Three out of five individual care plans examined were not developed by the multi-disciplinary team following a comprehensive assessment, 15.**
b) **One individual care plan did not identify the appropriate care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment, 15.**
c) **One individual care plan did not identify the resources required to provide the care and treatment identified, 15.**
d) **Two individual care plans were not reviewed by the multi-disciplinary team, 15.**

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 documented in their individual care plans (ICPs). Residents had access to occupational therapy (OT), social work and clinical psychology on an individual basis as required. Clinical files reviewed also showed evidence of the provision of dietetics, physiotherapy, and speech and language therapy as required. Therapeutic services and programmes were delivered on an individual or group basis by members of the multi-disciplinary team (MDT). Residents had access to full-time OT and an OT assistant. At the weekly MDT meeting, residents' progress at therapeutic services and programmes was evaluated.

The therapeutic services and programmes provided by the approved centre were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. The recovery-orientated therapeutic programme was facilitated by appropriately qualified professionals. The therapeutic activity programme included the following: goal-setting groups; self-esteem groups; pharmacy groups; ICP planning groups; relaxation groups; positive affirmation groups; creative exposure groups; pet therapy; stress management groups; recovery through activity groups; and, a breakfast group. The MDT therapeutic programme was reviewed on a continuous basis with staff and residents through written and verbal feedback.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in place in relation to the transfer of residents. The policy was last reviewed in June 2022. The clinical file of one resident who had been transferred from the approved centre was examined. Communications between the approved centre and the receiving facility were documented. Full, complete, and relevant written information about the resident was transferred to the receiving hospital. The transfer documentation included a letter of referral including a list of current medication.

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 November 2022. The approved centre had an emergency resuscitation 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 had access to national screening programmes in accordance with their age and gender. No resident was in the approved centre more than six months.

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 policy and procedures in relation to the provision of information to residents. The policy was last reviewed in February 2021.

Residents were provided with a resident information booklet on admission that included details of mealtimes, personal property arrangements, the complaints procedure, visiting times and visiting arrangements, relevant advocacy and voluntary agencies details, and residents' rights. The booklet was available in the required formats to support resident needs and the information was clearly and simply written. Residents were provided with details of their multi-disciplinary team.

Residents were provided with written and verbal information on their diagnosis. Written and verbal medication information was provided in a format appropriate to residents' needs. The content of medication information sheets included information on indications for use of all medications to be administered to the resident, including any possible side-effects. Residents had access to interpretation and translation services 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 staff and the manner in which staff interacted with residents indicated respect. Staff were discreet when discussing the resident's condition or treatment needs. All bathrooms, showers, and toilets had locks on the inside of the door, unless there was an identified risk to a 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 any identifiable resident information. Residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating MODERATE

(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 had access to personal space and the approved centre had appropriately sized communal rooms; the day room had been redecorated since the 2022 inspection; it had been painted and had new and furnishings. The visitors room had been refurbished and painted. Residents had supervised access to an enclosed garden. There was suitable and sufficient heating in the approved centre. Rooms were adequately ventilated.

Private and communal areas were suitably sized and furnished to remove excessive noise and acoustics. The lighting in communal rooms suited the needs of residents and staff; it was sufficiently bright and positioned to facilitate reading and other activities. Appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

The approved centre was not consistently kept in a good state of repair, externally and internally. There was evidence of wear and tear in the shared rooms and single rooms, which included chipped paint, sections of the wall that hadn't been painted when items were removed from the wall in one bedroom and another had a hole in the wall from the door handle; there was also writing on the wall of one bedroom. The ceiling in one of the renovated toilets needed to be painted as well as the wall outside of the tribunal room. At the time of inspection, there was no evidence of a plan to address these issues.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment; records of such were maintained. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 42 ◦C. Current national infection control guidelines were followed. There was a sufficient number of toilets and showers for residents in the approved centre; two bedrooms were en suite. There was at least one assisted toilet per floor. The approved centre had a designated sluice room and a designated cleaning room, as appropriate. All resident bedrooms were appropriately sized to address the resident's needs. The approved centre provided suitable furnishings to support resident independence and comfort. The approved centre provided assisted devices and equipment to address resident needs.

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

a) **The approved centre was not in a good state of repair as there was evidence of wear and tear in the bedrooms. This included chipped paint, there was writing on the wall in one bedroom and another bedroom had a small hole in the wall. The ceiling in one of the renovated toilets needed to be painted, as well as the wall outside of the tribunal room, 22(1)(a).**
b) **Ligature anchor points were not minimised to the lowest practicable level, based on risk assessment, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in November 2022.

Each resident had a Medication Prescription and Administration Record (MPAR), and five of these were inspected. The MPARs contained: a record of any allergies or sensitivities to any medications, including if the resident had no allergies, the administration route for the medication, a record of all medications administered to the resident, and the minimum interval time between doses of as required medication. There was also a record of all medications administered to the resident, as well as a clear record of the date of discontinuation for each medication. The Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident was also included.

All entries to the MPARs were legible and contained the signature of the medical practitioner or nurse prescriber for each entry. There was no resident in the approved centre in excess of six months. There was no withheld medication or prescription for crushed medication. Medication was stored in the appropriate environment as indicated on the label or as advised by the pharmacist. Where medication needed refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was advised to be stored elsewhere, such as a refrigerator. Scheduled 2 and 3 controlled drugs were locked in a separate cupboard from any other medicinal products to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the health and safety of residents, staff and visitors. The health and safety policy was last reviewed in August 2020.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating LOW

(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 staffing policy and procedures in place in relation to the recruitment, selection and Garda vetting requirements. The staffing policy was last reviewed in June 2021.

The numbers and skill mix of staffing were sufficient to meet resident needs. An appropriately qualified staff member was on duty and in charge at all times; this was documented. However, not all staff were trained in Basic Life Support, Fire Safety, and Management of Violence and Aggression. Furthermore, not all healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance, were available to staff throughout the approved centre.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (13)	13	100%	13	100%	13	100%	13	100%
Medical (26)	20	77%	24	92%	21	81%	25	96%
Occupational Therapist (2)	2	100%	2	100%	2	100%	2	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%
OT Assistant (1)	1	100%	1	100%	1	100%	1	100 %

The approved centre was non-compliant with this regulation because not all medical staff were trained in Basic Life Support, Fire Safety, and Management of Violence and Aggression, 26(4).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating **MODERATE**

(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 an operational policy and procedures in relation to the creation of, access to, retention of, and destruction of records. The policy was last reviewed in May 2023. All residents' records were secure, up to date, and in good order, with no loose pages. Records were constructed, maintained, and used in accordance with the national guidelines and legislative requirements.

In general, resident records were reflective of the residents' status and the care and treatment being provided. However, some documentation did not contain identifiers as required. Some clinical notes were corrected retrospectively by the writer for accuracy reasons; however, they were not consistently altered using national guidelines for correcting errors. Resident records were developed and maintained in a logical sequence. Records were appropriately secured from loss or destruction and tampering and unauthorised access or use.

Documentation relating to food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was non- compliant with this regulation because some documentation did not contain identifiers as required and some entries into the clinical file were not altered using national guidelines for correcting errors, 27(1).

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures required by the regulations were reviewed within the required three-year time frame.

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 facilities and resources to support the Mental Health Tribunals process. Adequate resources were provided by the approved centre to support the Mental Health Tribunal process. Staff accompanied and assisted patients to attend a Mental Health Tribunal as required. The resources and facilities provided by the approved centre supported patients accessing Mental Health Tribunals remotely.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

The nominated Complaints Officer was responsible for dealing with all complaints in the approved centre. A consistent and standardised approach had been implemented for the management of all complaints. The complaints procedure and nominated person's contact details were publicised and accessible to residents, their representatives and families. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

All complaints were handled promptly, appropriately and sensitively. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made. All complaints were dealt with by the nominated person and recorded in the complaints log. Minor and formal complaints were documented. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan. 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 approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management, which was last reviewed in May 2023. The risk management policy covered all requirements.

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 risks and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified and treated. The approved centre implemented a plan to reduce risks to residents while and works to the premises were ongoing.

Individual risk assessments were completed prior to and during the following: resident seclusion; physical restraint; at admission; resident transfer; and resident discharge. This also occurred in conjunction with medication requirements or administration. Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of 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; all clinical incidents were reviewed by the MDT at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviews incidents for any trends or patterns occurring in the services. Then approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths

and Incident Reporting; information provided was anonymised at resident level. There was an emergency plan which specified responses by approved centre staff to possible emergencies; the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre was insured against accidents and injury to residents. The approved centre insurance certificate and indemnity scheme statement covered public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating CRITICAL

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

INSPECTION FINDINGS

Processes: There was a written policy and procedures in relation to the use of seclusion, and the policy was reviewed annually. The seclusion policy was last reviewed January 2023 . The policy included:

a. Who may initiate and carry out seclusion
b. The provision of information to the resident including information about the person's rights
c. The safety, safeguarding and risk management arrangements that must be followed during an episode of seclusion.

The approved centre also had a policy on Restrictive Practice Reduction. This policy contained all the required aspects detailed in the Rule under Section 10.5.

Training and Education: There was a written record to indicate that staff involved in seclusion had read and understood the policy. The training record was available to the inspector.

Monitoring: There was a multi-disciplinary and oversight committee in the approved centre that met quarterly.

Evidence of Implementation: Seclusion facilities were furnished, maintained and cleaned in such a way that ensured the person's inherent right to personal dignity and that their privacy was respected. The design, maintenance and cleanliness of the seclusion room was in adherence with section 8 of the Rule on Seclusion.

The documentation pertaining to three episodes of seclusion were examined; these had been documented within the residents' clinical files. In each case, seclusion was initiated by a registered medical practitioner or a registered nurse. It was only initiated following a comprehensive assessment of the person.

There was a medical examination of the person by a registered medical practitioner as soon as was practicable and, in any event, no later than two hours after the commencement of the episode of seclusion The registered medical practitioner recorded this information on the seclusion register. A seclusion order was not made for a period of time longer than four hours from the commencement of the seclusion episode. The order of the consultant psychiatrist confirmed that there were no other less restrictive ways available to manage the person's presentation. The consultant psychiatrist undertook a medical examination of the person and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The examination was recorded in the person's clinical file. In all cases, the person was informed of the reasons for, likely duration of, and the circumstances which would lead to the discontinuation of seclusion. The clothing worn in seclusion respected the right of the person to dignity, bodily integrity and privacy.

Each person placed in seclusion was kept under direct observation by a registered nurse for the first hour following the initiation of a seclusion episode. After the first hour, a registered nurse kept the person under continuous observation and was within sight and sound of the seclusion room. A written record of the person was made by a registered nurse at least every 15 minutes. A nursing review of the person took place every two hours. A Seclusion Care Plan was developed for each of the three people who had been secluded. These care plans contained all required aspects of 5.7 of the Rule on Seclusion. Each case of seclusion was ended by the registered medical practitioner (RMP) or most senior registered nurse.

In two out of three cases, there was no evidence of an in-person debrief following the episodes of seclusion. In two out three clinical files inspected, it was evident that seclusion was not reviewed by members of the multi-disciplinary team (MDT) involved in the person's care and treatment within five days of the episode of seclusion. One file indicated that the clinician involved in initiating seclusion did not demonstrate a clear understanding of the circumstances under which seclusion is permitted when documenting the seclusion episode.

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

a) **An in-person debrief did not follow every episode of seclusion inspected, 7.6, 7.8, 7.9.**
b) **Not all episodes of seclusion were reviewed by members of the MDT involved in the person's care and treatment and documented in the clinical file as soon as practicable and, in any event, no later than five working days after the episode of seclusion, 10.3, 10.4.**
c) **One file inspected indicated that the clinician who updated the file did not demonstrate a clear understanding of the circumstances under which seclusion is permitted when completing the seclusion documentation, 10.1 ii.**

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating CRITICAL

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: There was a written policy in relation to the use of physical restraint. The policy was reviewed annually, and it was last reviewed in January 2023. The approved centre also had a policy on Restrictive Practice Reduction. This policy contained all the required aspects detailed in the Rule under Section 10.5.

The physical restraint policy covered:

- The provision of information to the person.
- Who can initiate and who may implement physical restraint.
- Staff who will receive training based on the identified needs of the person.
- The areas to be addressed in the training.
- The prevention and therapeutic management of violence and aggression
- The identification of appropriately qualified persons to give training.
- The mandatory nature of training for those involved in Physical Restraint.

The policy on Restrictive Practice Reduction was last reviewed in April 2023. This policy included all aspects required by the Code of Practice, Part 7.2.

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. The record was available to the inspector.

Monitoring: There was a multi-disciplinary and oversight committee in the approved centre that met quarterly.

Evidence of Implementation: The clinical file of three residents who had been physically restrained were inspected. In all cases, physical restraint was initiated by a registered nurse or a registered medical practitioner. In one of the three cases, the order confirmed that there were no other, less restrictive ways available to manage the persons' presentation. In two cases this was not documented. The consultant psychiatrist was notified about the physical restraint as soon as was practicable. In two of the three cases, the registered medical practitioner completed a medical examination of the person within two hours. This was not documented in one case. In all cases, the order for physical restraint lasted for a maximum of ten minutes. Each episode of physical restraint was recorded in the person's clinical file and in the Clinical Practice Form in accordance with Provision 3.7. A copy of each clinical practice form was kept in the clinical file and was made available to the Mental Health Commission on request.

In all cases, the relevant section of the clinical practice form was completed by the person who initiated and ordered the use of physical restraint as soon as was practicable and no later than three hours after

the conclusion of the restraint. The clinical practice form was signed by the consultant psychiatrist within 24 hours. It was not documented in any of the three episodes that the resident was informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint, unless the provision of such information may be prejudicial to the persons' mental health, well-being, or emotional condition. In one of the three episodes, it was not documented that the person's representative was informed of the person's restraint. The Mental Health Commission were informed of the start time and end time and date and date of the physical restraint within three days in all cases.

It was not documented in any of the three cases that the person was continually assessed throughout the use of the restraint to ensure their safety. There was no documented evidence the persons' head and neck were protected and supported where necessary. Similarly, there was no documented evidence the persons' airway and breathing was not compromised. There was no documented evidence that observations were conducted, including vital clinical indicators such as the monitoring of pulse, respiration and complexion (with special attention to pallor/discolouration). Neither was there documentation indicating that that effective communication was maintained with the person and the person's physical and psychological health was monitored for as long as clinically necessary after the use of physical restraint.

In two of three episodes, the person was restrained in the prone position and this was not recorded in the clinical file. It was not documented in the episodes of physical restraint reviewed that the person responsible for leading the physical restraint also ended each episode. Staff members of the same gender were present at all times during the physical restraint and all staff involved in the physical restraint had undertaken appropriate training in accordance with the policy.

None of the three cases reviewed documented an in-person debrief with the resident to give an opportunity to discuss the episode of physical restraint with members of the multi-disciplinary team (MDT) involved in each persons' care and treatment. Therefore the following requirements of the code of practice were not met: a debrief, including a discussion regarding the person's preferences in the event of a restrictive intervention being required in the future. The person's individual care plan was not updated to reflect the outcomes of debrief and the person's preferences in relation to any restrictive interventions going forward were not established. It was also unclear whether or not emotional support was offered to the person in the direct aftermath of the episode.

None of the episodes of physical restraint documented an MDT review within five working days. As a result it was not possible for the MDT to identify; trigger events, de-escalation strategies to be used by staff when caring for the person in the future, any missed opportunities for earlier intervention or to assess the factors in the physical environment that may have contributed to the use of physical restraint.

The approved centre was non-compliant with the Code of Practice for the following reasons:

a. **In two of three episodes, the order did not confirm that there were no other less restrictive ways available to manage the person's presentation, 3.2.**
b. **In one of three episodes, the registered medical practitioner did not complete a medical examination of the person no later than two hours after the start of the episode of physical restraint, 3.4.**
c. **None of the three physical restraint episodes examined contained documentation indicating that the person was informed of the reasons for and the circumstances which lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition, 3.8.**
d. **In one of three episodes, it was not documented that the person's representative was informed of the person's restraint, 3.9(a).**
e. **In three of three episodes, the person was not continuously assessed, throughout the use of restraint to ensure the person's safety, 4.5[i-v].**
f. **In two of three episodes, the person was restrained in the prone position and this was not recorded in the clinical file, 4.9.**
g. **It was not documented in the three files examined that the person who led the physical restraint ended the restraint, 5.1.**
h. **In three of three episodes, there was no in person debrief with the resident to give an opportunity to discuss the episode of physical restraint with members of the MDT involved in the person's care and treatment, 5.3[i - vii] and, 5.7.**
i. **None of the three episodes of physical restraint were reviewed by MDT involved in the person's care and treatment, 7.3[i-vi].**

Admission of Children

NON-COMPLIANT

Risk Rating MODERATE

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in March 2021. It addressed the following:

- A policy requiring each child to be individually risk assessed.
- Policy and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: The files of three children who had been admitted to the approved centre were reviewed during the inspection. The facilities provided were not appropriate to the children's age and ability. Provisions were in place for the following: ensuring the safety of the children; responding to the children's special needs as young people in an adult setting; and ensuring the rights of the children to have their voice heard. Staff who had contact with the children had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated, including age and gender segregated sleeping and bathroom areas. Staff observation acknowledged gender sensitivity; observation arrangements, including assignment of a designated staff member, was provided as considered clinically appropriate. Each child resident had a bespoke Individual Care Plan which identified age appropriate interventions and therapies.

Children had access to age-appropriate advocacy services. Children had their rights explained and information about the ward and facilities provided was in a form and language they could understand; the clinical files recorded the child's understanding of the explanation given. Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre. Appropriate visiting arrangements for families were available, including children. The Commission was notified of all child admissions within 72 hours of admission using the associated notification form. Consent for treatment was obtained from one or both parents.

The approved centre was non-compliant with this code of practice because age-appropriate facilities were not provided to child residents 2.5(b).

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

The approved centre had a written policy in relation to admission, transfer, and discharge, which was last reviewed in February 2022.

Training and Education: Relevant staff had signed the policy log to indicate that they had read and understood the admission, transfer, and discharge policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident admission was inspected in relation to the admission process. Their admission was because of a mental illness. With the resident's consent, their family member was involved in the admission process. The resident was assigned a keyworker. The resident received an admission assessment, which included: presenting problem, past psychiatric history, family history, medical history, current and historic medication, current mental state and a risk assessment. The resident received a full physical examination.

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

Discharge: The clinical file of one resident who was discharged was inspected. The discharge was co-ordinated by a keyworker. A discharge meeting was held and attended by the resident and their key worker, relevant members of the multi-disciplinary team (MDT) and the resident's family. A comprehensive pre-discharge assessment was completed, which addressed the resident's psychiatric and psychological needs, a current mental state examination, social and housing needs, and a comprehensive risk assessment and risk management plan. A discharge summary was provided to community healthcare services within two weeks. The discharge summary included all relevant information including details of diagnosis, prognosis, medication, mental state at time of discharge, and timely follow-up appointment.

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 13: Searches					
Reason ID : 10004279		**In one case the outcome of the search was not documented, 13(9).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Memo available to all nursing staff in search log Focus meetings with staff re documenting outcome of searches Search process highlighted by CNMs at handovers	Auditing	Achievable	08/03/2024	ADON
Preventative Action	All new staff familiar with policy on Searches memo on log to document the outcome of each search Focus meetings done with nursing staff	Ensure the audit captures this element of Searches and will audit in the first quarter of 2024	Achievble	29/03/2024	ADON Policy and Audit Commitee

Regulation 15: Individual Care Plan					
Reason ID : 10004284		**Three out of five individual care plans examined were not developed by the multi-disciplinary team following a comprehensive assessment, 15.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for the non-compliance with this regulation appears to be poor adherence to completing the ICP as designed. Whilst we are unable to retrospectively correct those Individual Care Plans from 2023, the Approved Center has Preventative Actions as below.	Please see Preventative Actions section below	Please see Preventative Actions section below	05/12/2023	Clinical Director
Preventative Action	All admitted patients have an ICP. All admitted patients have the input of multi-disciplinary team who attend the weekly team meeting with the patient. The meeting identifies patient needs and associated goals, actions, resources required, a responsible person	Regulation 15 will be audited quarterly for compliance. The audit will include all preventative actions	Achievable.	29/03/2024	ADON

	and a review date. As the issue affecting compliance is obviously inadequate documentation when working on ICPs, the Policy and Audit committee are reviewing the current ICP template and associated policy to make the template more user friendly. Members of the committee will also remind all team members at the weekly team meeting of the need to meet Regulation 15 in terms of documentation when working on ICPs. A handy tip sheet will be developed and brought to each team meeting. New staff are required to sign a log to state they have read and understood the Approved Center Policy concerning ICPs (Regulation 15).				

Reason ID : 10004285		One individual care plan did not identify the appropriate care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment, 15.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for the non-compliance with this regulation appears to be poor adherence to completing the ICP document as designed. Whilst we are unable to retrospectively correct those Individual Care Plans from 2023, the Approved Center is implementing Preventative Actions as below.	See Preventative Action section below	See Preventative Action section below	05/12/2023	ADON
Preventative Action	All admitted patients have an ICP. All admitted patients have the input of multi-disciplinary team who attend the weekly team meeting with the patient. The meeting identifies patient needs and associated goals, actions, resources required, a	Regulation 15 will be audited quarterly for compliance. The audit will include all preventative actions.	Achievable	29/03/2024	ADON and CD

	responsible person and a review date. As the issue affecting compliance is obviously inadequate documentation when working on ICPs, the Policy and Audit committee are reviewing the current ICP template and associated policy to make the template more user friendly. They will also remind all team members at the weekly team meeting of the need to meet Regulation 15 in terms of documentation when working on ICPs. A handy tip sheet will be brought to each team meeting. New staff are required to sign a log to state they have read and understood the Approved Center Policy concerning ICPs (Regulation 15).				
Reason ID : 10004286		**One individual care plan did not identify the resources required to provide the care and treatment identified, 15.**			

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The reason for the non-compliance with this regulation appears to be poor adherence to completing the ICP document as designed. Whilst we are unable to retrospectively correct those Individual Care Plans from 2023, the Approved Center is implementing Preventative Actions as below.	Please see Preventative Action section below	Please see Preventative Action section below	05/12/2023	ADON
Preventative Action	All admitted patients have an ICP. All admitted patients have the input of multi-disciplinary team who attend the weekly team meeting with the patient. The meeting identifies patient needs and associated goals, actions, resources required, a responsible person and a review date. As the issue affecting	Regulation 15 will be audited quarterly for compliance The audit will include all preventative actions	Achievable	29/03/2024	ADON

	compliance is obviously inadequate documentation when working on ICPs, the Policy and Audit committee are reviewing the current ICP template and associated policy to make the template more user friendly. They will also remind all team members at the weekly team meeting of the need to meet Regulation 15 in terms of documentation when working on ICPs. A handy tip sheet will be developed and brought to each team meeting. New staff are required to sign a log to state they have read and understood the Approved Center Policy concerning ICPs (Regulation 15).				
Reason ID : 10004287		**Two individual care plans were not reviewed by the multi-disciplinary team, 15.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for the non-compliance with this regulation	Please see Preventative Action section below	Please see Preventative Action section below	05/12/2023	ADON

	appears to be poor adherence to completing the ICP document as designed. Whilst we are unable to retrospectively correct those Individual Care Plans from 2023, the Approved Center is implementing Preventative Actions as below.				
Preventative Action	All admitted patients have an ICP. All admitted patients have the input of multi-disciplinary team who attend the weekly team meeting with the patient. The meeting identifies patient needs and associated goals, actions, resources required, a responsible person and a review date. As the issue affecting compliance is obviously inadequate documentation when working on ICPs, the	Regulation 15 will be audited quarterly for compliance. The audit will include all preventative actions	Achievable	29/03/2024	ADON and CD

	Policy and Audit committee are reviewing the current ICP template and associated policy to make the template more user friendly. They will also remind all team members at the weekly team meeting of the need to meet Regulation 15 in terms of documentation when working on ICPs. A handy tip sheet will be developed and brought to each team meeting. New staff are required to sign a log to state they have read and understood the Approved Center Policy concerning ICPs (Regulation 15).				

Regulation 22: Premises					
Reason ID : 10004280		Ligature anchor points were not minimised to the lowest practicable level, based on risk assessment, 22(3).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Items identified during the inspection have now been removed or minimised to the lowest practicable level. Ligature audit will be repeated in Q1 2024 The outcome of this will be reviewed in relation to a further minimisation of ligature points where practicable and a remedial time bound action plan introduced, plus a review of mitigation practices which will further reduce the risk. If required this will be documented in the risk register.	Ligature audit completed by 29/03/2024	Achievable	29/03/2023	ADON
Preventative Action	Ligature Audit will be repeated in Q1 2024. Any identified ligature points will be risk assessed and an	Annual Audit	Achievable	29/03/2024	CD, DON, ADON

	action plan will be developed for each point with the RP and Estates Dept				
Reason ID : 10004281		**The approved centre was not in a good state of repair as there was evidence of wear and tear in the bedrooms. This included chipped paint, there was writing on the wall in one bedroom and another bedroom had a small hole in the wall. The ceiling in one of the renovated toilets needed to be painted, as well as the wall outside of the tribunal room, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The wall outside the Tribunal room has been resurfaced and painted. The Estates dept are currently liaising with ward management to identify a suitable date to decorate the bedrooms and toilet noted in the report. The patients are have had a community meeting and have chosen colours.	Quarterly executive walk-around.	Achievable	29/02/2024	ADON, Registered Proprietor
Preventative Action	Quarterly executive walk-arounds. Maintenance Schedule agreed with MMUH Dept of estates and facilities.	Quarterly	Achievable	08/03/2024	ADON, Registered Proprietor, Dept of Estates and facilities

Regulation 26: Staffing					
Reason ID : 10004283		**Not all medical staff were trained in Basic Life Support, Fire Safety, and Management of Violence and Aggression, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	St Aloysius Ward CD contacted all medics and their line managers by email to remind them that all staff must have these areas of training. This was reinforced at the weekly academic meeting and at the induction training. A personalised email was then sent to non-compliant individuals. This was then followed up with a individual phone call from the Clinical Director.	The ward maintains a live training record for all staff.	Achievable	05/12/2023	Clinical Director
Preventative Action	As medical staff are employed by both the MMUH and the HSE, the Approved Center engaged with both departments of medical administration (HR) to facilitate the early	The training record is live and updated at least weekly. It is available for inspection. Please find the up to date Training report attached. A new audit/ report will be	Achievable	29/03/2024	Clinical Director

	identification of the training needs of new medics coming to the service. As the great majority of medics switch posts every 4-6 months, this is a significant challenge. All medics are contacted by Admin staff to request and to remind them to submit the relevant certs. The Mater Hospital has recently launched a comprehensive online training system to make booking and delivery of training easier. In addition both "MAPA" (or CPI) training and BLS training are now delivered in-house by accredited trainers. The ward maintains a live training record which the administrator maintains, and which is reviewed regularly by the CD.	produced in March 2024			

Regulation 27: Maintenance of Records					
Reason ID : 10004282		**Some documentation did not contain identifiers as required and some entries into the clinical file were not altered using national guidelines for correcting errors, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	We note one reported example of an entry into the clinical record made in breach of national guidelines and one example of inadequate identification of documentation. Whilst unable to correct these errors retrospectively , the Approved Center has taken Preventative action (see below).	Please see Preventative Action section below	Please see Preventative Action section below	05/12/2023	CD
Preventative Action	The Clinical Director (CD) has contacted all staff to inform them of the need to be compliant with Regulation 27. In addition the CD has sent all staff/ line managers a copy of the National Healthcare Records Standards Version 3 obtained from the	Evidence of email send to all staff by CD. Available on request. Annual Healthcare Records Audit.	Achieved	29/03/2024	Clinical Director.

	HSE. Audit tool redesigned to include this item of non-compliance.				

Rules Governing the Use of Seclusion					
Reason ID : 10004276		**An in-person debrief did not follow every episode of seclusion inspected, 7.6, 7.8, 7.9.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Unable to do so as we are not aware of which MRNs these debrief relate to	N/A	Achievable	07/12/2023	CD ADON
Preventative Action	Memo and emails have been sent to all staff Focus groups done with all staff MDT addressing restrictive practice at the start of each MDT meeting All staff have completed the modules on restrictive practice on HseLand	Quarterly audit Oversight Committee reports	Achievable	29/03/2024	MDT Oversight Committee
Reason ID : 10004277		**Not all episodes of seclusion were reviewed by members of the MDT involved in the person's care and treatment and documented in the clinical file as soon as practicable and, in any event, no later than five working days after the episode of seclusion, 10.3, 10.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate knowledge of staff and inadequate documentation when completing the paperwork in the period shortly after the updated Rules	Please see Preventative Actions below	Please see Preventative Actions below	11/12/2023	MDT and Oversight Committee to monitor areas of non-compliance

	were introduced in January 2023. The reason for this was lack of experience and training regarding the updated Rules and paperwork. Whilst the Approved Centre cannot correct the paperwork completed in 2023, the Approved Centre has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on Preventative Actions below).				
Preventative Action	All staff are instructed to complete the HSELanD training modules concerning Restrictive Practice. Each person who enters seclusion has a seclusion care plan with a de- brief section within this for post seclusion and for	Quarterly Audit Oversight report on restrictive practices Log of training kept on Ward	Achievable.	29/03/2024	MDT Oversight Committee

	MDT review which is outlined to occur within 5 days MDT raise awareness of any restrictive practices that have occurred in the past week since the team have last met. Diary used as a reminder for all staff when deadlines for de brief and reviews are to be completed. All staff have to complete the Restrictive practice modules on HSELand.				
Reason ID : 10004278		**One file inspected indicated that the clinician who updated the file did not demonstrate a clear understanding of the circumstances under which seclusion is permitted when completing the seclusion documentation, 10.1 ii.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate training regarding the Rules. Whilst he Approved Center cannot retrospectively correct the individual failing which occurred in 2023, it has implemented preventative actions to decrease the	Please see Preventative Action section below.	Please see Preventative Action section below.	11/12/2023	CD/ADON

	likelihood of non-compliance in the future. (Please see section on preventative actions below).				
Preventative Action	Ensure all clinicians have completed all modules on restrictive practice At induction provide teaching session to clinicians Informal education/reflection and focus sessions post restrictive practice Changes to documentation to make more user friendly	Quarterly Audit Oversight Committee quarterly report Log of staff training.	Achievable	29/03/2024	ADON/ DON, CD, MDT Oversight Committee

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10004266		**In two of three episodes, the order did not confirm that there were no other less restrictive ways available to manage the person's presentation, 3.2.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate documentation when completing the Order in the period shortly after the updated Code of Practice was introduced in January 2023. The reason for this was lack of experience and training regarding the updated Code and paperwork. Whilst the Approved Centre cannot correct the individual Orders completed in 2023, the Approved Centre has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on Preventative Actions below).	Please see Preventative Action section below.	Please see Preventative Action section below.	07/12/2023	CD

Preventative Action	All staff are instructed to complete the relevant modules on Restrictive Practice on HSELanD. All medics who work in the Approved Center receive an induction lecture by the CD. The lecture focuses on the MHA and associated Regulations concerning the Code of Practice of Physical Restraint and the relevant the ward policy. Reflective sessions held by the ADON following Physical Restraint. MDT to identify any incidents of restrictive practice at the start of each ICP meeting. Ward diary used to highlight when reviews are required. The Physical Restraint checklist has been reviewed by the Restrictive Practice	A record of completion of the relevant modules on HSElanD by all staff is kept by the Approved Center. Quarterly Audit The Restrictive Practice committee produces quarterly reports which we have already submitted to the MHC.	Achievable	14/12/2023	ADON, Restrictive Practice committee, CD

	Committee. The Committee has updated the checklist to improve compliance.				
Reason ID : 10004267		**In one of three episodes, the registered medical practitioner did not complete a medical examination of the person no later than two hours after the start of the episode of physical restraint, 3.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate training regarding the Code. Whilst the Approved Center cannot correct the delay in the medical examination reported to have occurred, the Approved Center has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on preventative actions below).	See preventative action below	See preventative action below	14/12/2023	CD
Preventative Action	All medics who work in the Approved Center receive an induction lecture by the CD. The lecture	An attendance sheet at the induction lecture is taken. A record of completion of the relevant	Achievable	29/03/2024	CD

	focuses on the MHA and associated Regulations concerning the Code of Practice of Physical Restraint and the relevant the ward policy. In addition all staff are instructed to complete the relevant modules on Restrictive Practice on HSELanD. The Physical Examination is already listed on the Physical Restraint Checklist.	modules on HSElanD is kept by the Approved Center. Quarterly audit of Physical Restraint compliance			
Reason ID : 10004268		**None of the three physical restraint episodes examined contained documentation indicating that the person was informed of the reasons for and the circumstances which lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition, 3.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate documentation when completing the paperwork in the period shortly after the updated Code of Practice was introduced in January 2023. The reason for this was lack of	See Preventative Action section below.	See Preventative action section below.	14/12/2023	CD

	experience and training regarding the updated Code and paperwork. Whilst the Approved Centre cannot correct the paperwork completed in 2023, the Approved Centre has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on Preventative Actions below).				
Preventative Action	All staff are instructed to complete the relevant modules on Restrictive Practice on HSELanD. All medics who work in the Approved Center receive an induction lecture by the CD. The lecture focuses on the MHA and associated Regulations concerning the Code of Practice of Physical	A record of completion of the relevant modules on HSEland by all staff is kept by the Approved Center. Quarterly Audit The Restrictive Practice committee produces quarterly reports which we have already submitted to the MHC.	Achievable	29/03/2024	ADON

	Restraint and the relevant the ward policy. Reflective sessions held by the ADON following Physical Restraint. MDT to identify any incidents of restrictive practice at the start of each ICP meeting. Ward diary used to highlight when reviews are required. The Physical Restraint checklist has been reviewed by the Restrictive Practice Committee. The Committee has updated the checklist to improve compliance. The occurrence that " the person was informed of the reasons for and the circumstances which lead to the discontinuation of physical restraint unless the provision of such information might be prejudicial				

	to the person's mental health, well-being or emotional condition, 3.8" has been added to our Audit tool.				
Reason ID : 10004269		**In one of three episodes, it was not documented that the person's representative was informed of the person's restraint, 3.9(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate documentation when completing the paperwork in the period shortly after the updated Code of Practice was introduced in January 2023. The reason for this was lack of experience and training regarding the updated Code and paperwork. Whilst the Approved Centre cannot correct the individual paperwork completed in 2023, the Approved Centre has implemented preventative actions to decrease the likelihood of non-	See preventative action section below.	See preventative action section below.	14/12/2023	CD

	compliance in the future. (Please see section on Preventative Actions below).				
Preventative Action	All staff are instructed to complete the relevant modules on Restrictive Practice on HSELanD. All medics who work in the Approved Center receive an induction lecture by the CD. The lecture focuses on the MHA and associated Regulations concerning the Code of Practice of Physical Restraint and the relevant ward policy. Reflective sessions held by the ADON following Physical Restraint. MDT to identify any incidents of restrictive practice at the start of each ICP meeting. Ward diary used to highlight when reviews are required.	A record of completion of the relevant modules on HSEland by all staff is kept by the Approved Center. Quarterly Audit The Restrictive Practice committee produces quarterly reports which we have already submitted to the MHC.	Achievable	29/03/2024	ADON

	The Physical Restraint checklist has been reviewed by the Restrictive Practice Committee. The Committee has updated the checklist to improve compliance.				
Reason ID : 10004270		**In three of three episodes, the person was not continuously assessed, throughout the use of restraint to ensure the person's safety, 4.5[i-v].**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate documentation when completing the Order in the period shortly after the updated Code of Practice was introduced in January 2023. The reason for this was lack of experience and training regarding the updated Code and paperwork. Whilst the Approved Centre cannot correct the individual Orders completed in 2023, the Approved Centre has implemented preventative actions	Please see preventative action section below.	Please see preventative action section below.	14/12/2023	CD/ADON

	to decrease the likelihood of non-compliance in the future. (Please see section on Preventative Actions below).				
Preventative Action	All staff are instructed to complete the relevant modules on Restrictive Practice on HSELanD. All medics who work in the Approved Center receive an induction lecture by the CD. The lecture focuses on the MHA and associated Regulations concerning the Code of Practice of Physical Restraint and the relevant ward policy. Reflective sessions held by the ADON following Physical Restraint. The Physical Restraint checklist has been reviewed by the Restrictive Practice Committee. The	A record of completion of the relevant modules on HSEland by all staff is kept by the Approved Center. Quarterly Audit The Restrictive Practice committee produces quarterly reports which we have already submitted to the MHC.	Achievable	29/03/2024	CD/ADON Oversight Committee

	Committee has updated the checklist to improve compliance.				
Reason ID : 10004271		**In two of three episodes, the person was restrained in the prone position and this was not recorded in the clinical file, 4.9.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inaccurate and inadequate documentation in the period shortly after the updated Code of Practice was introduced in January 2023. The reason for this was lack of experience and training regarding the updated Code and paperwork. Whilst the Approved Centre cannot correct the individual paperwork completed in 2023, the Approved Centre has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on	Please see Preventative Action section below.	Please see Preventative Action section below.	14/12/2023	CD

	Preventative Actions below).				
Preventative Action	All staff are instructed to complete the relevant modules on Restrictive Practice on HSELanD. All medics who work in the Approved Center receive an induction lecture by the CD. The lecture focuses on the MHA and associated Regulations concerning the Code of Practice of Physical Restraint and the relevant ward policy. Reflective sessions held by the ADON following Physical Restraint. All staff are aware that any period of restraint in the prone position must be documented in the clinical file. MDT to identify any incidents of restrictive practice at the start of each ICP meeting. Ward diary	A record of completion of the relevant modules on HSEland by all staff is kept by the Approved Center. Quarterly Audit The Restrictive Practice committee produces quarterly reports which we have already submitted to the MHC.	Achievable	29/03/2024	ADON

	used to highlight when reviews are required. The Physical Restraint checklist has been reviewed by the Restrictive Practice Committee. The Committee has updated the checklist to improve compliance. The audit tool was updated to include this item.				
Reason ID : 10004272		**It was not documented in the three files examined that the person who led the physical restraint ended the restraint, 5.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate knowledge and training of staff regarding the changes to the Code of Practice introduced in January 2023. Whilst the Approved Centre cannot correct the actions and documentation completed in 2023, the Approved Center	Please see Preventative Actions section below.	Please see Preventative Actions section below.	14/12/2023	ADON/CD

	has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on preventative actions below).				
Preventative Action	All staff are instructed by CD to complete the relevant modules on Restrictive Practice on HSELanD. ADON has carried out reflective sessions with all staff post restrictive practice incidents highlighting the importance of documenting who started and ended physical restraint. Physical Restraint Checklist updated	A record of completion of the relevant modules on HSEland by all staff is kept by the Approved Center. Quarterly Audit The Restrictive Practice committee produces quarterly reports which we have already submitted to the MHC.	Achievable	29/03/2024	CD/ADON/Oversight Committee
Reason ID : 10004273		**In three of three episodes, there was no in person debrief with the resident to give an opportunity to discuss the episode of physical restraint with members of the MDT involved in the person's care and treatment, 5.3[i - vii] and, 5.7.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The reason for non-compliance was inadequate documentation when	Please see Preventative Action section below.	Please see Preventative Action section below.	14/12/2023	CD

	completing the paperwork in the period shortly after the updated Code of Practice was introduced in January 2023. The reason for this was lack of experience and training regarding the updated Code and paperwork. Whilst the Approved Centre cannot correct the individual paperwork completed in 2023, the Approved Centre has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on Preventative Actions below).				
Preventative Action	All staff are instructed to complete the relevant modules on Restrictive Practice on HSELanD. All medics who work in the Approved Center	A record of completion of the relevant modules on HSEland by all staff is kept by the Approved Center. Quarterly Audit The Restrictive Practice committee	Achievable	29/03/2024	ADON

	receive an induction lecture by the CD. The lecture focuses on the MHA and associated Regulations concerning the Code of Practice of Physical Restraint and the relevant ward policy. Reflective sessions held by the ADON following Physical Restraint. MDT to identify any incidents of restrictive practice at the start of each ICP meeting. Ward diary used to highlight when reviews are required. The Physical Restraint checklist has been reviewed by the Restrictive Practice Committee. The Committee has updated the checklist to improve compliance.	produces quarterly reports which we have already submitted to the MHC.			
Reason ID : 10004274		**None of the three episodes of physical restraint were reviewed by MDT involved in. the person's care and treatment, 7.3[i-vi].**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The reason for non-compliance was inadequate documentation that occurred in the period shortly after the updated Code of Practice was introduced in January 2023. The reason for this was lack of experience and training regarding the updated Code and the new form. Whilst the Approved Centre cannot correct the documentation completed in 2023, the Approved Center has implemented preventative actions to decrease the likelihood of non-compliance in the future. (Please see section on preventative actions below).	Please see Preventative action section below.	Achievable	14/12/2023	CD and ADON
Preventative Action	All staff are instructed to complete the relevant modules on Restrictive Practice	A record of completion of the relevant modules on HSEland by all staff is kept by the Approved	Achievable	29/03/2024	CD and ADON and Oversight Committee

	on HSELanD. All medics who work in the Approved Center receive an induction lecture by the CD. The lecture focuses on the MHA and associated Regulations concerning the Code of Practice of Physical Restraint and the relevant ward policy. Reflective sessions held by the ADON following Physical Restraint. MDT to identify any incidents of restrictive practice at the start of each ICP meeting. Ward diary used to highlight when reviews are required. The Physical Restraint checklist has been reviewed by the Restrictive Practice Committee. The Committee has updated the checklist to improve compliance.	Center. Quarterly Audit The Restrictive Practice committee produces quarterly reports which we have already submitted to the MHC.			

COP Relating to Admission of Children under the Mental Health Act 2001					
Reason ID : 10004275		**Age-appropriate facilities were not provided to child residents 2.5 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	This cannot be corrected by this Approved Center as this unit is resourced and licensed as an Adult Approved Center. It is not an Adolescent Unit. The adequate provision of adolescent admission beds for the region is dependent on external organisations. There are no children currently admitted to this Approved Center. Occasionally an adolescent is admitted as a last resort from the MMUH Emergency Department when there is no access to a Approved HSE Adolescent Unit within a reasonable period of time.	N/A	Unachievable	05/12/2023	N/A

Preventative Action	The Approved Center is an adult admission unit and is not an age appropriate facility for adolescents or children. The Approved Center is unable to and does not intend to develop facilities to change to an admission unit for minors. In rare cases under 18s have been admitted as a last resort because of lack of availability of HSE adolescent admission beds at that time. The staff ensure that transfer to an Approved Adolescent Unit occurs as quickly as possible. Whilst the adolescent is in our unit for the brief period prior to transfer they have a single ensuite room and one to one gender-appropriate nursing. We use a standardised age appropriate "Headspace" pack	Admissions as per the CIS notification	No action	05/12/2023	Clinical Director and ADON

	and the OTs tailor age appropriate activities..				

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.

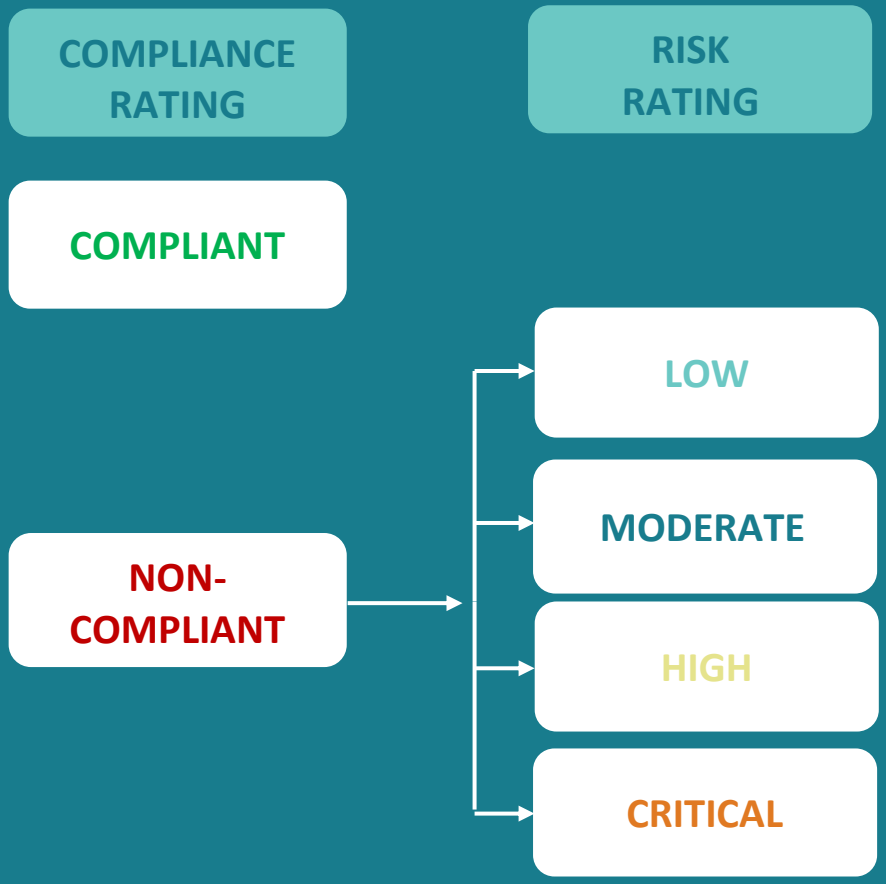
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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