Adult Acute Mental Health Unit, University Hospital Galway

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ADULT ACUTE MENTAL HEALTH UNIT, UNIVERSITY HOSPITAL GALWAY

Newcastle Road, Galway

Date of Publication:
02 April 2024

ID Number: AC0076

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life
Mental health care for people with intellectual disability
Other: Homeless

Conditions Attached:
None

Most Recent Registration Date:
30 June 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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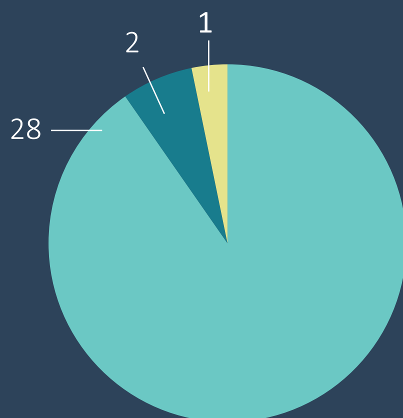
Inspection Date:
11 – 13 July 2023

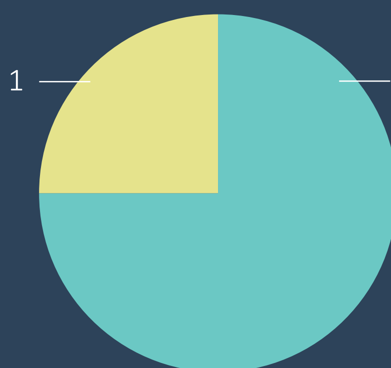
Previous Inspection date:
14 – 17 June 2022

Inspection Type:
Announced Annual Inspection

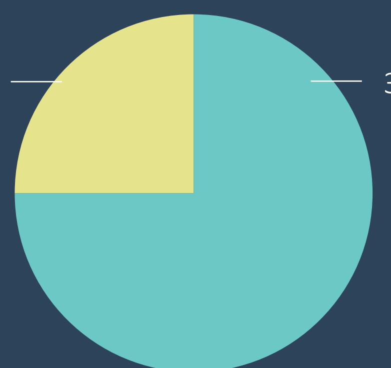
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



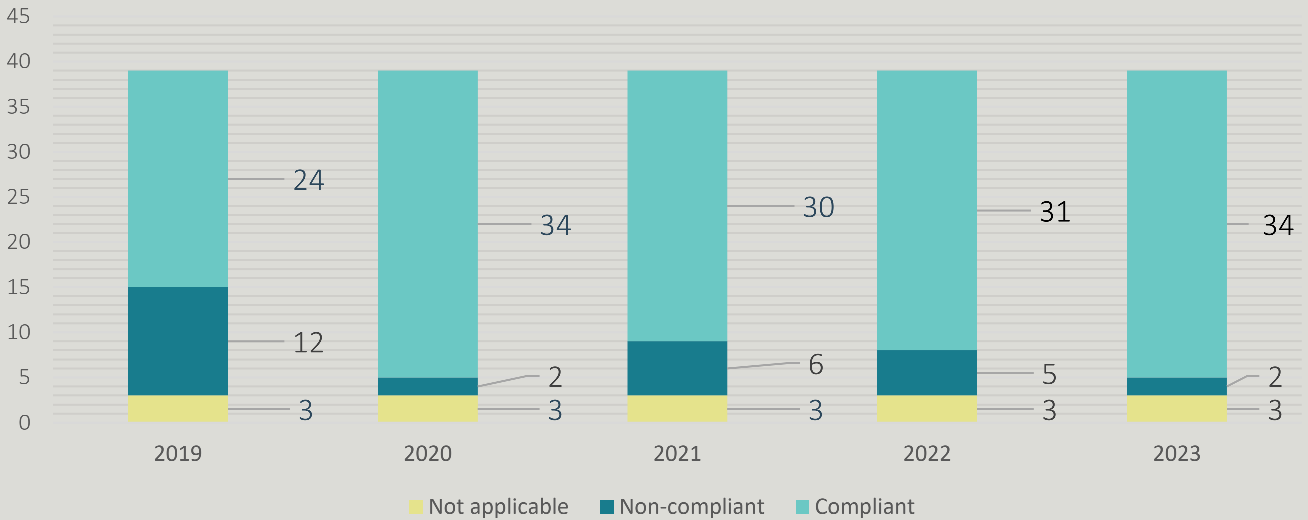
CODES OF PRACTICE

Compliant | Non-Compliant | Not applicable

RATINGS SUMMARY 2019 – 2023

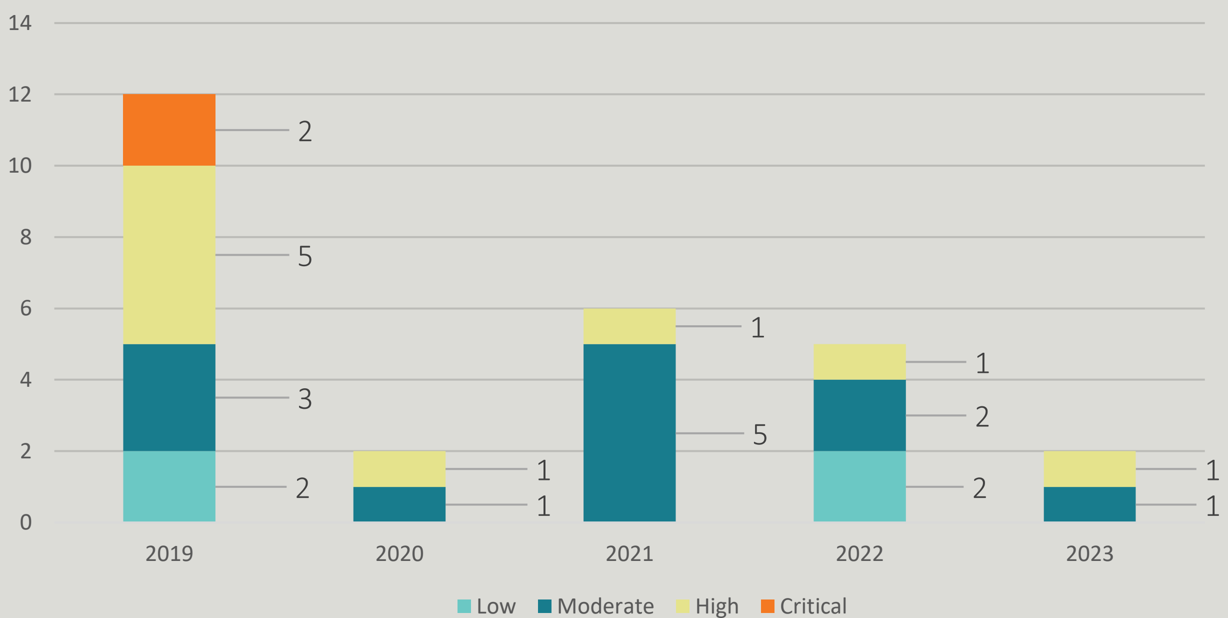
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

The Adult Acute Mental Health Unit, University Hospital Galway was located on the grounds of the University Hospital Galway. It had a bed capacity of 50, and it accommodated 49 residents at the time of the inspection. The approved centre was divided into four separate suites: Hazel, Ash, Holly, and Oak. It provided the following services: acute adult mental health care, psychiatry of later life, and mental health care for people with intellectual disabilities. The approved centre was also registered to provide care for individuals without a home. The registered proprietor was the Health Service Executive.

Thirteen consultant-led teams admitted residents to the approved centre, including Galway sector teams, psychiatry of later life teams, a mental health intellectual disability team, a rehabilitation and recovery team, and a mental health for homeless people team. Two more consultant-led teams had admitting rights; the liaison psychiatry team, and the perinatal mental health team.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	67%	94%	83%	86%	94%

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

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*21/07/2022*	*Further to numerous overcapacity notifications received across CHO 2, the Mental Health Commission decided to issue an Immediate Action Notice.*	*The approved centre submitted protocols regarding overcapacity escalation in the approved centre and the Mental Health Commission continues to closely monitor the notifications.*

Warning Letter	*27/01/2023*	*Further to the overcapacity notifications received the Mental Health Commission decided to issue a warning letter.*	*The approved centre submitted a Risk Assessment and the Mental Health Commission continued to monitor the overcapacity. This issue was further escalated in July 2023 as part of CHO 2 wide escalation.*

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre***: There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** All staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act.
- ***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***: All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Access to essential information***: The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Infection control***: The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Staffing:*** The numbers of occupational therapy staff were not appropriate to the assessed needs of residents. The approved centre had a designated senior occupational therapist but two staff grade occupational therapy posts were vacant.

Appropriate care and treatment of residents

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

- **Appropriateness of environment:** The layout and the decoration of the Adult Acute Mental Health Unit in University Hospital Galway was of a high standard and met the needs of the residents.
- ***Initial assessments***: All residents had a comprehensive initial assessment on admission.
- ***Physical assessment***: Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) that documented the resident's needs, goals that had been decided with the resident's input, and appropriate interventions to address those goals. There was an identified staff member to deliver the interventions. Each ICP had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, social worker, registered psychiatric nurse, a psychologist, a senior occupational therapist and a dietitian. There were regular multi-disciplinary team meetings to discuss residents' care plans. There was one occupational therapist working in the approved centre.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan. The therapeutic programme included group and individual work, incorporating psycho-education, trauma informed groups, sensory groups, discharge planning, MOHO (Model of Human Occupations) assessments, seating assessments, AMPS (Assessment of Motor and Process Skills) assessment, music therapy, art therapy, and Safe Wards programme.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** There was a mixture of shared bedrooms and single en suite bedrooms.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialising. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy.

- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Privacy and dignity: CCTV:*** Monitoring systems in the approved centre were not viewed solely by the health professional with responsibility for the resident. Two monitors, that displayed multiple images of both internal corridors and external areas, were observed in the security office adjacent to the entrance foyer. This office was staffed by an external security company who had access to view all images displayed on the monitors. Some of these images on the monitor displayed residents within the wards.

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***: Residents had access to a library, pool table, television, DVDs, music, outdoor exercise equipment, board games, playing cards, arts and crafts material, gardening, and walking groups.
- ***Residents' feedback:*** The residents were complimentary of staff in the approved centre. One resident completed a service-user questionnaire and rated their overall experience of care and treatment as 8 (out of 10).

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was under the governance of Community Healthcare West which consisted of the counties Mayo, Galway, and Roscommon. The Galway and Roscommon Mental Health Services overarching governance process encompassed the monthly Area Management Team Meeting and the Quality and Safety Committee.
- ***Leadership:*** Within the approved centre, the governance was enhanced by a local Acute Unit Business Meeting which was schedule for every 6-8 weeks but only one meeting occurred on 21st January 2023 from October 2022 to April 2023. The Acute Unit Business Meeting was supported by various committees, and sub-groups. The approved centre has very strong leadership and leadership achieved an improvement of 8% in compliance between 2022 (86%) and this year 2023 (94%).
- ***Restrictive practices reduction:*** The approved centre had a strategy in place to reduce restrictive practices. The Rule on the Use of Seclusion and the Code of Practice on Physical Restraint were deemed compliant. The approved centre did not use Mechanical Restraint.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk-assessed. Risk assessments had been completed for identified risks and included on the local risk register which was reviewed regularly and escalated where appropriate.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. The approved centre had implemented six quality improvements since the last inspection, including: the approved centre's information booklet was reviewed and updated with the Area Lead for Mental Health Engagement to enhance the recovery ethos within the approved centre and to ensure that the information was up to date. (*Please refer to section 2.0 of this report for a full list of quality initiatives).*
- ***Policies:*** The approved centre's policies were up-to-date.
- ***Staff training:*** All staff had received mandatory training. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development.
- ***Complaints:*** There was a robust complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Residents' feedback was also obtained via the complaints, compliments, and feedback process, which was displayed throughout the approved centre.
- ***Advocacy services:*** A designated advocate from the Peer Advocacy in Mental Health Network visited the approved centre regularly and spoke with residents.
- ***Regulatory compliance and engagement:*** The approved centre has had a high average compliance rate of 94% over the last 4 years. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- **Risk: Staffing:** The numbers of occupational therapy staff were not appropriate to the assessed needs of residents. The approved centre had a designated senior occupational therapist but two staff grade occupational therapy posts were vacant.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The Restrictive Practices Multi-disciplinary and Oversight Committee revised the seclusion and restraint pathways to meet the rights of individuals subjected to restrictive practices.

2. The Restrictive Practices Multi-disciplinary and Oversight Committee also introduced the BEVAN debrief tool to provide a structured way to assist in the debriefing of service users after a restrictive practice.

3. The occupational therapy department established a fortnightly individual care plan (ICP) group to promote service user engagement with their ICP.

4. A new Medication Prescription and Administration Recording (MPAR) was devised and implemented by the Senior Pharmacist with assistance from the Drugs and Therapeutic Committee; the new MPAR enhanced safe prescribing and administration of medications.

5. The information booklet was reviewed and updated with the Area Lead for Mental Health Engagement to enhance the recovery ethos within the approved centre and to ensure that the information was up to date.

6. The approved centre, in conjunction with the Irish Centre Applied Patient Safety and Simulation with University of Galway, rolled out simulations on physical health emergencies such as myocardial infarction, sepsis, and respiratory distress in acute mental health units. This quality improvement project provided learning for the approved centre's healthcare professionals.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Adult Acute Mental Health Unit, University Hospital Galway was located on the grounds of the University Hospital Galway. The approved centre was registered for 50 beds and consisted of four separate suites: Hazel, Ash, Holly, and Oak. Thirteen consultant-led teams admitted residents to the approved centre, including Galway sector teams, psychiatry of later life teams, a mental health intellectual disability team, a rehabilitation and recovery team, and a mental health for homeless people team. Two more consultant-led teams had admitting rights; the liaison psychiatry team, and the perinatal mental health team.

Access to the building was facilitated by security staff, located in the main reception. Hazel, Oak and Ash suites were all located on the ground floor. Ash and Hazel were general adult units, which consisted of 18 and 19 beds respectively. Hazel suite contained one three-bedded and two two-bedded bedrooms. Ash suite contained one three-bedded and one two-bedded bedrooms. Both Hazel and Ash suites had access to a shared area, which contained a dayroom, a games room, a quiet room, a dining area, and an outdoor garden area. Oak suite was a high observation unit and consisted of five single en suite bedrooms. Oak suite also contained a dining room, a relaxation room, a seclusion facility, and an outdoor garden area.

Holly suite, located on the first floor, consisted of eight single en suite bedrooms, and was dedicated to Psychiatry of Later Life. Residents had access to an outdoor enclosed space, which contained seating areas and raised garden beds. The first floor also housed administration/management offices, training rooms, an Electroconvulsive Therapy (ECT) suite and therapy facilities that included a relaxation room, an art room, and a therapy kitchen.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**49**
Number of detained patients	15
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	5
Number of patients on Section 26 leave for more than 2 weeks	4

3.2 Governance

The approved centre was under the governance of Community Healthcare West, which consisted of the counties Mayo, Galway, and Roscommon. There were two area management teams; Mayo Mental Health Service and the Galway and Roscommon Mental Health Service. The Galway and Roscommon Mental Health

Services overarching governance process encompassed two core monthly meetings; Area Management Team Meeting and the Quality and Safety Committee. Minutes of these meetings were provided to the inspection team. Standing agenda items included; risks management, health and safety, quality improvements, human resources updates and key performance indicators. Within the approved centre, the governance was enhanced by a local Acute Unit Business Meeting, which was scheduled every 6-8 weeks. However, only one meeting occurred on 21st January 2023 from October 2022 to April 2023. The Acute Unit Business Meeting was comprehensive meeting and covered a range of topics such as operational issues, quality, safety and risk, restrictive practices and audit. The Acute Unit Business Meeting was supported by various committees, sub-groups, and meetings. For example; Consultant Meetings, Nursing Meetings, Resident Feedback meetings, Clinical Governance meetings, Galway General Hospital meetings, daily Safety Pause Meetings, Restrictive Practice Review Committee, Drugs and Therapeutic Committee, Delayed Discharge Meetings, and Garda Liaison group Meetings.

There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability within the approved centre. The Galway and Roscommon Mental Health Services' General Manager was the Approved Centre's Registered Proprietor nominee. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development. Regarding Regulation 26 Staffing, the approved centre had a designated senior occupational therapist. However, two staff grade occupational therapy posts were vacant.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. 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 occurring in the service. In line with the approved centre's Risk Management policy, the local risk register was reviewed regularly. Examples of key risks identified by the approved centre were; potential unavailability of admission beds, limited availability of dietetics and ligature anchor points. The Mental Health Commission received eight notifications of overcapacity in the approved centre since the last inspection. However, the approved centre had implemented processes to mitigate this risk; the last occurrence of overcapacity was in January 2022. In response to identified risks, it was anticipated that a new designated dietitian post would be filled in September 2023. Furthermore, the approved centre had implemented a significant ligature reduction programme since the last inspection in June 2022.

Mental Health Engagement and Recovery was a standing agenda item of the Galway and Roscommon Mental Health Services Area Management Team meeting. The Area Lead for Mental Health Engagement was a member of the Galway and Roscommon Area Management Team and the Quality and Safety Committee. A designated advocate from the Peer Advocacy in Mental Health Network visited the approved centre regularly and spoke with residents. Residents' feedback was also obtained via the complaints, compliments, and feedback process, which was displayed throughout the Approved Centre.

The Mental Health Commission's new Rule on the Use of Seclusion and the Code of Practice on the Use of Physical Restraint were implemented on 1st January 2023. The approved centre had a new Restrictive Practice Reduction Policy and the Registered Proprietor had appointed a named Senior Manager who was

responsible for the approved centre's reduction of restrictive practices. The approved centre established a Restrictive Practices Multi-disciplinary and Oversight Committee, in which all restrictive practices were reviewed. On inspection this year, the Rule on the Use of Seclusion and the Code of Practice were deemed compliant.

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 25: CCTV	✗	Moderate	✓		✓		✓		✗	High
Regulation 26: Staffing	✗	High	✓		✗	Moderate	✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, 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 three residents during the inspection. The residents were complimentary of the staff within the approved centre. All three residents raised specific concerns regarding their individual care and treatment; with the residents' consent, the inspection team discussed these issues with the relevant nursing staff.

The inspection team also received one completed service user experience questionnaires. On a scale of 1 – 10, with 1 being poor and 10 being excellent, the resident rated their overall experience of their care and treatment as 8. The resident reported that they understood their Individual Care Plan (ICP) and that they knew their multi-disciplinary team (MDT) member.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the Peer Advocacy in Mental Health representative.

Positive aspects of the service included:

- The food was nice and there was enough of it
- No complaints about cleanliness
- The approved centre had a pool table
- Occupational therapy input within the unit
- Staff are friendly and attentive

Areas in Need of Improvement:

- Complaints about the short visiting hours
- Comments were made about the absence of ash trays outside
- Reports that the days are long in the approved centre
- Some service users felt they were not ready to go home and were worried about what supports they would receive once discharged

6.0 Feedback Meeting

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

- Clinical Director
- Area Director of Nursing
- Occupational Therapy Manager
- Acting Principal Social Worker (nominee)
- Principal Psychologist
- Psychologist
- Registered Proprietor
- Business Manager
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Electro-Convulsive Therapy (ECT) Nurse
- Mental Health Act Administrator
- Pharmacist
- Maintenance Manager
- Dietitian in Charge

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 resident identifiers - name, date of birth, and medical record number (MRN) - 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.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, and serving of food. Hygiene was maintained to support food safety requirements, 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 November 2021. 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. Residents had access to a library, pool table, television, DVDs, music, outdoor exercise equipment, board games, playing cards, arts and crafts material, gardening, and walking groups.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

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

The 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 August 2020.

Visiting times were appropriate and reasonable, and the justifications for any visiting restrictions were documented in the clinical file. Appropriate steps were taken to ensure the safety of residents and visitors during visits. 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. 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 January 2023.

Residents in the approved centre had access to mail, e-mail, Internet, telephone or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health. Residents had access to guest Wi-Fi and no resident had any restriction on their communication at the time of inspection.

It was the approved centre's policy that 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. No resident communication was examined at the time of inspection.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The clinical files of two residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. Where consent was not received, this was documented and the process relating to searches without consent was implemented. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A minimum of two clinical staff were in attendance at all times during the searches, and due regard was shown to the resident's dignity, privacy, and gender. At least one of the staff members conducting the search were the same gender as the resident being searched. A written record of every resident and property search was available, which included the reason for the search, the names of both

staff members who undertook the search, and details of who was in attendance for the search. Policy requirements were implemented when illicit substances were found as a result of a search.

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 January 2023.

There were no deaths in the approved centre since the last inspection.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to review by the MDT in consultation with the resident, weekly in an acute setting, and at least every six months for residents in a continuing care facility. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. The therapeutic programme included group and individual work, incorporating psychoeducation, trauma informed groups, sensory groups, discharge planning, MOHO (Model of Human Occupations) assessments, seating assessments, AMPS (Assessment of Motor and Process Skills) assessment, music therapy, art therapy, and Safe Wards programme.

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

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in August 2020. The clinical file of one resident who had been transferred from the approved centre was inspected. It was an emergency transfer and all required documentation was sent with the resident on transfer. Communications between the approved centre and the receiving facility were documented and followed up with a written referral.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in October 2021. The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator (AED). Residents received appropriate general health care interventions in line with individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs, but not less than every six months. Referral to physiotherapy, dietitian, chiropody, and out-patient general health specialties was evident from clinical files.

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

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

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written provision of information policy and procedures in place. The policy was last reviewed in February 2021.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support 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 was appropriate, and staff showed discretion when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room, as appropriate.

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. Where residents shared a room, bed screening ensured that their privacy was not compromised. 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; pull-down roller blinds were in use for all patient communication boards. Residents were facilitated to make private calls.

The approved centre was compliant with this regulation.

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. Underfloor centrally controlled heating provided 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 large external gardens. 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.

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

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

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

The approved centre was compliant with this regulation.

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in November 2021, and included the following requirements:

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

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

All entries in the MPARs were legible, and included the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. Where a resident's medication was withheld, the justification was noted in the MPAR and also documented in the clinical file. The pharmacist was consulted about the type of preparation to be used.

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

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in November 2021. The approved centre's Health and Safety Statement had been reviewed and updated as required.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating HIGH

(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 October 2022.

The inspection found that there were clear signs in prominent positions where CCTV cameras or other monitoring devices were utilized throughout the approved centre. The approved centre's use of CCTV and any other monitoring system was disclosed to residents, residents' representatives, and the Mental Health Commission. Residents were monitored solely for the purpose of ensuring their health, safety and welfare. However, monitoring systems in the approved centre were not viewed solely by the health professional with responsibility for the resident. Two monitors, that displayed multiple images of both internal corridors and external areas, were observed in the security office adjacent to the entrance foyer. This office was staffed by an external security company who had access to view all images displayed on the monitors. Some of these images on the monitor displayed residents within the wards.

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 non-compliant with this regulation because CCTV cameras used to observe residents transmitted images to a monitor that was not viewed solely by the health professionals responsible for the health and welfare of the resident, 25(1)(d).

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in February 2021, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

Residents within the approved centre had access to medical, nursing, social work, psychology, and occupational therapy disciplines. The approved centre had a designated senior occupational therapist, a social worker and a psychologist. While the approved centre had a designated senior occupational therapist, two staff grade occupational therapy posts were vacant.

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

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (68)	68	100%	68	100%	68	100%	68	100%
Medical (28)	28	100%	28	100%	28	100%	28	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%

Psychologist (1)	1	100%	1	100%	1	100%	1	100%
Pharmacist (1)	1	100%	1	100%	1	100%	1	100%
Dietitian (1)	1	100%	1	100%	1	100%	1	100%

The approved centre was non-compliant with this regulation as there were two staff grade occupational therapy vacancies at the time of inspection, 26(2).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and assisted the patient where necessary.

The approved centre 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 February 2021, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management, last reviewed in November 2021, as well as a site-specific safety statement, an emergency plan, and various other risk-related policies. Together, these policies addressed all the requirements for this regulation, including the following:

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

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 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was last reviewed in December 2022. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. Material and equipment for ECT, including emergency drugs, were in line with best international practice. There was a facility for monitoring EEG on two channels. ECT machines were regularly maintained and serviced, and this was documented. There was confirmation of servicing of ECT machines. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical record of one involuntary patient receiving ECT was reviewed. As the patient had been assessed as not having capacity to provide consent, ECT was administered according to section 59(1)(b) of the Mental Health Act 2001, and a *Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent* was completed by two consultant psychiatrists (CPs). The Form 16 was placed in the patient's clinical file and a copy was sent to the Mental Health Commission within five days. Both CPs

assessed and recorded how ECT would benefit the patient, any discussion with and views expressed by the patient, any assistance provided in relation to the discussion and views expressed, and the patient's capacity to consent to ECT.

The programme of ECT was only prescribed by the responsible CP. The prescription for ECT was recorded in the patient's clinical file, and the record included: the reason for the decision to use ECT; alternative therapies that were considered or proved ineffective; and documentation of discussion with the patient and, where appropriate, their next of kin or representative.

The initial stimulus dose was discussed and considered by the treating CP and CP responsible for ECT in advance of treatment and prescribed accordingly. Cognitive assessments were completed before each programme of ECT, and the patient's clinical status was assessed before and after each ECT treatment session. The patient's cognitive functioning was monitored throughout the ECT programme. Cognitive assessment, in line with best international practice, was completed after each ECT programme. In consultation with the patient, the CP reviewed the patient's progress and need for continuation of ECT, and if the programme of ECT was terminated, a reason was documented in the clinical file.

A pre-anaesthetic assessment was also recorded in the patient's clinical file and included all requirements, such as a duration of fasting, detailed medical history and full physical exam. Anaesthetic risk was assessed and recorded by the anaesthetist, and the variation in risk was recorded before the ECT treatment. A consistent anaesthetic induction agent was used throughout the programme of ECT, unless contraindicated. The doses of anaesthetic agents used, the patient's response, the monitoring of recordings before and after treatment, and the patient's recovery were recorded, dated, signed, and placed in the clinical file by the anaesthetist. The ECT was only given by a registered medical practitioner and was administered by constant current, brief pulse ECT machine. The stimulus dosing, or recommended starting dose regimes, as relevant, was used and documented in the ECT record.

The approved centre was compliant with this rule.

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. It had been reviewed annually and was last reviewed in December 2022.

The policy addressed the following:

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

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

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

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

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

Monitoring: A multi-disciplinary review and oversight committee had been established and was meeting on a quarterly basis to analyse every episode of seclusion in detail.

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

The seclusion facilities and furnishings were compliant with all other requirements of the Rules.

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

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

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

Where close confinement was contraindicated, seclusion was only used when all other options had proven unsuccessful and following risk assessment. The clothing worn in seclusion respected the right of the residents to dignity, bodily integrity and privacy.

The residents placed in seclusion were kept under direct observation by an RN for the first hour following the initiation of seclusion. After the first hour, an RN kept the residents under continuous observation and

remained within sight and sound of the seclusion room throughout the episode. A written record of the resident was made by the RN every 15 minutes.

Following risk assessment, a nursing review of the residents took place every two hours. During this review, a minimum of two staff members entered the seclusion room and assessed the resident to determine whether the episode could be ended. This assessment and decision were recorded. A medical examination was carried out by a RMP every four hours. For each review, the decision to end or continue seclusion was recorded.

Ending of Seclusion: The residents were informed of the ending of each episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date the seclusion was ended. An in-person debrief followed each episode. This occurred within two working days of the episode, unless it was the preference of the resident to have the debrief outside of this timeframe. The debrief was person-centred, gave the residents the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved with their care and treatment, and included where appropriate a discussion regarding alternative de-escalation strategies that could be used to avoid future use of restrictive interventions.

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

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

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

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

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

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

INSPECTION FINDINGS

The clinical files of four patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication were examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment for all four; one of the four was deemed to have capacity to consent, whereas the other three were unable to consent.

In respect of the patient who had capacity to consent, there was a written record of consent which detailed the following:

- The name of the medications prescribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of a discussion with the patients, including on the nature and purpose of the medications, the effects of medications such as the risk and benefits, and any views expressed by the patient.

- Any supports provided to the patient in relation to the discussion and their decision-making.

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

- The names of the medications proscribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in December 2022, and addressed the following:

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

Policies and procedures regarding staff training included the following:

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

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

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

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

Monitoring: The approved centre had established a multi-disciplinary review and oversight committee to meet quarterly and analyse every episode of physical restraint in detail.

Evidence of Implementation: Three episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there

were no other less restrictive methods available to manage the person's presentation. The consultant psychiatrist (CP) or duty CP was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the resident had been completed no later than two hours after the start of each episode of restraint.
The orders for physical restraint did not exceed a duration of 10 minutes. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode, and signed by the consultant psychiatrist within 24 hours.

The residents were informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical file as soon as was practicable.

The residents' representatives were informed of the physical restraint as soon as practicable, in accordance with the residents' wishes and their individual care plans (ICPs). Where the resident's representative was not informed, there was a record explaining why this did not occur in the clinical file. The Mental Health Commission was notified via Comprehensive Information System (CIS) of the start time and date, and the end time and date, of each episode of physical restraint in the correct format and within three days of each episode.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the person's ICP pertaining to the person's specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy.

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

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

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

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

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

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

The multi-disciplinary team recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the residents. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

The approved centre was compliant with this code of practice.

Use of Electro-Convulsive Therapy (ECT) for Voluntary Patients

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary residents. The policy had been reviewed annually and was last reviewed in December 2022. It contained protocols that were developed in line with best international practice, including

- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in ECT had been trained in line with best international practice. All staff involved in ECT had appropriate training in Basic Life Support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite for the delivery of ECT. The ECT suite had a private waiting room and adequately equipped treatment and recovery rooms. Material and equipment for ECT, including emergency drugs, were in line with best international practice. There was a facility for monitoring EEG on two channels. ECT machines were regularly maintained and serviced, and this was documented. There was confirmation of servicing of ECT machines. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for the management of cardiac arrest, anaphylaxis, and malignant hyperthermia were prominently displayed. A named consultant psychiatrist had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The file of a voluntary resident who had received ECT was reviewed. All relevant requirements relating to capacity and consent were followed by the approved centre and the appropriate information on ECT given to the resident by the consulting psychiatrist (CP). The resident had capacity to understand and received appropriate verbal and written information explaining the nature, purpose, procedure, benefits, consequences of not receiving ECT, alternative treatments, and side-effects of the treatment proposed.

The programme of ECT was only proscribed by the responsible CP. The prescription for ECT was recorded in the resident’s clinical file, and the record included: the reason for the decision to use ECT; alternative therapies that were considered or proved ineffective; and documentation of discussion with the patient

and, where appropriate, their next of kin or representative. The initial stimulus dose was discussed and considered by the treating CP and CP responsible for ECT in advance of treatment and prescribed accordingly. A pre-anaesthetic assessment was also recorded in the patient's clinical file and included all requirements, such as a duration of fasting, detailed medical history and full physical exam.

The resident had capacity to make a free choice whether to receive ECT or not. The resident was given 24 hours to reflect on the information they were given and was informed of their right to access an advocate of their choosing. The resident could raise questions at any time, and these were answered. The resident communicated their decision to consent to each programme of ECT in writing to the consultant psychiatrist or a registered medical practitioner. An assessment of capacity to consent was undertaken and documented. Evidence of systematic monitoring of cognitive functioning throughout the programme of ECT was documented, ensuring that the resident could give informed consent for ECT, including anaesthesia.

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

Transfer: The transfer policy, which was last reviewed in August 2020, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in December 2022, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

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

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

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

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10004489		CCTV cameras used to observe residents transmitted images to a monitor that was not viewed solely by the health professionals responsible for the health and welfare of the resident, 25(1)(d).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Access to the CCTV in the security office has been restricted in keeping with MHC feedback. Where CCTV cameras are used to observe residents ,these are viewed solely by health professionals responsible for the health and welfare of the resident.	Audit in keeping with the audit cycle for regulation 25 CCTV.	The restricted access to CCTV by security staff will reduce observations within the approved centre, however, this is required to achieve compliance based on the MHC's interpretation of regulation 25.	27/02/2024	Mr. Steve Jackson (registered proprietor)
Preventative Action	CCTV will continue to be audited as per audit cycle.	Audit in keeping with the audit cycle for regulation 25 CCTV.	The restricted access to CCTV by security staff has been achieved with consequent reduction in observations within the approved centre. See attached report from CCTV maintenance company Cube.	27/02/2024	Mr. Steve Jackson

Regulation 26: Staffing

Reason ID : 10004490		The approved centre was non-compliant with this regulation as there were two staff grade occupational therapy vacancies at the time of inspection, 26(2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The corrective action(s) to address the area of non-compliance/concern was that the recruitment process for the lack of 2 x Occupational Therapy staff grade posts was underway at the time on inspection and they have since commenced in post.	Staff are now in post	The barriers to implementation was related to the delay in recruiting staff due to the recruitment process through HBS Recruitment	27/02/2024	Esther Crowe Mullins, Occupational Therapy Manager
Preventative Action	Ensure recruitment department are aware of the importance of filling posts in a timely manner to avoid staffing deficits. Ensure manager submits appropriate documentation once they are informed a staff member is leaving to expediate recruitment.	Monitor staffing levels	The barriers to implementation require collaboration between recruitment and line management. HSE are required to adhere to the recruitment license and obtain references, garda vetting, etc. which is a factor.	27/02/2024	Esther Crowe Mullins, Occupational Therapy Manager

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.

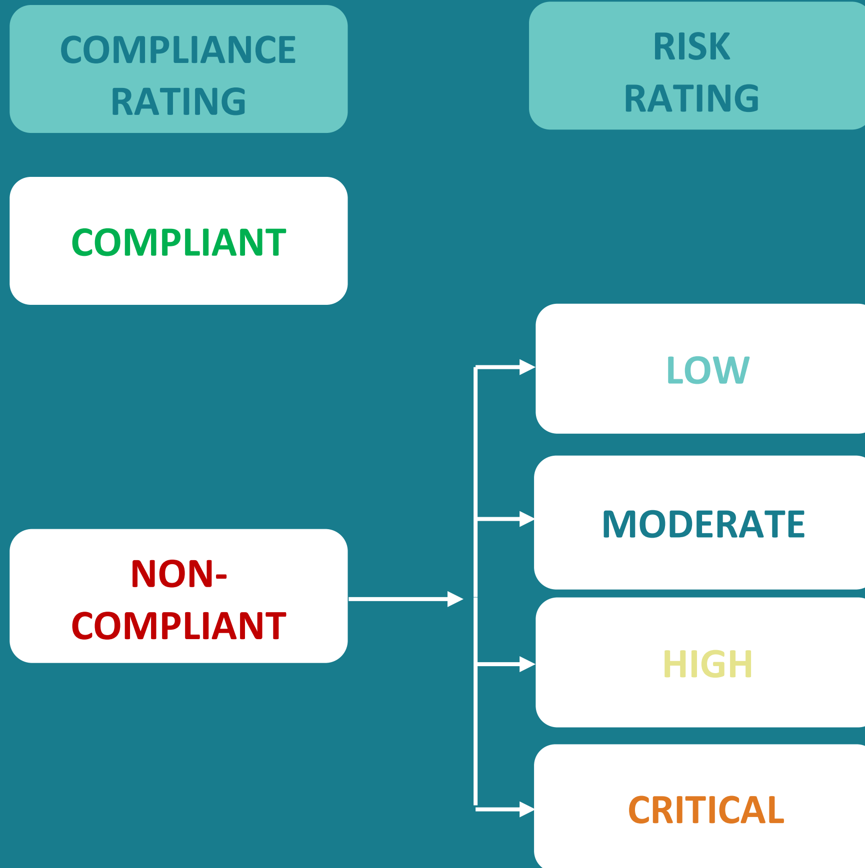
Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services 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.



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.