St Joseph's Intellectual Disability Service

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ST JOSEPH'S INTELLECTUAL DISABILITY SERVICE

St Joseph's Intellectual Disability Service
St Ita's Campus, Portrane, Donabate, Co. Dublin

Date of Publication: 11th March 2024

ID Number: AC0179

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Mental Health Care for People with Intellectual Disability

Conditions Attached:
No

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
HSE

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

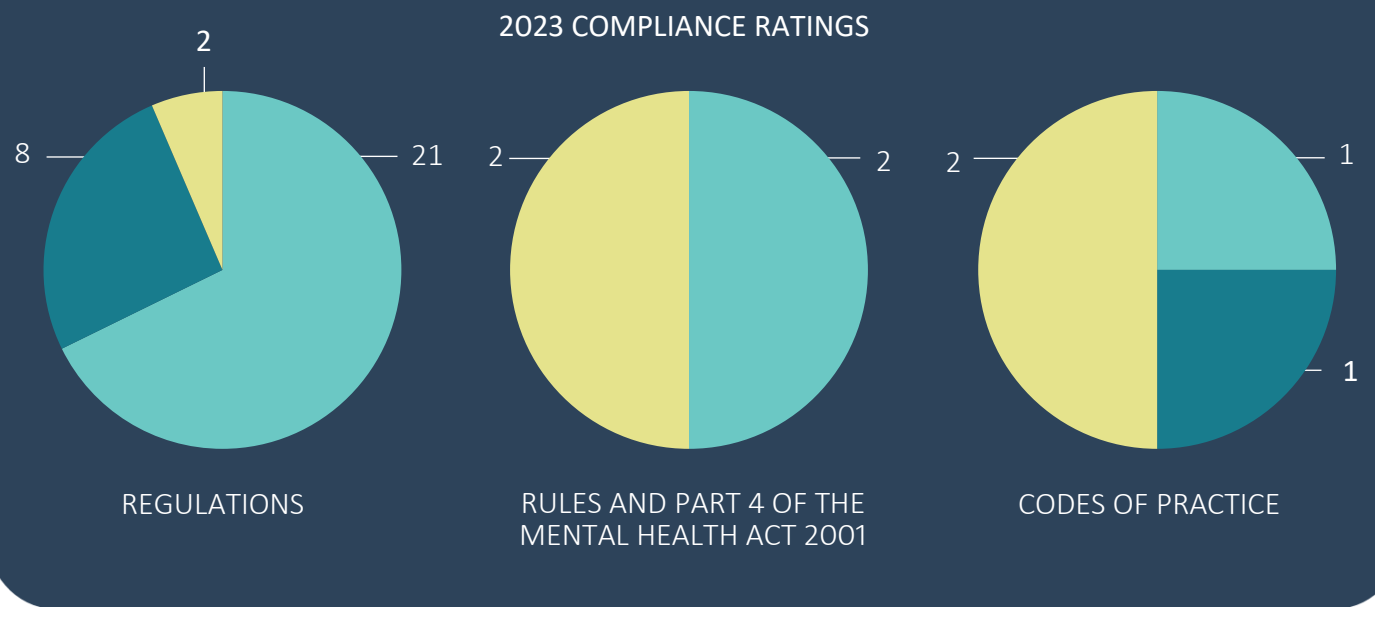
Inspection Team:
Karen McCrohan, Lead Inspector
Marianne Griffiths
Martin McMenamin
Mary Connellan
Susan O'Neill

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
30 May to 2 June 2023

Previous Inspection date:
8 – 11 March 2022

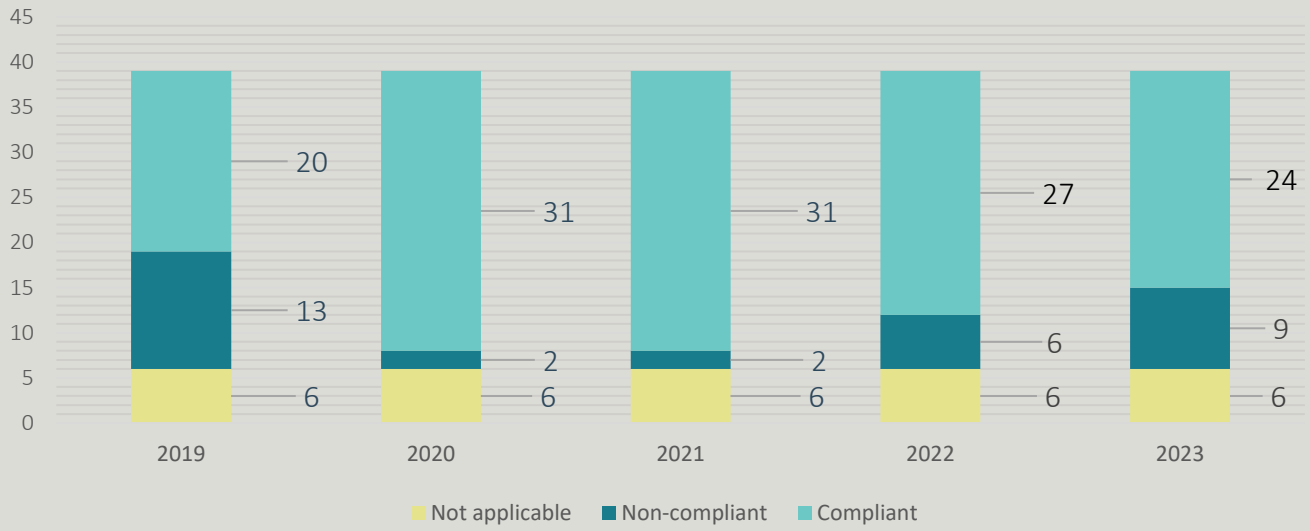
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2019 – 2023

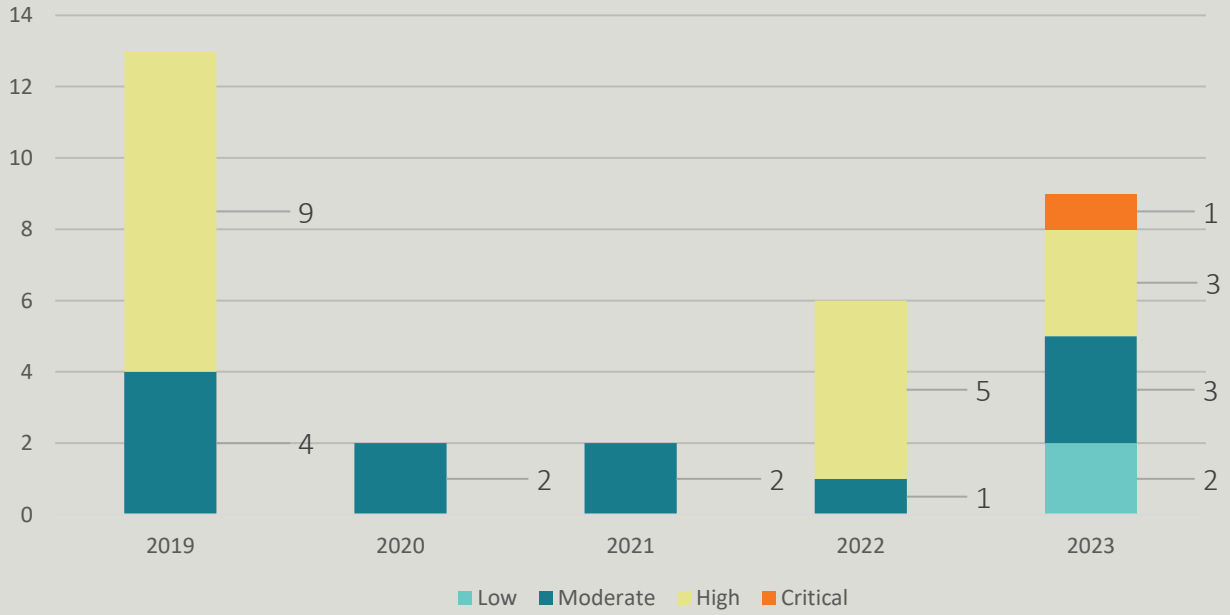
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

St Joseph's Intellectual Disability Service was designed as 14 units and was located on the ground of St. Ita's Hospital in Portrane, Co. Dublin. The approved centre provided mental health care for adults with an intellectual disability and a mental health diagnosis for the Dublin North City and County Community Healthcare Organisation. It was registered for 82 beds and 54 beds were occupied at the time of the inspection.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	61%	94%	94%	82%	73%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*21/06/2023*	*Non-compliant with regulation 32 Risk, risks identified by the service were not appropriately assessed, treated or monitored.*	*Approved centre submitted assurances which were unsatisfactory.*

Regulatory compliance meeting	*21/11/2023*	*Further assurances were required following the Immediate Action Notice*	*More detailed plans were received at the regulatory compliance meeting. The Mental Health Commission continues to monitor.*

Safety of people in the approved centre

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

- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Ligature anchor points:*** Ligature points were minimised to the lowest level, based on individual risk assessment.
- ***Assessment and management of individual risk*****:** Individual risk assessments were completed in conjunction with medication requirements or administration, and prior to and during resident seclusion, physical restraint, mechanical restraint, and resident transfer.
- ***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.

However:

- ***Access to essential information*****:** The clinical files were not all up-to-date. Two clinical files were found to store out of date information which was not reflective of the residents' current care and treatment. Some clinical files contained several different documents that appeared to be the individual care plan.
- ***Assessment and management of risks:*** In one resident's discharge process, risks identified by the service were not appropriately assessed, treated or monitored. One resident's discharge process and clinical file did not include an appropriate individual risk assessment. The approved centre did not implement appropriate measures to ensure the protection of a vulnerable resident.
- ***Register of Residents:*** The discharge date and discharge diagnosis for a resident discharged to a community residence was not included on the approved centre's register of residents.
- ***Staffing*****:** The number of Registered Psychiatric Nurses (RPNs) on duty did not align with the approved centre's registered staffing numbers.
- ***Mandatory training:*** Not all healthcare staff were trained in Fire Safety, Basic Life Support, and the Mental Health Act 2001.
- ***Cleanliness:*** The approved centre was not clean everywhere, two bathrooms in separate houses were malodourous and there were stains on both of these bathroom floors.

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.
- ***Multi-disciplinary team working:*** Residents within the approved centre had access to medical, nursing, social work, psychology, and occupational therapy disciplines.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan.
- ***Access to other medical services:*** Specialist therapeutic interventions, were available when needed. Residents had access to a dedicated dietitian and a physiotherapist. Assessed needs for speech and language therapy were met via referral to an external provider.

However:

- **Transfers:** The approved centre was not compliant with Regulation 18: Transfer of Residents.
- **Discharges:** A preliminary discharge summary was not sent to the general practitioner/primary care/Community Mental Healthcare Team within three days. A comprehensive discharge summary was not issued within 14 days.
- **Individual care plans:** In the sample of individual care plans inspected, the approved centre had a number of deficits in their ICP processes:
  a) Six individual care plans were not a composite set of documents.
  b) Two individual care plans were not developed by the multi-disciplinary team.
  c) Eight individual care plans did not contain documented interventions to meet residents' goals.
  d) Eight individual care plans did not contain appropriate resources to provide interventions within the care plan.
  e) Resident input was not documented in eight individual care plans.
  f) Two individual care plans were not reviewed by the multi-disciplinary team – review was by nursing and medical staff only.
- **Physical assessments:** Residents' general health needs were not monitored and assessed on a six-monthly basis. Five general health assessments were examined on inspection, and all had been completed on an annual basis. Four residents did not have their waist circumference recorded, three residents did not have their levels of physical activity recorded, and five residents did not have their dental checks recorded as part of their six-month physical assessment. One resident on antipsychotic medication did not receive an annual electrocardiogram.

Respect for residents' privacy, dignity and autonomy

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

- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed

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

- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialising. Clinical files were securely stored.
- ***Use of restrictive practices:*** Mechanical restraint was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The approved centre was compliant with the Rule on the Use of Mechanical Restraint, the Rule on Seclusion, and the Code of Practice on Physical Restraint.
- ***Rights-based care:*** There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***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***: A selection included; golfing, cycling, garden activities, baking, meet-ups for coffee, gym, and games and quizzes in the Knockamann resource centre.
- ***Residents' feedback:*** The residents were complimentary of the staff, food, premises and overall care and treatment they received. One resident stated that they would like their '*liberty back*', while another reported that they would enjoy '*more activities*' and more opportunities '*to go out on the bus*'. *(Please refer to section 5.1 of this report for additional service-user feedback).*

However:

- ***Environment: Premises***: The condition of the entrance porches for a number of the houses was not adequate. There were cobwebs, gathered leaves, house numbers missing or loose, and a bell was not working.

Governance, Leadership and Accountability

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

- ***Structure in place:*** St Joseph's Intellectual Disability Service (SJIDS) was part of Community Healthcare Organisation Dublin North City and County (CHO DNCC) and was governed by the North Dublin Management Team. There was a monthly Management Team meeting. Additional monthly meetings included the Management Team Working Meeting, Compliance Meeting and Quality and Patient Safety Committee Meeting.
- ***Leadership:*** CHO DNCC Mental Health Service's general manager was the approved centre's registered proprietor nominee. The area director of nursing and the executive clinical director reported to the head of service and the service manager, principal psychologist, principal social worker and occupational therapy manager reported to the general manager. While the North Dublin Management Team's Principal Social Worker was responsible for the governance of SJIDS, the Senior Social Work Practitioner reported to the Service Manager and received clinical supervision from the North Dublin Management Team's Principal Social Worker.
- **Clinical governance:** There were areas of good clinical governance: Admission processes were good, therapeutic services and programmes and recreational activities met the needs of the residents, and there was evidence in the files of multi-disciplinary team working. Audits were carried out.
- ***Restrictive practices reduction:*** The Rule on the Use of Seclusion, the Rule on the Use of Mechanical Restraint and the Code of Practice were all found to be compliant.
- ***Risk:*** The person with responsibility for risk was identified and known by all staff. The approved centre had a local risk register which was reviewed quarterly at the Management Team Working Meeting.
- ***Quality improvement:*** The approved centre had established processes for the measurement of quality, which included a clinical audit programme. Four quality initiatives had been implemented in the approved centre since the last inspection, such as the establishment of a Wellness Room - a relaxing room for residents to have quiet time or pampering sessions and to show case residents' artwork. *(Please refer to section 2.0 of this report for all quality initiatives).*
- ***Policies:*** The approved centre's policies were all up to date.
- ***Staff training:*** Not staff had received mandatory training. Significant improvements in staff training were noted from the previous inspection in 2022.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Resident engagement with the complaints, compliments, feedback and advocacy processes were the principal mechanisms for resident and carer involvement in the process of quality improvement.

- ***Advocacy services:*** Residents within the approved centre had access to an advocacy service and there was an established advocacy group.
- ***Regulatory compliance and engagement:*** The compliance rate dropped by 9% since last year in 2022 (82%) to this year 2023 (73%). The approved centre continues to engage with the regulatory process and the Mental Health Commission.

However:

- ***Regulatory compliance and engagement:*** The approved centre was not compliant with nine areas of this inspection in 2023, and one area was rated as critical risk: Regulation 32: Risk Management.
- ***Risk:*** In one resident's discharge process, risks identified by the service were not appropriately assessed, treated or monitored. One resident's discharge process and clinical file did not include an appropriate individual risk assessment. The approved centre did not implement appropriate measures to ensure the protection of a vulnerable resident. There was an inadequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Clinical governance:*** There were areas where clinical governance needed improvement i.e. how risk was assessed and managed was inadequate in relation to one resident, the maintenance of records documentation was inadequate, not all residents general health care needs were monitored and met, and individual care planning processes had deficits.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Refurbishment of the polytunnel; with new concrete flooring to facilitate wheelchair access.

2. Establishment of a Wellness Room, which provided residents with a relaxing space for quiet time or pampering sessions. This space was also used to show case residents' artwork, which were created in the Art Department.

3. Introduction of a gardening project, which was a resident led planting initiative in the Approved Centre.

4. Development of mood boards for residents, which was utilised as a communication tool to positively support self-awareness and emotional regulation.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St Joseph's Intellectual Disability Service was located on the St. Ita's Campus in Portrane, Co. Dublin. The approved centre was registered with the Mental Health Commission for the provision of mental health care for adults with an intellectual disability and a mental health diagnosis. The approved centre was registered for 82 beds. However, 54 beds were occupied at the time of the inspection.

The approved centre consisted of 14 units; 10 units on Knockamann Street (Units 1, 2, 3, 4, 5, 6, 7, 8, 10 & 11) and four named units which were Fáilte, Grove Lodge, Fern Lodge and Seafield. Unit 9 was known locally as the Administration Block. All the units on Knockamann Street could accommodate six residents, except for Unit 11 which had been divided into two one bed apartments. The Knockamann resource centre was located onsite and was accessible to all residents; this space included a gymnasium, a multi-sensory room, a kitchen known as '*Tuas Nua*', a quiet room and a new Wellness Room. The resource centre's poly tunnel was recently refurbished with concrete floors to facilitate wheelchair access. The Knockamann resource centre acted as a hub of social, vocational, educational and leisure activities for all residents.

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

Resident Profile	
Number of registered beds	***82***
Total number of residents	**54**
Number of detained patients	0
Number of wards of court	5
Number of children	0
Number of residents in the approved centre for more than 6 months	54
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

St Joseph's Intellectual Disability Service (SJIDS) provided mental health care for adults with an intellectual disability within the approved centre, as well as the community. SJIDS was part of Community Healthcare Organisation Dublin North City and County (CHO DNCC) and was governed by the North Dublin Management Team. A monthly Management Team meeting was chaired by the head of service, mental health. Agenda items included head of service updates, human resources, finance, quality and patient safety, performance and service user engagement. Additional monthly meetings included the Management Team Working Meeting, Compliance Meeting and Quality and Patient Safety Committee Meeting. Local operational issues pertaining to the approved centre were discussed at the SJIDS Multi-disciplinary Team Business Meeting. Various local committees and groups were established; for example, the Policy Review Group, Drugs and

Therapeutic Group, Safeguarding Review Group, Individual Care Plan Group and the Augmentative Communication Group.

In accordance with the Health Service Executive's (HSE's) strategy on congregated settings 'Time to Move on from Congregated Settings' (2011), the approved centre was implementing a Transition Project. Membership of the Transition Project included; the head of service mental health, head of service disabilities, executive clinical director, general manager, service manager, heads of disciplines / representatives, consultant psychiatrists, project manager, area accountant and an advocacy representative. The aim of this project was to maximise residents' independence and autonomy, by integrating residents in the community with the necessary supports.

There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability of the approved centre's staff. CHO DNCC Mental Health Service's general manager was the approved centre's registered proprietor nominee. The area director of nursing and the executive clinical director reported to the head of service and the service manager, principal psychologist, principal social worker and occupational therapy manager reported to the general manager. While the North Dublin Management Team's Principal Social Worker was responsible for the governance of SJIDS, the Senior Social Work Practitioner reported to the Service Manager and received clinical supervision from the North Dublin Management Team's Principal Social Worker.

The number of staff was sufficient to meet resident needs but the nursing skill mix was not. The number of registered psychiatric nurses (RPNs) on duty did not align with the approved centre's registered staffing numbers. Residents within the approved centre had access to medical, nursing, social work, psychology, and occupational therapy disciplines. The residents also had access to a dedicated dietitian and a physiotherapist and assessed needs for speech and language therapy were met via referral to an external provider. All staff were trained in the Management of Violence and Aggression. While not all staff were trained in Basic Life Support, Fire Safety and the Mental Health Act significant improvements in staff training were noted from the previous inspection in 2022.

The person with responsibility for risk was identified and known by all staff. In line with the approved centre's risk management policy, the local risk register was reviewed quarterly at the Management Team Working Meeting. The multi-disciplinary team was involved in the development, implementation, and review of individual risk management processes. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF) and incidents were reviewed to identify any trends or patterns that had occurred in the service. However, risk management deficits were identified in relation to one resident's discharge process.

The Mental Health Commission's Rule on the Use of Seclusion, Rule on the Use of Mechanical Restraint and Code of Practice on the Use of Physical Restraint were implemented on 1st January 2023. Mechanical restraint was utilised within the approved centre and there were two episodes of physical restraint and one episode of seclusion since the last inspection in March 2022. On inspection this year, the Rule on the Use of Seclusion, Rule on the Use of Mechanical Restraint and Code of Practice were all deemed compliant.

Resident engagement was encouraged and facilitated. Resident engagement was an agenda item for the CHO DNCC Mental Health Service's Management Team meeting. Residents within the approved centre had

access to an advocacy service and there was an established advocacy group. Residents' feedback was also obtained via the complaints, compliments, and feedback process, which was displayed throughout the approved centre.

The approved centre had established processes for the measurement of quality, which included a clinical audit programme. Key findings were reviewed by the multi-disciplinary team at the Compliance Meeting. This year's annual inspection identified an increase in the Approved Centre's non-compliance rating from six in 2022 to nine in 2023. While Regulation 15: Individual Care Plan was non-compliant, with a high-risk rating, the inspection team acknowledged that the approved centre had developed a new Individual Care Plan template and were in the process of implementing it 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 15: Individual Care Plan	✗	Moderate	✓		✓		✗	High	✗	High
Regulation 18: Transfer of Residents	✗	High	✓		✓		✓		✗	Moderate
Regulation 19: General Health	✗	High	✓		✓		✓		✗	Moderate
Regulation 22: Premises	✗	High	✓		✓		✗	High	✗	High
Regulation 26: Staffing	✗	High	✓		✓		✗	High	✗	High
Regulation 27: Maintenance of Records	✓		✓		✓		✗	Moderate	✗	Low
Regulation 28: Register of Residents	✓		✓		✓		✓		✗	Low
Regulation 32: Risk Management Procedures	✗	High	✗	Moderate	✗	Moderate	✗	High	✗	Critical
Code of Practice: Admission, Transfer, and Discharge	✗	High	✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.

Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

- The inspection team informally approached residents and sought their views on the approved centre.
- Posters were displayed inviting the residents to talk to the inspection team.
- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Set times and a private room were available to talk to residents.
- The Peer Advocacy in Mental Health representative was contacted to obtain residents' feedback about the approved centre.

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 four residents during the inspection. The residents were complimentary of the care and treatment provided. The staff, food and the premises were described positively by all of the residents. No concerns were voiced by any of the residents.

The inspection team also received ten completed service user experience questionnaires. On a scale of 1 – 10, with 1 being poor and 10 being excellent, the residents rated their overall experience of their care and treatment between 8 and 10. Eight residents reported that they understood their Individual Care Plan (ICP) and that they knew their multi-disciplinary team (MDT) members. A number of residents described being '*happy*' within the Approved Centre. One resident stated that they would like their 'liberty back', while another reported that they would enjoy '*more activities*' and more opportunities '*to go out on the bus*'.

5.2 Advocacy

The approved centre had an advocacy service.

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

6.0 Feedback Meeting

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

- Head of Service
- General Manager (Registered Proprietor)
- Service Manager
- Executive Clinical Director
- Consultant Psychiatrist x 2
- Senior Social Work Practitioner
- Occupational Therapy Manager
- Principal Psychologist
- Area Director of Nursing
- Assistant Director of Nursing x 2
- Nurse Practice Development Coordinator
- Risk Advisor

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers which were appropriate to the resident group profile and individual residents' needs.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their 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 at all times in the approved centre.

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. A speech and language therapist and dietitian were available and gave regular input into meal plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2020. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Recreational activities included relaxation, story-telling, newspaper-reading groups, and a book club. Nursing staff provided access to other activities, including games, puzzles, and walks. Frequent outings took place at the weekend. Individual programmes encompassed GAA matches at Croke Park, concerts, golfing, cycling, garden activities, baking, meet-ups for coffee, gym, and games and quizzes in the Knockamann resource centre (Monday to Friday and on a weekend day, every second 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 practicable. Facilities and resources were provided for religious practices.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in February 2023.

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

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in February 2023.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents had access to mail, internet, and telephone, and could use their own mobile phones where applicable. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where 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

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in February 2023, and included all requirements related to:

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

As no searches had been conducted since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in February 2023.

The clinical files of two residents who had died in the approved centre were examined on inspection. The end of life care provided was appropriate to the residents' physical, emotional, social, psychological, and spiritual needs. The deaths were managed in accordance with the residents' religious and cultural practices, with dignity and propriety, and in a way that accommodated their representatives, family, next of kin, and friends. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

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); 13 ICPs were inspected. All ICPs were not a composite set of documentation: six out of the thirteen appeared to be in two or more documents. Specific space and sections were allocated for needs, goals, resources required, and reviews. However, the older template employed by the approved centre did not allocate a space for care and treatment.

Eight of the ICPs inspected were not discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin. The ICPs were stored within the clinical file, and not amalgamated with progress notes. The ICPs were not readily identifiable, as there were several different documents which could be interpreted as the ICP.

ICPs identified appropriate goals for the resident. In eight of the ICPs inspected, however, there was no space for the care and treatment required to meet resident goals. Also, in eight of the ICPs, resources identified to provide care and treatment were generic and/or not properly specified. Two of the thirteen ICPs were not reviewed by the multi-disciplinary team in consultation with the resident; review in these instances was by medical and nursing staff only. The 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) **Six of 13 individual care plans examined were not a composite set of documents.**
b) **Two of the individual care plans examined were not developed by the multi-disciplinary team.**
c) **Eight of the individual care plans examined did not contain documented interventions to meet residents' goals.**
d) **Eight of the individual care plans examined did not contain appropriate resources to provide interventions within the care plan.**

e) **Resident input was not documented in eight of the individual care plans examined.**
f) **Two individual care plans were not reviewed by the multi-disciplinary team – review was by nursing and medical staff only.**

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in February 2023. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was not sent to a named individual in the receiving facility when the resident was transferred. No resident transfer form or letter of referral (with list of current medications) was in evidence on inspection.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all relevant information about the resident was provided to the receiving facility, as no resident transfer form or letter of referral was found on inspection, 18(1).

Regulation 19: General Health

NON-COMPLIANT

Risk Rating MODERATE

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in May 2023. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were not monitored and assessed on a six-monthly basis. Five general health assessments were examined on inspection, and all had been completed on an annual basis.

The general health assessments documented a physical examination, family or personal history, blood pressure, smoking status, and medication review. Body mass-index and weight were noted in all assessments; however, waist circumference was not recorded in four assessments. Nutritional status was noted in all assessments; however, physical activity was not recorded in three assessments. None of the five inspected assessments recorded a dental check.

For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, and prolactin. However, one resident (out of four applicable) had not had an assessment of electrocardiogram (ECG) heart function completed in the last year.

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

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

a) **The registered proprietor did not ensure that residents general health needs were assessed at six-monthly intervals, 19(1)(b).**

b) **The registered proprietor did not ensure that each general health assessment recorded the resident's waist circumference, levels of physical activity, and dental checks, 19(1)(b).**
c) **The registered proprietor did not ensure that an annual electrocardiogram was completed for one resident who was prescribed anti-psychotic medication, 19(1)(b).**

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in April 2023.

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

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Sufficient spaces were provided for residents to move about, including outdoor spaces. The approved centre was set amid ample gardens, and each house had suitable gardens or garden courtyards. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimised in the approved centre. Ligature points were minimised to the lowest practicable level, based on risk assessment.

Overall, the approved centre was kept in a good state of repair. One exception was a bedroom in Seafield where there was notable scuffing on the wall. A broken privacy screen was observed in one bedroom, one door frame in House 8 required repair, and the area directly outside Seafield House and House 4 were dirty with cobwebs present. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Current infection control guidelines were followed.

Overall, the approved centre was free from offensive odours with the exception of one toilet in Seafield House and one toilet in Failte. Both had lino-style flooring and there was a malodour which appeared to be coming from under the flooring, which appeared stained despite being clean.

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

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

a) **The approved centre was not clean and maintained in good structural and decorative condition throughout, as two bathrooms identified in separate houses had a malodour and there was staining on both these bathroom floors, 22(1)(a).**
b) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and patients, as upkeep relating to entrance porches for a number of the houses had not been provided. There were cobwebs, gathered leaves, house numbers missing or loose, and a bell not working, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a site-specific safety statement, Adapted HSE Corporate Safety Statement (2022), and a Health and Safety policy – relating to the health and safety of residents, staff and visitors.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

(a) it shall be used solely for the purposes of observing a resident by a health

professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

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

The number of staff was sufficient to meet resident needs but the nursing skill mix was not. The number of Registered Psychiatric Nurses (RPNs) on duty did not align with the approved centre's registered staffing numbers.

An appropriately qualified staff member was on duty and in charge at all times. The approved centre was registered with the Mental Health Commission for the provision of mental health care to people with an intellectual disability. Residents within the approved centre had access to medical, nursing, social work, psychology, and occupational therapy disciplines. The residents also had access to a dedicated dietitian and a physiotherapist and assessed needs for speech and language therapy were met via referral to an external provider.

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. All staff were trained in the Management of Violence and Aggression. While not all staff were trained in Basic Life Support, Fire Safety, and the Mental Health Act 2001, significant improvements were noted in staff training from the previous inspection in 2022. The following table provides a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (115)	113	98%	110	96%	115	100%	115	100%
Consultant Psychiatrist (2)	2	100%	2	100%	2	100%	2	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%
Healthcare Assistants (81)	81	100%	71	88%	81	100%	77	95%
Other MDT (2)	2	100%	2	100%	2	100%	2	100%

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

(a) The number of Registered Psychiatric Nurses (RPNs) on duty did not align with the approved centre's registered staffing numbers, 26(2).

(b) Not all healthcare staff were trained in Fire Safety, Basic Life Support, and the Mental Health Act 2001, 26(4).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating LOW

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in May 2023, and included the following:

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

Resident records were secure and in good order, and physically stored together where possible. However, not all records were up to date as an individual care plan (ICP) and other documents from 2014 and 2019 were observed in two files. Resident records were not reflective of the resident's current status and the care and treatment being provided, as it was not always possible to identify the current resident ICP document within the files. The records were developed and maintained in logical sequence and kept in good order with no loose pages.

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

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

a) Two files stored information that was out of date and not current to the residents' care and treatment, 27(1).

b) Some files contained several different documents that appeared to be the individual care plan, 27(1).

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating LOW

(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 not up to date. The register did not include a discharge date or discharge diagnosis for a resident discharged from the Approved Centre to a community residence. The register of residents contained all the other information required in Schedule 1 of the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the register included all the information specified in Schedule 1 to the Mental Health Act (Approved Centres) Regulations 2006 i.e. discharge date and discharge diagnosis for a resident discharged to a community residence, (28).

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in May 2023, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person available to the approved centre with responsibility for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives at admission or soon thereafter. Information about the complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre. As the nominated person was not based in the approved centre, their contact details were publicly displayed.

Residents, their representatives, family, and next of kin were informed of the methods by which a complaint could be made. All complaints, whether oral or written, were investigated promptly and handled appropriately and sensitively. Minor complaints were documented, and all non-minor complaints were dealt with by the nominated person and recorded in the complaints log. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident's individual care plan (ICP).

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management, which was last reviewed in September 2021, a health and safety statement dated 2022, and various other related policy documents. Together, these documents address all the policy requirements for this regulation, including the following:

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. In one resident's discharge process, risks identified by the service were not appropriately assessed, treated or monitored.

Clinical risks were documented in the risk register, as appropriate. Corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and

safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were completed in conjunction with medication requirements or administration, and prior to and during resident seclusion, physical restraint, mechanical restraint, and resident transfer. However, one resident's discharge process did not include an appropriate individual risk assessment. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The approved centre did not implement appropriate measures to ensure the protection of a vulnerable resident.

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

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

a) **In one resident's discharge process, risks identified by the service were not appropriately assessed, treated or monitored, 32(2)(a).**
b) **One resident's discharge process did not include an appropriate individual risk assessment, 32(2)(a).**
c) **The approved centre did not implement appropriate measures to ensure the protection of a vulnerable resident, 32(2)(f).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion, which was last reviewed in February 2023, and a restrictive practice reduction policy.

The seclusion policy addressed the following:

- Who may implement seclusion.
- Provision of information to the resident.
- Ways of reducing seclusion use.

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

Monitoring: An annual report on the use of seclusion been completed. The report was available to the inspector.

Evidence of Implementation: Seclusion facilities were furnished and maintained to ensure respect for resident dignity and privacy, as far as practicable. Residents in seclusion had access to adequate toilet and washing facilities. All furniture and fittings were of a design and quality so as not to endanger patient safety. Seclusion rooms were not used as bedrooms.

One episode of seclusion was reviewed on inspection. Seclusion was only used in rare and exceptional circumstances and in residents' best interests when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated after an assessment, including risk assessment, and after all other interventions to manage resident's unsafe behaviour were considered.

Seclusion was initiated by a registered medical practitioner and/or a registered nurse and a consultant psychiatrist was notified as soon as practicable of the use of seclusion. The resident was informed of reasons for, likely duration of, and circumstances leading to discontinuation of seclusion. The resident's right to dignity, bodily integrity, and privacy was respected. Cultural awareness and gender sensitivity was demonstrated.

A registered nurse undertook direct observation for the first period following the initiation of the seclusion episode. A written record of the resident's well-being was made by the nurse every 15 minutes, including the level of distress and behaviour displayed by the resident. The episode of seclusion lasted 39 minutes. A medical review of the patient took place no later than four hours after the commencement of the episode of seclusion.

The resident was informed of the ending of an episode of seclusion. The reason for ending seclusion was recorded in the clinical file. All uses of seclusion were clearly recorded in the clinical file and on the seclusion register. The seclusion register was signed by the responsible consultant psychiatrist or duty consultant psychiatrist within 24 hours of the episode. A copy of the seclusion register was placed in the clinical file. The episode was reviewed by members of the multi-disciplinary team and documented in the clinical file within two working days.

The approved centre was compliant with this rule.

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Evidence of Implementation: Three episodes of mechanical restraint were reviewed under Part 4: Use of Mechanical Means of Bodily Restraint for Enduring Risk of Harm to Self or Others. Mechanical restraint was only used where there was an enduring risk of harm to the resident or others, and addressed an identified clinical need. It was used only when other less restrictive alternatives were unsuitable. Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of a consultant psychiatrist or by the duty consultant psychiatrist acting on his/her behalf.

The clinical files contained a contemporaneous record that specified that there was an enduring risk of harm to the self or others, and that restrictive alternatives were implemented without success prior to the prescription of mechanical restraint. The documentation also recorded the type of mechanical restraint, the situation in which mechanical restraint was being applied, the duration of the restraint, the duration of the order, and the review date.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

- The provision of information to the resident
- Who can initiate and who may implement physical restraint.

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy.

Monitoring: An annual report on the use of physical restraint in the approved centre had been completed.

Evidence of Implementation: Two episodes of physical restraint were examined on inspection. Physical restraint was only used in rare, exceptional circumstances and the best interest of the resident. Physical restraint had only used after all alternative interventions had been considered. The use of physical restraint had been based on risk assessment and cultural and gender sensitivity were demonstrated.

Physical restraint was initiated by a registered medical practitioner (RMP), registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the resident. The consultant psychiatrist was notified as soon as was practicable and this was documented in the clinical file. A physical examination of the resident was completed no later than three hours after the start of each episode.

The orders for physical restraint lasted for a maximum of 30 minutes. The clinical practice forms were completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the consultant psychiatrist within 24 hours. There was evidence that the resident had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

As soon as practicable and with the resident's consent, the resident's next of kin or representative was informed of the use of physical restraint, and this was recorded in the clinical file. There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where practicable, same sex staff

members were present during the physical restraint episodes. Completed clinical practise forms had been placed in the resident's clinical files.

The resident was afforded an opportunity to discuss the episodes with members of the multi-disciplinary team involved in their care as soon as was practicable. Each episode of physical restraint was reviewed by members of the multi-disciplinary team and documented in the clinical files no later than two working days after each episode.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to admission, transfer, and discharge. The policy was last reviewed in July 2020, and addressed all the policy requirements for this code of practice.

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

Monitoring: Audits had been completed on the implementation of and adherence to the transfer and discharge aspects of the policy.

Evidence of Implementation:

Admission: There had been no admissions to the approved centre since the last inspection.

Transfer: The approved centre did not comply with Regulation 18: Transfer of Residents.

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, and reference to risks and early warning signs of relapse. The same intellectual disability team were responsible for the resident's care when in the approved centre and in the community. Planning for the resident's discharge was noted in the St Joseph's Mental Health Intellectual Disability (MHID) resettlement notes and multi-disciplinary team (MDT) minutes. The discharge meeting was attended by the resident, key worker, relevant members of the resident's MDT, and family or representative, where appropriate.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and social and housing needs. As the same intellectual disability team were responsible for the resident's care, the discharge was considered by the approved centre to be a 'transition' only. No preliminary discharge summary was completed, and no comprehensive discharge summary was issued within 14 days of the discharge.

The approved centre was non-compliant with this code of practice for the following reasons:

a) **A preliminary discharge summary was not sent to the general practitioner/primary care/Community Mental Healthcare Team within three days, 38.3.**
b) **A comprehensive discharge summary was not issued within 14 days, 38.3(b).**
c) **The approved centre did not comply with Regulation 18: Transfer of Residents, 30.1.**

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10004429		Six of 13 individual care plans examined were not a composite set of documents.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	All Individual Care Plans were reviewed to ensure they are a composite set of documents that includes allocated sections for goals, treatment, care, resources required. There are allocated spaces for reviews. The ICP is stored in the residents clinical files and not amalgamated with the progress notes.	Monthly audits conducted to determine compliance utilizing Quality Care Metrics measurement tool Quarterly audits conducted by NPD	Achievable - all staff are trained in the use of the ICPs process	31/03/2024	interim Area Director of Nursing ADON team Consultant Psychiatrists GP MDT members NPD
Preventative Action	Education, support and training provided to staff in ensuring their understanding of the process involved in documentation and recording Auditing of the documentation to determine compliance in	Monthly audits conducted to determine compliance utilizing Quality Care Metrics measurement tool Quarterly audits conducted by NPD After action reviews by the MDT members for future learning	Achievement relies on the input from all members of MDT - staff shortages/ vacant posts of MDT members will affect successful outcomes.	30/06/2024	Interim Area Director of Nursing ADON team/ CNMs NPD - compliance officers Consultant Psychiatrists MDT members

	Regulation 15 and to gain further understanding / learning as to any challenges that may be affecting compliance				
Reason ID : 10004430		**Two of the individual care plans examined were not developed by the multi-disciplinary team.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	the two individual care plans are now developed with Multidisciplinary input (where applicable and possible)	Quarterly audits conducted by NPD After action reviews by MDT	Achievement relies on the input /availability of all MDT members - staff shortages / vacant posts of MDT members will affect successful outcomes.	31/03/2024	MDT members
Preventative Action	All members of MDT will ensure that their input for each resident's care and treatment is discussed and documented clearly in the individual ICP. ICPs will be audits on a quarterly basis to determine compliance in regulation 15	Quarterly audits conducted by NPD After action reviews by MDT	Achievement relies on the input /availability of all MDT members - staff shortages / vacant posts of MDT members will affect successful outcomes.	31/03/2024	MDT members NPD
Reason ID : 10004431		**Eight of the individual care plans examined did not contain documented interventions to meet residents' goals.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Individual Care plans were reviewed	Monthly audits will be conducted to	Achievement relies on the input / availability of all	31/03/2024	MDT members

	to ensure that the care and treatment are clearly documented to meet the individual's goals which will address challenges, issues or identified needs of each resident.	determine compliance in this instance	MDT members - staff shortages / vacant posts of MDT members will affect successful outcomes.		
Preventative Action	Education, support & Training provided to staff in ensuring their understanding of the process involved in documentation & recording . Auditing of the documentation to determine compliance in Regulation 15 and to gain further understanding / learning as to any challenges that may affect compliance.	Monthly Audits to determine compliance (QCM) Quarterly audits to determine compliance with Regulation 15 After action reviews for further learning	Achievement relies on the input from all MDT members - staff shortages / vacant posts of MDT members will affect successful outcomes	30/06/2024	interim Area Director of Nursing Consultant Psychiatrists All MDT members ADONs / CNM's NPD
Reason ID : 10004432		**Eight of the individual care plans examined did not contain appropriate resources to provide interventions within the care plan.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All individual care plans were reviewed to ensure that all	Audit will be conducted to determine	Achievement relies on the input / availability of all MDT members and	31/03/2024	Interim Area Director Of Nursing Consultant Psychiatrist MDT members

	necessary resources identified are available to support the resident and the MDT in order to implement the necessary goals identified.	compliance in this instance	Resources available to support the interventions. Staff shortages / vacant post / budget restrictions will affect successful outcomes		
Preventative Action	MDT input is paramount as well as the involvement of the resident to determine the necessary resources needed to implement interventions required.	Quarterly audits will be conducted to determine compliance with regulation 15 After action reviews for future learning	Achievement relies on the input / availability of all MDT members and Resources available to support the interventions. Staff shortages / vacant post / budget restrictions will affect successful outcomes	30/06/2024	MDT members Operations
Reason ID : 10004433		**Resident input was not documented in eight of the individual care plans examined.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All individual care plans were reviewed to ensure that the resident's input is paramount in the development of their individual care planning process, or where the resident is unable to represent themselves the MDT ensured that the individual's views	Audits will be conducted to determine compliance in this instance	Achievable	31/03/2024	MDT members

	were properly represented in all decision-making processes.				
Preventative Action	Education, support and training provided to all staff to ensure that the resident's input is paramount in the development of their individual care planning process, or where the resident is unable to represent themselves the MDT ensured that the individual's views were properly represented in all decision-making processes.	Quarterly audits to determine compliance	achieved	30/06/2024	MDT members
Reason ID : 10004434		**Two individual care plans were not reviewed by the multi-disciplinary team – review was by nursing and medical staff only.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Individual Care plans are now reviewed by the relevant multi-disciplinary team (where applicable)	Documentation pertaining to ICP recorded and stored in residents clinical file.	achieved	28/01/2024	MDT members
Preventative Action	Education, support & training provided	Quarterly audits to determine	Achievement relies on the input from all MDT	31/03/2024	MDT members

	to all MDT members to ensure their understanding and awareness of the importance of ensuring all MDT members regularly review and update all identified goals for the resident and these are clearly documented	compliance After action reviews for further learning	members - staff shortages / vacant posts of MDT members will affect successful outcomes		

Regulation 18: Transfer of Residents					
Reason ID : 10004420		**The registered proprietor did not ensure that all relevant information about the resident was provided to the receiving facility, as no resident transfer form or letter of referral was found on inspection, 18(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A transfer form/ letter of referral was completed by the referring consultant psychiatrist was compiled on 02/05/23 and is now in the resident's clinical file. a checklist for transfers to guide and support staff is in place	documentation contained in the resident's file	achieved	25/01/2024	Consultant psychiatrist Interim Area DON ADON team Nursing staff
Preventative Action	All residents who are being transferred or discharged from the Approved Centre will have a transfer letter / referral detailing all relevant information about the individual and a copy kept in their clinical file. A checklist is in place for all Admissions, transfers and	An audit will be conducted following all admissions / transfers/ or Discharges	achievable	28/07/2024	Area DON Interim ADON team CNM Nursing staff

	discharges to support and guide staff in ensuring a complete and safe process and compliance in regulation 18.				

Regulation 19: General Health					
Reason ID : 10004426		**The registered proprietor did not ensure that residents' general health needs were assessed at six-monthly intervals, 19(1)(b). The registered proprietor did not ensure that each general health assessment recorded the resident's waist circumference, levels of physical activity, and dental checks, 19(1)(b). The registered proprietor did not ensure that an annual echocardiogram was completed for one resident who was prescribed anti-psychotic medication, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• A GP is now contracted to ensure that residents' general health needs are assessed for the Approved Centre and there is a schedule in place to ensure all residents have their general health needs assessed on a six monthly basis. • All resident's general health assessments will have the resident's waist circumference, levels of physical activity, and dental checks recorded. . All resident's who are prescribed anti-psychotic medication now	• A schedule to determine dates for each resident will be implemented to determine when six monthly general health needs assessments will occur. . Documentation of six monthly general health needs assessments for each resident will be stored in each individual's clinical file. . Audits will be conducted on a bi annual basis to determine compliance in Regulation 19 General Health that will indicate each resident has their general health needs	Achieved	01/03/2024	• Interim Area Director of Nursing • Executive Clinical Director . G.P. • Treating Consultant Psychiatrists . Nursing Staff

	have an annual echocardiogram conducted as per requirements of MHC Judgement Support Framework.	assessed on a six monthly basis and will include the resident's waist circumference, levels of physical activity, dental checks and will determine where an annual echocardiogram was conducted for any individual who was prescribed anti-psychotic medication.			
Preventative Action	• All residents will have their general health needs assessed on a six monthly basis and this will be scheduled and implemented accordingly, that will indicate each resident has their general health needs assessed on a six monthly basis and will include the resident's waist circumference, levels of physical activity, dental	• Audits will be conducted on a bi annual basis to determine compliance in Regulation 19 General Health that will indicate all resident have their general health needs assessed on a six monthly basis.	Achievable	01/07/2024	• Interim Area Director of Nursing • Executive Clinical Director . GP • Treating Consultant Psychiatrists . Nursing Staff

	checks and will determine where an annual echocardiogram was conducted for any individual who was prescribed anti-psychotic medication.				

Regulation 22: Premises					
Reason ID : 10004415		**The approved centre was not clean and maintained in good structural and decorative condition throughout, as two bathrooms identified in separate houses had a malodour and there was staining on both these bathroom floors, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Flooring in Seafield and Failte bathrooms were replaced in July 2023.	Walk around completed by Grade VI Operations Manager. Quality and Safety Walk around by Interim Area DON and QSSI Advisor.	Achieved	31/07/2023	Interim Area Director of Nursing, Service Manager Nurse Managers in each house, Grade VI Operations Manager Maintenance Manager
Preventative Action	IBM Tririga System has been introduced and is an automated system for demand and preventative maintenance in the Service to log maintenance requests. Senior Nurse Managers in each house log maintenance works as required by logging on to Tririga.	Walkaround by Unit Managers Health and Safety Checklist Audit by Unit Manager	Achievable	01/07/2024	Interim Area Director of Nursing, Senior Nurse Managers in each house Maintenance Manager
Reason ID : 10004416		**The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the specific needs of residents and patients, as upkeep relating to entrance porches for a number of the houses had not been provided. There were cobwebs, gathered leaves, house numbers missing or loose, and a bell not working, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The following works were completed immediately following inspection: • Entrance porches to houses cleaned • Broken privacy screen in House 4 bedroom replaced • Door frame in House 8 repaired • Old house number on House 10 removed • Scuffing on wall in Seafield repaired • Broken doorbell fixed • Toilet seat in Failte replaced • Walls in Grove Lodge Pharmacy repaired and repainted • Wash hand basin in Seafield stabilised • Hole in ceiling of bathroom in Seafield repaired • Garden in Seafield weeded	Walk around completed by Service Manager Walkaround by Senior Nurse Managers Health and Safety Checklist Audit by Senior Nurse Manager	Achieved	31/07/2023	Interim Area Director of Nursing, Senior Nurse Managers Service Manager Maintenance Manager
Preventative Action	• Tririga System has been introduced in the Service to log maintenance requests. Reactive	Walkaround by Senior Nurse Managers Health and Safety Checklist	Achievable	01/07/2024	Interim Area Director of Nursing, Support Services Manager Maintenance Manager Service Manager

	maintenance works can be flagged for attention by the Senior Nurse Manager by logging on Tririga. • Cleaning of cobwebs from porches has been added to the Planned Preventative Maintenance Programme. Cleaning will be completed twice yearly. Should cleansing be required outside these times staff can request same. This will form part of the unit's nursing audit process.	Audit by Senior Nurse Manager			

Regulation 26: Staffing					
Reason ID : 10004424		**The number of Registered Psychiatric Nurses (RPNs) on duty did not align with the approved centre's registered staffing numbers, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	numbers of RPN's were below 8 on the day due to illness/ absence/ vacancies - however there where adequate number of registered nurses to address this deficiency	Roster system in place and a record will be maintained of this. Audits conducted to determine compliance in regulation 26 Staffing.	Staff shortages may affect successful outcomes	28/01/2024	interim Area DON ADON team
Preventative Action	staffing rosters will ensure that there is a minimum of 8 RPN's on duty in alignment with the approved centre's registered staffing numbers, and ensure that the numbers of staff and skills mix of staff are appropriate to the assessed needs of the residents, the size and layout of the service.	Roster system in place and a record will be maintained of this. Audits conducted annually to determine compliance in regulation 26 Staffing.	staff shortages may affect successful outcomes	29/09/2024	Interim Area DON ADON
Reason ID : 10004425		**Not all healthcare staff were trained in Fire Safety, Basic Life Support, and the Mental Health Act 2001, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	training is scheduled to accommodate the training needs of staff identified as requiring training	training tracker / database is in place	Staff shortages may affect successful outcomes	05/05/2024	Interim Area DON ADON team MDT members NPD
Preventative Action	A comprehensive training schedule is in place to ensure that all healthcare staff are trained in Fire Safety, Basic Life Support, and the Mental Health Act 2001	Documented schedule of training in place Training trackers / Database Audits conducted on a quarterly basis	Staff shortages may affect a successful outcome	04/08/2024	Area DON ADON team MDT members NPD

Regulation 27: Maintenance of Records					
Reason ID : 10004417		**Two files stored information that was out of date and not current to the resident's care and treatment, 27(1). Some files contained several different documents that appeared to be the individual care plan, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is an archiving system in place whereby all clinical documents that are not current are removed from the residents current clinical file and stored in a locked storage press - The out of date information identified was removed from the current individual care plan and filed in the archive folder in the locked storage press. The files now reflect the residents current status and the care and treatment provided.	audit of individual care plans for compliance in relation to Regulation 27 conducted	Achievable	28/01/2024	ADON team CNM Nursing
Preventative Action	There is an archiving system in place whereby all clinical documents that are not current/	Audits will be conducted on an annual basis	Achievable	30/06/2024	ADON team CNMs Nursing

	relevant are removed from the residents current clinical file and stored in a locked storage press This will ensure all clinical files reflect the residents current status and the care and treatment provided.				
Reason ID : 10004418		**Some files contained several different documents that appeared to be the individual care plan, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is an archiving system in place whereby all clinical documents that are not current are removed from the residents current clinical file and stored in a locked storage press - The out of date information/ unrelated documents identified was removed from the current individual care plan and filed in the archive folder in	Documentation was audited to ascertain compliance	achieved	20/01/2024	Area DON ADON team CNM

	the locked storage press. The files now reflect the residents current status and the care and treatment provided.				
Preventative Action	There is an archiving system in place whereby all clinical documents that are not current are removed from the residents current clinical file and stored in a locked storage press	audits will be conducted on a quarterly basis to determine compliance	achievable	30/06/2024	Area DON ADON team CNM

Regulation 28: Register of Residents					
Reason ID : 10004419		**The registered proprietor did not ensure that the register included all the information specified in Schedule 1 to the Mental Health Act (Approved Centres) Regulations 2006 i.e. discharge date and discharge diagnosis for a resident discharged to a community residence, (28).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The register is now updated and includes discharge date and discharge diagnosis of the resident discharged to our community service.	register updated and maintained	achieved	20/01/2024	Interim Area DON ADON team
Preventative Action	Register will be established and maintained	Audit of register will be conducted as and when required	achievable	31/05/2024	Interim Area DON ADON team

Regulation 32: Risk Management Procedures					
Reason ID : 10004421		**In one resident's discharge process, risks identified by the service were not appropriately assessed, treated or monitored, 32(2)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The residents clinical risk assessment was completed by the MDT in conjunction with the required assessed needs and is now in the individual care plan	documentation present in clinical file	achieved	20/01/2024	Interim Area DON ADON team Nursing staff Consultant Psychiatrist MDT members
Preventative Action	all residents will have a clinical risk assessment conducted prior to discharge or transfer	audits will be conducted following any transfers to determine compliance	achievable	28/04/2024	Interim Area DON ADON team Nursing team Consultant psychiatrist MDT members
Reason ID : 10004422		**One resident's discharge process did not include an appropriate individual risk assessment, 32(2)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An appropriate and relevant clinical risk assessment was conducted on the resident and is now in the clinical file	Documentation will be maintained in clinical file	achieved	20/01/2024	Interim Area DON ADON team CNM Consultant psychiatrist MDT members
Preventative Action	All residents will have individual risk assessments completed prior to their discharge or transfer to meet their individual assessed needs	audits will be conducted following any discharge/transfer	achievable	30/06/2024	Interim Area DON ADON team CNM Consultant psychiatrist MDT members

Reason ID : 10004423		The approved centre did not implement appropriate measures to ensure the protection of a vulnerable resident, 32(2)(f).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	An MDT meeting was held and an Action Review was held and risk assessments were subsequently compiled to assess the resident's individual needs and to determine resources required to ensure the protection and safety of the resident	AAR review conducted and learning outcomes on risk assessments in resident clinical file Audit conducted to determine all resources are in place	achievable	20/01/2024	Interim Area DON ADON team CNM MDT members Consultant psychiatrist
Preventative Action	All residents will have individual risk assessments completed to include appropriate resources to meet the assessed needs of the individual in order to ensure the safety and protection of all vulnerable residents in compliance with MHC Code of Practice.	audits will be conducted following all discharges to determine compliance. Action Reviews conducted for future learnings	achievable	28/07/2024	MDT members

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10004412		**A preliminary discharge summary was not sent to the general practitioner/primary care/Community Mental Healthcare Team within three days, 38.3. A comprehensive discharge summary was not issued within 14 days, 38.3(b). The approved centre did not comply with Regulation 18: Transfer of Residents, 30.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A preliminary discharge summary relating to the resident and a discharge summary was compiled and is now in the resident's clinical file and they were discussed with the MDT in the receiving facility.	audits will be conducted to determine compliance	achieved	07/06/2023	Interim Area DON Consultant Psychiatrist ADON team CNM Key worker MDT members
Preventative Action	All resident's who are being discharged to another facility within the service will have a preliminary and a comprehensive discharge summary completed as required . This will be ensured using a checklist for all admissions / discharges and transfers to support	audits will be conducted to determine compliance after action reviews will be conducted for future learnings	achievable	30/06/2024	Interim Area DON Consultant psychiatrist ADON team CNM Key worker MDT members

	and guide staff during this process.				

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.

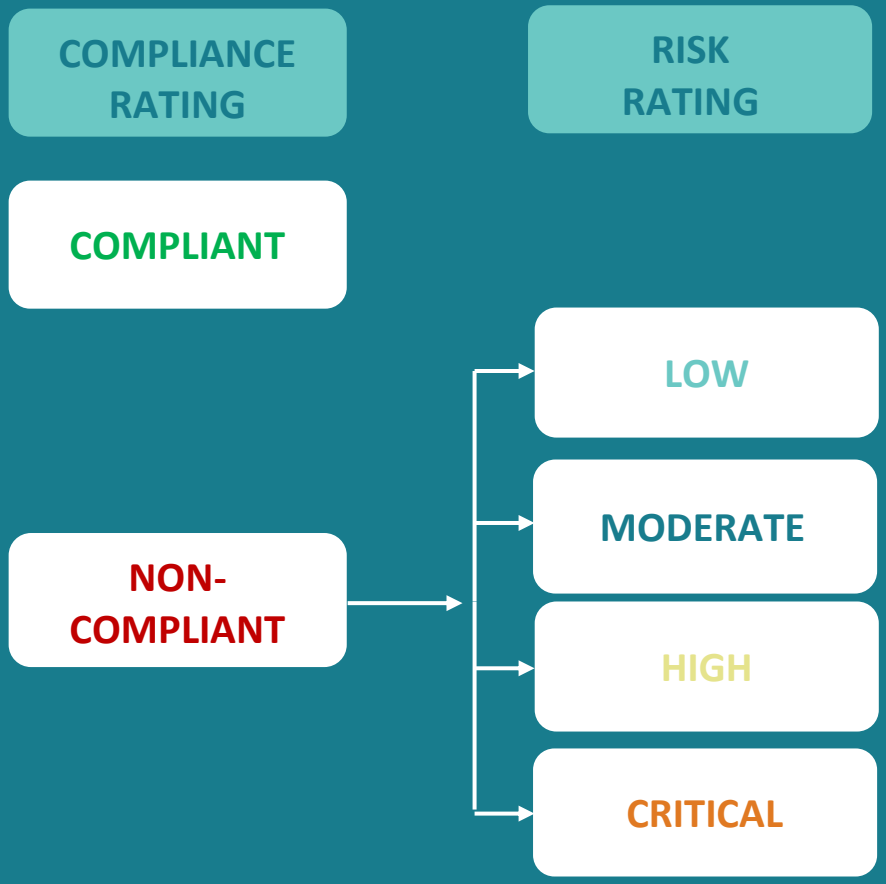
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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