# Adult Mental Health Unit, Mayo University Hospital

Annual Inspection Report 2023

*Promoting Quality, Safety and Human Rights in Mental Health*

# ADULT MENTAL HEALTH UNIT, MAYO UNIVERSITY HOSPITAL

Castlebar, Co. Mayo, F23H529

**Date of Publication:**
02 April 2024

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## 2023 Approved Centre Inspection Report (Mental Health Act 2001)

**Approved Centre Type:**
Acute Adult Mental Health Care

**Conditions Attached:**
None

**Most Recent Registration Date:**
1 March 2023

**Registered Proprietor:**
HSE

**Registered Proprietor Nominee:**
Mr Steve Jackson, General Manager, Mental Health Services, Community Healthcare West

**Inspection Team:**
Martin McMenamin, Lead Inspector
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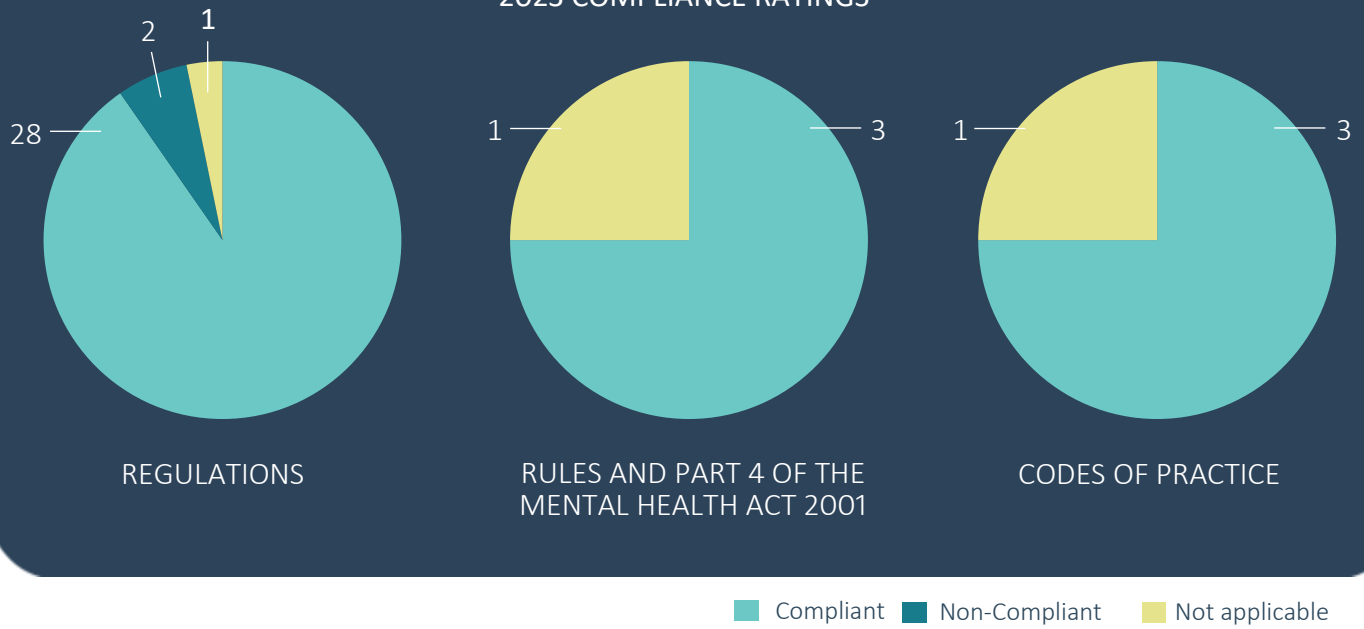
**The Inspector of Mental Health Services:**
Dr Susan Finnerty MCRN009711

**Inspection Date:**
25 – 28 July 2023

**Previous Inspection date:**
11 – 14 October 2022

**Inspection Type:**
Announced Annual Inspection

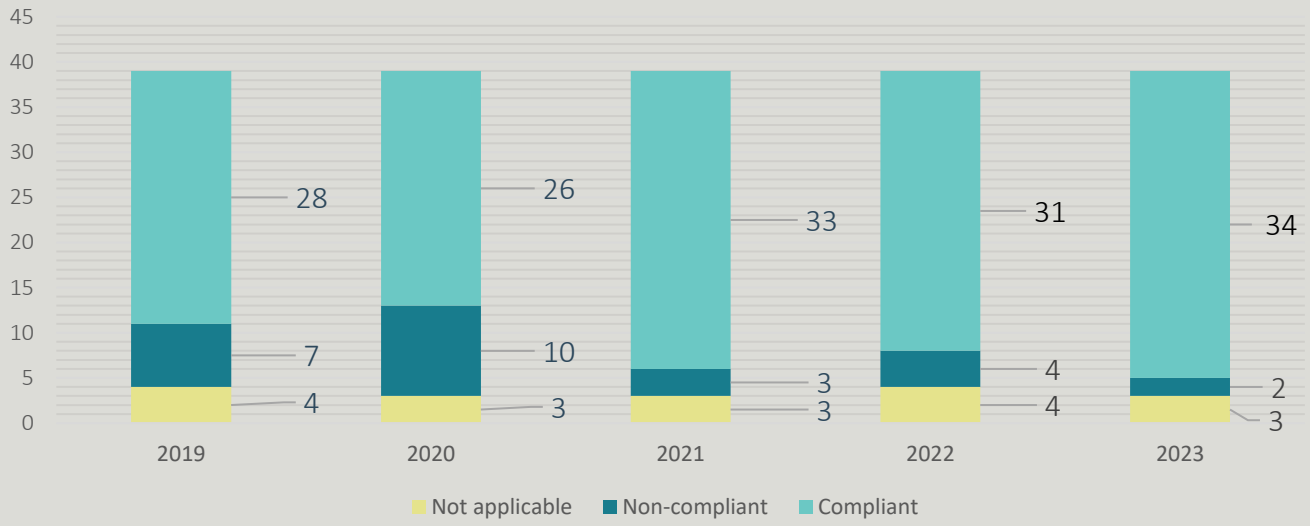
2023 COMPLIANCE RATINGS



## RATINGS SUMMARY 2019 – 2023

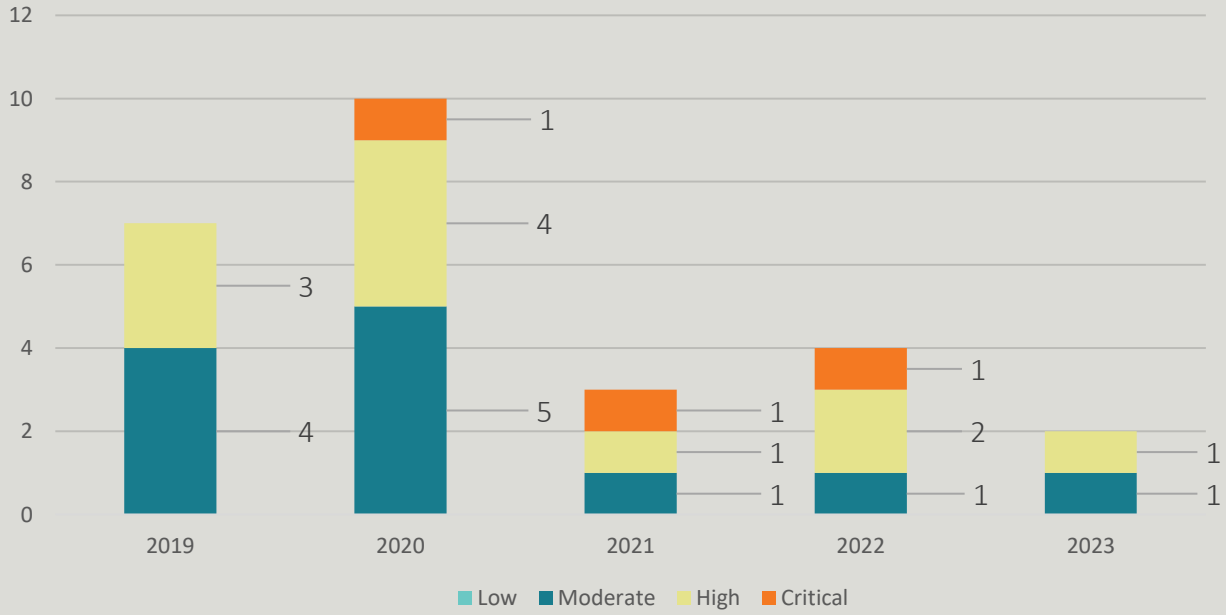
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

### CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023




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

### CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



# Contents

# 1.0 Inspector of Mental Health Services – Review of Findings

## Inspector of Mental Health Services — Dr Susan Finnerty

## In brief

The Adult Mental Health Unit (AMHU) was located on the ground floor of Mayo University Hospital (MUH). It provided acute adult mental health care services. Sleeping accommodation was a mixture of a small number of single bedrooms, and dormitory style accommodation which had up to five single beds within each dormitory. The approved centre was registered for 32 beds and at the time of the inspection accommodated 24 residents. Admissions to the unit were referred from any of the area's five adult community mental health care teams, and four specialist teams (Psychiatry of Old Age Teams: North Team and South Team; the Mental Health Intellectual Disability Team; and the Rehabilitation and Recovery Team).

| Compliance Summary | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| % Compliance | 80% | 72% | 92% | 89% | 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.* |

## 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:**

- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*:** All residents had an individual risk assessment 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. Hazards were minimised.
- ***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:

- ***Mandatory training:*** While all staff were up-to-date with training in the Mental Health Act 2001, not all staff were trained in fire safety, basic life support, and the management of violence and aggression.
- ***Cleanliness:*** The approved centre was not kept in a good state of repair. Walls and windowsills of the main garden area, and the walls and windowsills in the High Dependency Unit courtyard were dirty and paint was peeling off the walls. The main garden area paving and the High Dependency Unit courtyard paving was dirty.
- ***Ligature anchor points:*** Ligature points were not minimised to the lowest level, based on individual risk assessment.

## Appropriate care and treatment of residents

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

- ***Initial assessments:*** All residents had a comprehensive initial assessment on admission.
- ***Physical assessment:*** Each resident had a physical examination on admission. 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:*** There was evidence of significant engagement with residents in respect of their individual care plan (ICP). Each resident had an individual care plan 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 had access to a multi-disciplinary team (MDT) consisting of a social worker, occupational therapist, consultant psychiatrist, registered psychiatric nurse, a psychologist, and a dietitian. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan.
- ***Access to other medical services:*** Specialist therapeutic interventions, such as chiropody were available to residents when needed.
- ***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:*** Was a mixture of a small number of single bedroom accommodation, and dormitory style accommodation which had up to five single beds within each dormitory.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors. All bathrooms, showers, and toilets had locks on the inside of the door except in the case of an identified risk to the resident. Residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were pleasant areas where the resident could go if they wanted privacy as well as areas for socialisation. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Physical restraint and, separately, seclusion was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained by physical means, and for each person placed in seclusion, including information on attempts to reduce or eliminate the use of restraint and seclusion for the relevant person. Mechanical restraint was not used in the approved centre. The approved centre was compliant with the Code of Practice on Physical Restraint and with the Rules Governing Seclusion.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There

was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

## Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***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***: Included television, books, board games, newspapers, magazines, music, keyboard, arts, movies, jigsaws, bingo, gardening, community kick start football, therapeutic journaling, and table tennis, indoor and outdoor exercise equipment, cookery demonstrations by chefs, peer support workers provided information sessions, and a daily newspaper group was established by the occupational therapist was available to residents. Residents had access to the activity room on the weekends.
- ***Residents' feedback:*** The residents were very complimentary about their environment and care received. All residents were aware of their weekly multi-disciplinary team (MDT) meeting and had been offered a copy of their care plan. Psychology and social work were especially valued by two residents. Many valued occupational therapy activities especially baking. Residents generally felt comfortable in sharing rooms with others, though some residents expressed that there is some noise at night making it hard to sleep. *(Please refer to Section 5.1 of this report for more detailed resident feedback).*

However:

- ***Environment:*** Three single bedrooms and one dormitory bedroom were in need of repair. The hall to the main garden area had markings on the floor and walls and a loose ceiling tile. Armchairs in resident areas were torn and worn.

## Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was part of Community Healthcare West and was governed under the Mayo Mental Health Services (MMHS). The approved centre was closely aligned with Mayo University Hospital (MUH) for certain shared services including premises and maintenance, food supplies and pharmaceutical products and services. The approved centre operated an in-reach model of care.
- ***Leadership:*** The Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee (QPSC) meeting were both held monthly. Formal and informal structures and processes were in place for measuring and encouraging staff performance and personal development.
- ***Clinical governance:*** There were many areas of good clinical governance: Individual care planning processes were good, general health care provided met the needs of the residents and there was evidence in the files of multi-disciplinary team working and strong documentation. Audits were carried out.
- ***Restrictive practices reduction:*** The approved centre had implemented a Restrictive Practice Reduction Policy and strategy, 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 was compliant with the Rule on the Use of Seclusion and the Code of Practice on Physical Restraint and did not use Mechanical Restraint.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Risk management was supported by a Quality and Patient Safety (QPS) advisor who worked across the Mayo Mental Health Service. There were clear processes around risk assessments, maintaining a local risk register and escalation to the QPS committee for the Area Management Team (AMT) risk register as applicable.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. Significant refurbishment works were on-going since the previous inspection. Although not finished these quality improvements had made a significant impact in the approved centre. In addition, there were six *Quality Initiative Improvements* established since the last inspection including a new Medication Prescription and Recording (MPAR) document which had been developed, piloted and implemented (*please refer to section 2.0* of this report for details of all six quality initiatives).
- ***Policies:*** The approved centre's policies were up-to-date. Policies in the approved centre were developed by a multi-disciplinary steering Policies, Procedures, Protocols and Guidelines (PPPG) group.
- ***Staff training:*** Not all staff had received mandatory training.
- ***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. A weekly Patient Protected Time meeting, attended by residents and senior staff working in the approved centre, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement.

- ***Advocacy services:*** A representative from the Peer Advocacy in Mental Health service attended the approved centre on a weekly basis to meet with residents. Separately, representatives from the Irish Advocacy Service worked with individuals on a case-by-case basis and this was a by-referral arrangement.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 87% over the last four years. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- **Risk**: ***Ligature anchor points:*** Ligature points were not minimised to the lowest level, based on individual risk assessment.

# 2.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

1. A screening occupational assessment, scheduled for every resident within seven days of admission, had been initiated. Also, increased access to dietitian and psychology therapeutic services had been provided.

2. The approved centre had initiated a number of new therapeutic groups based on service user needs, including a psychologist providing a psychological skills groups and psychological therapies explained groups; medical trainees participating in a service user engagement group in conjunction with the University of Galway Medical Training programme; a new cognitive therapy group 'Coping through the Senses' provided by a clinical nurse specialist.

3. Environmental quality initiatives included the provision of a new phone charging station giving patients greater autonomy in charging of their phones.

4. The approved centre has developed and piloted a number of new documents which included physical restraint and seclusion care plan documents - developed to reflect the updated MHC Codes and Rules; upgrading of assessment and admission documentation booklets to include occupational therapy and further nursing assessments. Additionally, a new Medication Prescription and Recording (MPAR) document had been developed, piloted and implemented.

5. A Reducing Restrictive Practice (RRP) strategy was developed for the approved centre as well as the commencement of an oversight committee.

6. The approved centre had incorporated trauma informed care (TIC), cultural competency, human rights and positive behavioural support training within the TMVA training programme. The centre had also Introduced furniture including beanbags and de-escalation couches aimed towards reducing instances of restrictive practices.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

The Adult Mental Health Unit (AMHU) was located on the ground floor of Mayo University Hospital (MUH). The Adult Mental Health Unit was clearly signposted and accessible from the main hospital lobby. Within the unit appropriate infection prevention and controls protocols were in place, consistent with those of Mayo University Hospital.

The unit was comprised of a twenty-eight-bed single ward area with an accompanying high dependency unit (HDU) consisting of four single bedrooms and which also contained a seclusion room. There was a small courtyard style outdoor space that residents in the HDU could access. Within the main ward area, there were six dormitories, with four or five beds in each, and two single rooms. The unit contained facilities to provide recreational and therapeutic programmes and residents had access to an outdoor space. The unit also contained a reception area, a visiting room, an interview room, as well as a furnished seating area within the foyer. There was a large dining room, activity rooms, a quiet room that was suitable for visitors, and a garden with outdoor exercise equipment.

Maintenance upgrading works since the last inspection included the refurbishment of a number of bathrooms, toilets and showers, and refurbishment of the bedroom and dormitory areas had commenced, with suitable alternative arrangements to maintain bed capacity whilst works were ongoing. There were four occasions since the last inspection when marginal overcapacity of residents had occurred.

Admissions to the unit were referred from any of the area's five adult community mental health care teams, four specialist teams (Psychiatry of Old Age Teams: North Team and South Team; the Mental Health Intellectual Disability Team; and the Rehabilitation and Recovery Team). The service also had a liaison psychiatry team working directly in MUH. The approved centre facilitated Electroconvulsive Therapy (ECT) and there was an ECT suite on site. The approved centre was accredited with the Electroconvulsive Therapy Accreditation Service (ECTAS).

The approved centre adopted the in-reach model of care. The medical team, and the associated health and social care professionals from the respective sector teams attended the approved centre to provide care and treatment for their service users. The Mayo Mental Health Services in association with Mental Health Ireland provided a Family Peer Support service to family members and friends of adult people with mental health challenges including those admitted to the approved centre.

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

| **Resident Profile** | |
|---|---|
| ***Number of registered beds*** | ***32*** |
| **Total number of residents** | **24** |
| Number of detained patients | 5 |

| | |
|---|---|
| Number of wards of court | 1 |
| Number of children | 0 |
| Number of residents in the approved centre for more than 6 months | 4 |
| Number of patients on Section 26 leave for more than 2 weeks | 0 |

## 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 Adult Mental Health Unit (AMHU) was one of four approved centres under the governance of Mayo Mental Health Services (MMHS) and all were located in Castlebar town. The approved centre was closely aligned with Mayo University Hospital (MUH) for certain shared services including premises and maintenance, food supplies and pharmaceutical products and services.

There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability within the approved centre. Mayo Mental Health Service's governance processes encompassed two core monthly meetings: The Mayo Mental Health Services Area Management Team meeting and Quality and Patient Safety Committee (Q&PSC) meeting. Both meetings were scheduled monthly, and the meeting minutes were provided to the inspection team. The minutes evidenced discussions on key issues such as: risk management; quality initiatives; complaints and compliments; policies, procedures, protocols, and guidelines; regulatory compliance; resource requirements; and performance monitoring. These forums were further informed by various committees, sub-groups, and meetings. For example: Consultant Meetings, Nursing Meetings, Protected Patient Time meetings, Clinical Risk and Governance meetings, Restrictive Practice Review Committee, Drugs and Therapeutic Committee, Delayed Discharge Meetings, and Garda Liaison Group Meetings. There was also a working group based on enabling compliance with the Mental Health Commission's 'Judgement Support Framework' (JSF).

Senior management of the approved centre held quarterly meetings with the general manager from MUH to discuss common topics and issues. There was a development plan for MUH which included a proposal for the building of a new adult mental health unit. The Adult Mental Health Unit management meeting was held monthly and attended by medical, nursing, administrative, and health and social care professionals. There was a weekly clinical risk and governance meeting that discussed clinical concerns such as the HDU, one-to-one special nursing or chaperone requirements, restrictive practices, admissions and discharges.

Mental Health Commission's governance questionnaires were returned by the Executive Clinical Director, Principal Psychologist, Principal social Worker, Occupational Therapy Manager, Business Manager, Dietitian manager and the Area Director of Nursing. All managers confirmed that formal and informal structures and processes were in place for measuring and encouraging staff performance and personal development. Key issues identified included: the premises with its lack of regular maintenance, not being fully compliant in terms of anti- ligature standards and inadequate space ; staffing of nursing and allied health professionals positions; the constant tension between providing community services while also providing in-patient care

on a sector basis; the increasing demand for in-patient care, Other issues cited were: over capacity on occasions; delayed discharges and high level of 'one to one' (staff/resident) observation requirements.

Overcapacity remained an issue for the approved centre - with an Immediate Action Notice (IAN) issued to the service in July 2023. The service had identified that part of the issue was linked to changing community demographics and the number of mandated admissions under the MHA 2001 [where an application and recommendation had been completed] and sometimes this had involved 'out of area' residents. However, the approved centre had implemented processes to mitigate this risk; a consultant led briefing on the Friday of each week sought to establish available bed capacity, facilitate transfers, discharge and manage admissions. Additionally, there were a number of delayed discharges identified within the unit. Whilst more suitable care environments had been identified, and funding for packages of care had been approved, these had not yet been actioned through, amongst other things, difficulties in securing the accommodation identified. There was no doubt that every effort was pursued to address this situation and whilst residents' needs were being met by MDT team members, their interventions would never be a complete substitute for the specialist services and environment each resident required in other identified services.

Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes. The risk management procedures identified risks and their controls, and these were reviewed at the Q&PSC. Those risks which were outside the scope or capacity of the Adult Mental Health Management Team had been escalated to the Risk Register at area management level as appropriate.

Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. A named person with responsibility for risk management processes was known throughout the approved centre. It was understood that everyone had a responsibility for risk management through line management structures as appropriate. Risk management was supported by a Quality and Patient Safety (QPS) advisor who worked across the Mayo Mental Health Service. There were clear processes around risk assessments, maintaining a local risk register and escalation to the QPS committee for the Area Management Team (AMT) risk register as applicable.

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. All reported Serious Reportable Events (SREs), system analysis investigations; review panel reports and investigations were discussed at the Q&PSC and recorded systematically and actively managed. The approved centre's policies were developed by a multi-disciplinary steering Policies, Procedures, Protocols and Guidelines (PPPG) group.

The approved centre operated an in-reach model of care. This required medical and health and social care professionals from the treating teams to visit the approved centre and provide care and treatment to any resident from that sector or specialist team. These teams were supported by staff who worked directly in the approved centre, namely nursing staff and two occupational therapists. Additionally, a senior psychologist had commenced working directly in the approved centre two days per week. Plans were underway to transition to an inpatient consultant-led team, where residents would transfer temporarily to that team for care and treatment for the duration of their admission.

The Mental Health Commission's revised Rule on the Use of Seclusion, Rules Governing the Use of Mechanical Means of Bodily Restraint (2023) and the Code of Practice on the Use of Physical Restraint (2023) had been implemented on 1st January 2023. The approved centre had implemented 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, the approved centre had met these obligations in full, with the Rule on the Use of Seclusion and the Code of Practice on Physical Restraint being found compliant.

A representative from the Peer Advocacy in Mental Health service attended the approved centre on a weekly basis to meet with residents. Separately, representatives from the Irish Advocacy Service worked with individuals on a case-by-case basis. The latter was by referral, and available to any resident in the approved centre. There was a weekly Patient Protected Time meeting, attended by residents and senior staff working in the approved centre. This meeting which addressed general issues and concerns kept documented records with actions identified. The complaints procedure was publicly displayed, naming both the local and regional complaints managers with contact details. There was a Peer Support Worker (PSW) available to the residents. Mayo recovery college provided a range of courses and groups for the residents.

Significant refurbishment works were on-going since the previous inspection. Although not finished these quality improvements had made a significant impact in the approved centre. The maintenance department worked closely with the staff in the approved centre and were involved in the refurbishment programme.

The service continued to operate within the guidelines for a general hospital setting for the management of COVID-19.

## 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 22: Premises | ✗ | Moderate | ✗ | Critical | ✗ | High | ✗ | High | ✗ | High |
| Regulation 26: Staffing | ✗ | High | ✓ | | ✓ | | ✗ | Critical | ✗ | Moderate |

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

## 4.2 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice | Details |
|---|---|
| Regulation 17: Children's Education | As the approved centre had not admitted any children since the last inspection, this regulation was not applicable. |
| Rules Governing the Use of Mechanical Means of Bodily Restraint | As the approved centre had not used 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.

The residents were given the opportunity to speak with the inspection team and to complete feedback questionnaires. Seven residents availed of the opportunity to speak with the inspection team. The inspection team also received resident feedback from the Peer Advocacy in Mental Health Representative. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

The verbal feedback included the following quotes:
'food was good, there are good choices, drinks available during the day'.
'access to bedroom when I want'.
'I have enough to do during the day'.

All residents were aware of their weekly multi-disciplinary team (MDT) meeting and had been offered a copy of their care plan. Psychology and social work were especially valued by two residents. Many valued occupational therapy activities especially baking. Residents generally felt comfortable in sharing rooms with others.

Other comments embedded within the feedback reflected contrasting views and different perspectives, these included:
'Can find it boring - especially at weekends'.
'would like access to sky sports- limited range of TV channels at present'.
'would like more availability to the exercise bike'.
'don't always feel safe in the unit due to other residents'.
'staff are very nice- but I can't talk to them when I need them – 'they tend to be in the office a great amount of the time' and 'they only talk to me when giving meds'.

Storage for patients' personal property presented as an issue for residents- even though safe custody and storage facilities were available. Residents who chose to manage their own possessions and property felt they should be provided with reasonable secure solutions to enable self-management of property in addition to those offered by the service, for example, a lockable drawer or cupboard in the bedrooms.

Residents also felt that consideration should be given to increasing the availability of resource rooms such as the quiet room and the activities room by extending their opening times – offering more time for contemplation and prayer for one resident and a quiet environment to read for another.

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

With the residents' permission, their experience was fed back to the senior management team.

Where any resident brought a matter to the attention of the inspectors during the inspection process, that query or concern was relayed with their consent on an anonymised basis, to clinical or administrative staff.

## 5.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the Peer Advocacy in Mental Health representative. A small representative sample of comments are listed:

**Positive aspects of the service included:**

- Happy with the care here.
- Pleased to get referral to see a psychologist.
- Pleased to know she will have regular support after discharge.
- Feeling safer here
- Appreciate assistance form social worker in finding accommodation.

**Areas in Need of Improvement:**

- Sometimes there is some noise at night and it's hard to sleep.
- A resident was following some other residents around. They had told the nursing staff.
- At Patient Protected Time there was a request for more healthy options to be added to the vending machine
- Would like to know if an issue brough up at the Patient Protected Time was dealt with, staff should feedback to the person if they followed up on the issue.

# 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:

- Acting Executive Clinical Director
- Acting Area Director of Nursing
- Area Lead for Mental Health Engagement
- Dietitian Manager
- Assistant Director of Nursing
- Nurse Practice Development Co-ordinator
- Regulatory Compliance Advisor
- Mental Health Act Administrator
- Occupational Therapy Manager
- Senior Occupational Therapist
- Social Work Manager
- Principal Psychologist
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 X 2
- Clinical Nurse Manager 2/Electro-Convulsive Therapy (ECT) Nurse
- Registered Proprietor
- Maintenance Manager
- Business Manager

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

# 7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

## Regulation 4: Identification of Residents

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

Dinner and tea meals were prepared in the main hospital and transported to the approved centre in a heated food trolley. 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: fish or meat, poultry, and vegetarian options were available for hot meals, as well as a cold option. 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, cooking, and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

**The approved centre was compliant with this regulation.**

## Regulation 7: Clothing

**COMPLIANT**

The registered proprietor shall ensure that:

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

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

### INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents 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 March 2022. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

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

**The approved centre was compliant with this regulation.**

## Regulation 9: Recreational Activities

**COMPLIANT**

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

### INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Recreational activities took place both in groups and on a one-to-one basis; they included television, books, board games, newspapers, magazines, music, keyboard, arts, movies, jigsaws, bingo, gardening, community kick start football, therapeutic journaling, and table tennis. Exercise equipment was available for both indoors and outdoors use. Cookery demonstrations were held by the chef two-to-three times a year. Peer support workers provided information sessions, and a daily newspaper group was established by the occupational therapist was available to residents. Residents had access to the activity room on the weekends.

**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 April 2023.

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. A separate visitors' room or visiting area was provided 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 March 2022.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents had access to their own phones, postal mail, internet and email in the occupational therapy office, a Wi Fi hotspot, and a telephone for general use.

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. There were no restrictions on communication for any residents 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, last reviewed in March 2022, and a policy on the management of Illicit substances and weapons, last reviewed in September 2021. Together, these policies 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 three 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. General written consent was sought for routine environmental searches. 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. A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

**The approved centre was 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 June 2021.

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

**The approved centre was compliant with this regulation.**

## Regulation 15: Individual Care Plan

**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). Therapeutic groups in the approved centre included anxiety management skills, yoga, medicines education, wellness recovery action planning, psychological skills, psychological therapies explained, mindfulness, therapeutic journaling, emotional regulation, baking and cooking, and art instruction (cognitive behavioural therapy). Mayo Recovery College provided courses for mental health residents. One-to-one services included cognitive behavioural therapy (CBT), dietitian, pharmacy, occupational therapy, social work, and psychology. Speech and language therapy, physiotherapy, chiropody, diabetic nurse, and tissue viability were available via referral pathways through Mayo University Hospital or community care.

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning.

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

**The approved centre was compliant with this regulation.**

## Regulation 18: Transfer of Residents

**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 May 2023. The clinical file of one resident who had been transferred from the approved centre was inspected. As it was an emergency transfer, communications between the approved centre and the receiving facility are documented and followed up with a written referral. The resident was accompanied by a nurse. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

**The approved centre was compliant with this regulation.**

## Regulation 19: General Health

**COMPLIANT**

(1) The registered proprietor shall ensure that:

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in May 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.

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 September 2021.

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

The approved centre's information booklets 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. Staff were observed to be friendly, approachable and appropriate in communication with 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 was provided to ensure 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, and residents were facilitated to make private calls.

**The approved centre was compliant with this regulation.**

## Regulation 22: Premises

**NON-COMPLIANT**

**Risk Rating** HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space. Appropriately sized communal rooms were provided: residents had access to a quiet room, seating area at reception, activities room, sitting rooms, and interview room. There was suitable and sufficient heating in day areas and bedrooms; heating was centrally controlled. 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, including courtyard areas with seating in the main unit and High Dependency Unit (HDU), were provided for residents to move about. 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, despite specific improvements works, were not minimised to the lowest practicable level, based on risk assessment.

Work which had been completed on the premises since the last inspection included the following: new ceiling tiles had been installed in the large occupation therapy room and a new cooker in the occupational therapy kitchen; two assisted toilets had been upgraded; the approved centre had been painted internally with the introduction of a coloured strip on the walls; new windows and a new anti-ligature TV unit had been added to the activities room; the main courtyard had been power-hosed with planter boxes added; anti-ligature radiator covers and LED lighting had been installed; and fire doors in the HDU unit had been

replaced and a new TV with anti-ligature unit installed. Further works were ongoing at the time of inspection.

The approved centre was not kept in a good state of repair externally and internally. In the courtyard area, windowsills, paving slabs, and walls were observed to be dirty, with paint peeling off the walls. The concrete roof fascia was crumbling, but loose particles had been removed. The gazebo was dated and worn. In the area where residents exit the garden, the flooring was marked, walls were dirty and there was a loose roof tile. Outside one bedroom, a thermostat was broken; it had been covered over but not removed. One bedroom had a broken ceiling tile and one of the bedrooms did not have a wardrobe (there was a plan to replace it). Paint was peeling from the wall in another bedroom.

Outside the sitting room, a small section of the flooring had been replaced. The sofa in the activities room was torn and the arms were worn. In the sitting room, three armchairs were worn. In one bedroom in the HDU, the flooring was damaged where a section of the laminate had previously been replaced, and the wall was slightly damaged with evidence of recent repairs. A panel in the toilet had also been damaged resulting in exposed wires and plumbing pipes. At the time of inspection, the resident in this room did not have access to the en suite toilet, as it was locked and awaiting repairs. In the HDU garden, windowsills were observed to be dirty, as were the courtyard walls with paint peeling.

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. Relevant 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 available within the unit. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

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

a) **The registered proprietor did not ensure that premises were clean and maintained in good structural and decorative condition, in that the walls and windowsills of the main garden area and the walls and windowsills in the High Dependency Unit courtyard were dirty and paint was peeling off the walls, 22(1)(a).**
b) **The registered proprietor did not ensure that premises were clean and maintained in good structural and decorative condition, in that the paving of the main garden area and the High Dependency Unit courtyard was dirty, 22(1)(a).**

c) The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that three single bedrooms and one dormitory bedroom were in need of repair, 22 (1)(a).
d) The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that the hall to the main garden area had markings on the floor and walls and a loose ceiling tile, 22 (1)(a).
e) The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that armchairs in resident areas were torn and worn, 22(1)(a).
f) Ligature points had not been minimised to the lowest practicable level, based on risk assessment, 22(3).

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

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in August 2022, 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. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

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.

**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 May 2023. The approved centre's Safety Statement that had been reviewed and updated as required.

**The approved centre was compliant with this regulation.**

## Regulation 25: Use of Closed Circuit Television

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures relating to the use of CCTV, which detailed the purpose and function of using CCTV for the observation of residents in the approved centre. The policy was last reviewed in January 2022.

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

**The approved centre was compliant with this regulation.**

## Regulation 26: Staffing

**NON-COMPLIANT**

**Risk Rating** 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 2023, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. An appropriately qualified staff member was on duty at all times.

All staff were trained in the Mental Health Act 2001. Not all healthcare staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. 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. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects:

**Staff Training Table**

| Profession | Basic Life Support | | Fire Safety | | Management Of Violence and Aggression | | Mental Health Act 2001 | |
|---|---|---|---|---|---|---|---|---|
| Nursing (37) | 33 | 89% | 37 | 100% | 36 | 97% | 37 | 100% |
| Medical (27) | 23 | 85% | 27 | 100% | 16 | 59% | 27 | 100% |
| Occupational Therapist (7) | 6 | 86% | 7 | 100% | 7 | 100% | 7 | 100% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Social Worker (13) | 12 | 92% | 12 | 92% | 13 | 100% | 13 | 100% |
| Psychologist (7)* | 6 | 100% | 6 | 100% | 6 | 100% | 7 | 100% |
| Dietitian (1) | 1 | 100% | 1 | 100% | 1 | 100% | 1 | 100% |
| Peer Support (3) | 3 | 100% | 3 | 100% | 3 | 100% | 3 | 100% |

**Exemption applied.*

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

## Regulation 27: Maintenance of Records

**COMPLIANT**

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in July 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 provided resources and facilities to access the Mental Health Tribunals remotely if required.

**The approved centre was compliant with this regulation.**

## Regulation 31: Complaints Procedures

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in September 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. This was documented.

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

**The approved centre was compliant with this regulation.**

## Regulation 32: Risk Management Procedures

**COMPLIANT**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to risk management. The policy was last reviewed in October 2022, and included the following:

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

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

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

resident seclusion, physical restraint, specialised treatments (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

There was an up-to-date certificate of registration displayed prominently in the approved centre. Any changes in relation to the information detailed in the certificate had been communicated to the Mental Health Commission.

**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 June 2023. 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 an adequately equipped treatment and recovery room. High risk patients were treated in a rapid-intervention area. 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. A named consultant psychiatrist had responsibility for ECT management. A named consultant anaesthetist had 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 file of one Involuntary patient who had received ECT was inspected. ECT was administered according to section 59(1)(b) of the Mental Health Act 2001, as amended. A *Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent* was completed by two consultant psychiatrists for each ECT programme. A Form 16 was placed in the patient's clinical file and a copy of it was sent to the Mental Health Commission within five days.

Appropriate information on ECT was given by the consultant psychiatrist to enable the patient to make a decision on whether to agree to ECT. Information was provided on the likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. Information was provided both orally and in writing, in clear and simple language that the patient could understand. The patient was informed of their right to access an advocate of their choosing at any stage.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, and a current mental state examination. Cognitive assessments were completed before and after each ECT session, in line with best international practice. A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine.

The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre-ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post-ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT was recorded. Copies of all cognitive assessments were placed in the clinical file.

**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 January 2023. The policy included all the policy-requirements for this rule.

The approved centre had a policy on the reduction of seclusion, last reviewed in February 2023. It included all the policy-requirements for this rule.

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), the identification of appropriately qualified persons to give the training, and the areas to be addressed within the training programme.

**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 to analyse every episode of seclusion in detail, and was meeting on a quarterly basis.

**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 was an anti-barricade door. 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.

All other aspects of the seclusion room facility and furnishings met the requirements of the rule. Seclusion facilities were not used as bedrooms, nor bedrooms used as seclusion facilities.

**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) 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 noticed 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 Seclusion Care Plan for the resident was developed by a RN.

There was a medical examination of the resident 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, or emotional trauma caused to the resident as a result of the seclusion. Where the CP ordered the continued use of seclusion, they advised the duration of each order. 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 this communication did not occur, a record explaining the reason for this was entered in the clinical file.

The clothing worn in seclusion respected the right of the residents to dignity, bodily integrity and privacy.

**Monitoring of the Person:** 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 comprehensive written record of the resident was made by the RN every 15 minutes.

**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 both episodes. 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 a discussion regarding

alternative de-escalation strategies that could be used to avoid future use of restrictive interventions. The residents were given the opportunity of having their representative or nominated person present at the debrief with them; if this person did not attend, a record of the reasons why was recorded in the clinical file. The residents' ICPs were updated to reflect the outcome of the debrief, taking particular note of the residents' preferences in relation to restrictive interventions going forward.

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 resident's care and treatment and documented in the clinical file as soon as practicable and, in any event, no later than five working days after 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 file of two patients who had been in the approved centre for more than three months and who had been in continuous receipt of medication was examined. There was documented evidence that the responsible consultant psychiatrist had undertaken a capacity assessment in both cases, and that the patients were unable to consent.

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for both patients. 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 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 January 2023, and included all the policy-requirements for this code of practice.

The approved centre had a written policy on the reduction of physical restraint. The policy was last reviewed in February 2023, and included all the policy-requirements for this code of practice.

Policies and procedures regarding staff training included the identification of who would receive training based on the identified needs of residents who were restrained and staff, the identification of appropriately qualified individuals to give the training, the mandatory nature of training for those involved in physical restraint, and the areas to be addressed within the training programme.

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

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

**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 residents' presentation. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the residents 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.

It was the residents' wish in accordance with their individual care plans (ICP) that their representatives were not to be informed of the restraint, and no such communication occurred outside of necessary legal or professional requirement. This was recorded in the residents' 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 residents' ICPs pertaining to 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 ensure their safety, and this was documented.

**Ending Physical Restraint:** The physical restraint in each instance was ended by the person who had led it. The residents were 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. One of the residents had left the approved centre prior to the debrief; of the other two residents, one participated in the debrief and other declined. The decision of the resident not to participate in the debrief, where that was their wish, was respected. For the resident who did participate, the debrief included a discussion regarding their preferences in the event of a restrictive intervention being required in the future (noting which restrictive intervention they would not like to be used.) This resident's individual care plan was updated to reflect the outcome of the debrief.

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 residents 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. There was a copy of the clinical practice form in the clinical files, and it was available to the Mental Health Commission on request.

**Clinical Governance:** Each episode of physical restraint was reviewed by the members of the MDT involved in the resident's care and treatment and documented in the clinical files within five working days of the date of restraint. 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 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 patients. The policy had been reviewed annually and was last reviewed in June 2023. 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 an adequately equipped treatment and recovery room. High risk patients were treated in a rapid-intervention area. 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. A named consultant psychiatrist had responsibility for ECT management. A named consultant anaesthetist had 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 file of one voluntary patient who had received ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed able to consent to receiving ECT. Capacity to consent ensured that the patient could understand the nature of ECT (including risks, benefits, and alternatives), understand why ECT was proposed and the broad consequences of not receiving ECT, and make a free choice to receive or refuse ECT. Consent was obtained in writing for each ECT treatment session, including anaesthesia. All consent was obtained by the consultant psychiatrist, or registered medical practitioner (RMP) under supervision of the clinical psychiatrist, prior to each ECT treatment session and recorded in the clinical file.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin (where

appropriate), and a current mental state examination. Cognitive assessments were completed and recorded before and after each ECT session. The process was in line with best international practice by the consultant psychiatrists.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. ECT was administered by a constant current, brief pulse ECT machine. The ECT record which was completed after each treatment was placed in the clinical file, and the signature of the registered medical practitioners administering ECT was detailed. The ECT register was completed on conclusion of the ECT programme. All pre-ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post-ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT were recorded.

**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 March 2023, included all of the policy-related criteria for this code of practice.

**Transfer:** The transfer policy, which was last reviewed in May 2023, included all of the policy-related criteria for this code of practice.

**Discharge:** The discharge policy, which was last reviewed in May 2023, 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 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. The resident had undergone a full physical examination.

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

**Discharge:** 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; social and housing needs; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare provider within three days. A comprehensive discharge summary was issued within 14 days.

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

**The approved centre was compliant with this code of practice.**

## Appendix 1: Corrective and Preventative Action Plan

| Regulation 22: Premises | | | | | |
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| **Reason ID : 10004482** | | **The registered proprietor did not ensure that premises were clean and maintained in good structural and decorative condition, in that the walls and windowsills of the main garden area and the walls and windowsills in the High Dependency Unit courtyard were dirty and the paint was peeling off the walls, 22(1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The walls and windowsills in the High Dependency Unit courtyard were power washed and painted. The Garden Project stakeholders group has scoped out the works for refurbishment of garden area, which will include painting of walls and windowsills. Funding stream has been identified. Purchase order for this work has been authorised, external contractors identified and commencement of work is scheduled for April 2024. | Premises re-audit due in June 2024. | Yes - but have experienced challenges sourcing and retaining external contractors causing delays to commencement of project so far. Additional delays caused by poor weather conditions. | 01/09/2024 | Registered Proprietor, Business Manager & Maintenance Manager. |
| **Preventative Action** | Regular walk around by nurse managers. Any identified | Premises audit with quarterly reviews and updates | Yes | 01/09/2024 | Business Manager, Maintenance Manager & Nurse Management. |

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| | maintenance issues reported on PMAC to Maintenace department. Continue to review and update Premises audit involving key stakeholders. Reviewed and updated audit findings 3 monthly. | | | | |
| **Reason ID : 10004483** | | **The registered proprietor did not ensure that premises were clean and maintained in good structural and decorative condition, in that the paving of the main garden area and the High Dependency Unit courtyard was dirty, 22(1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | The High Dependency Unit courtyard was power washed. The paving of the main garden area will be replaced with new paving in garden, works scheduled for April 2024. PMAC sent for power washing to be completed for that area. | Premises re-audit due in June 2024. | Yes - but have experienced challenges sourcing and retaining external contractors causing delays to commencement of project so far. Additional delays caused by poor weather conditions. | 01/09/2024 | Registered Proprietor, Business Manager & Maintenance Manager. |
| **Preventative Action** | Regular walk around by nurse managers. Any identified maintenance issues reported on PMAC to Maintenace | Premises audit with quarterly reviews and updates | Yes | 01/09/2024 | Business Manager, Maintenance Manager & Nurse Management. |

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| | department. Continue to review and update Premises audit involving key stakeholders. Reviewed and updated audit findings 3 monthly. | | | | |
| **Reason ID : 10004484** | | **Ligature points had not been minimised to the lowest practicable level, based on risk assessment, 22(3).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Ligature re-audit completed as per the HSE Mental Health Services: Ligature Risk-Reduction Policy and Audit Tool, in Oct 2023. All identified ligature anchor points risk rated and action plan developed. This is reviewed and updated quarterly by the Ligature Reduction Group. Most recent meeting on 18th Jan 2024. A number of identified ligatures have been reduced for example upgrade of bathrooms and en-suite with reduced | Annual Ligature Audits with quarterly reviews and updates. | Yes | 18/04/2024 | Registered Proprietor, Business Manager & Maintenance Manager. |

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| | ligature fixtures and fittings, new reduced ligature curtains throughout the unit, reduced ligature wardrobe installed in some dormitories with further replacement of all wardrobes scheduled. Reduced ligature doors fitted throughout unit. | | | | |
| **Preventative Action** | Regular walk around by nurse managers. Continue to review and update ligature audit involving key stakeholders. | Annual Ligature Audits with quarterly reviews and updates. | Yes | 18/04/2024 | Business Manager, Maintenance Manager & Nurse Management. |
| **Reason ID : 10004485** | | **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that three single bedrooms and one dormitory bedroom were in need of repair, 22 (1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | A cleaning schedule is in place with monthly cleaning audits commenced with input from Infection Prevention Control Nurse. The dormitory has been refurbished including new flooring, curtains, wardrobes | Premises re-audit due in June 2024. Monthly cleaning audits. | Yes – but have experienced challenges sourcing and retaining external contractors causing delays to commencement of project so far. | 31/05/2024 | Registered Proprietor, Business Manager & Maintenance Manager. |

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| | etc. A purchase order has been issued for completion of works in the single bedrooms. Awaiting commencement day from external contractor. | | | | |
| **Preventative Action** | Regular walk arounds by nurse managers. Any identified maintenance issues reported on PMAC to Maintenance department. Continue to review and update Premises audit involving key stakeholders. Reviewed and updated audit findings 3 monthly. | Premises audit with quarterly reviews and updates. Monthly cleaning audits. | Yes | 01/01/2024 | Business Manager, Maintenance Manager & Nurse Management. |
| **Reason ID : 10004486** | | **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that the hall to the main garden area, in that the hall to the main garden area had markings on the floor and walls and a loose ceiling tile, 22 (1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | A cleaning schedule is in place with monthly cleaning audits commenced with input from Infection Prevention Control Nurse. Loose ceiling tile rectified. Flooring | Premises re-audit due in June 2024. Monthly cleaning audits. | Yes | 31/05/2024 | Registered Proprietor, Business Manager & Maintenance Manager. |

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| | – plan to re-floor full unit corridor. Contractor identified, purchase order issued and awaiting commencement day from external contractor. | | | | |
| **Preventative Action** | Regular walk arounds by nurse managers. Any identified maintenance issues reported on PMAC to Maintenance department. Continue to review and update Premises audit involving key stakeholders. Reviewed and updated audit findings 3 monthly. | Premises audit with quarterly reviews and updates. Monthly cleaning audits. | Yes | 01/01/2024 | Business Manager, Maintenance Manager & Nurse Management. |
| **Reason ID : 10004487** | | **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition, in that armchairs in resident areas were torn and worn, 22(1)(a).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | Old and damaged seating removed and replaced with new chairs & couches. | Premises re-audit due in June 2024. | Yes | 05/02/2024 | Registered Proprietor, Business Manager & Maintenance Manager. |
| **Preventative Action** | Regular walk around by nurse managers. Any identified maintenance issues | Premises audit with quarterly reviews and updates | Yes | 01/01/2024 | Business Manager, Maintenance Manager & Nurse Management. |

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| | reported on PMAC to Maintenace department.<br>Continue to review and update Premises audit involving key stakeholders.<br>Reviewed and updated audit findings 3 monthly. | | | | |

| Regulation 26: Staffing | | | | | |
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| **Reason ID : 10004488** | | **The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, as not all healthcare staff were trained in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26(4).** | | | |
| | **Specific** | **Measurable** | **Achievable/Realistic** | **Time-bound** | **Post-Holder(s)** |
| **Corrective Action** | All staff have access to education and training on line and face to face. Two training laptops have been provided to staff in AMHU to increase ease of access to online training. Additionally a staff training schedule has been developed and circulated to all line managers, outlining face to face training dates and requirements. | Audit of Reg 26 Staffing and maintenance of training records. | Yes | 01/01/2024 | Area Director of Nursing, Executive Clinical Director, Occupational Therapy Manager, Dietitian Manager, Principal Social Worker & Principal Psychologist. |
| **Preventative Action** | All line managers to ensure staff are up to date with required training. Training schedule developed and circulated to all line managers. New staff informed of training requirement | Training records maintained and updated by line managers. | Yes | 01/01/2024 | Area Director of Nursing, Executive Clinical Director, Occupational Therapy Manager, Dietitian Manager, Principal Social Worker & Principal Psychologist. |

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| | and schedule as part of induction | | | | |

## Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

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

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

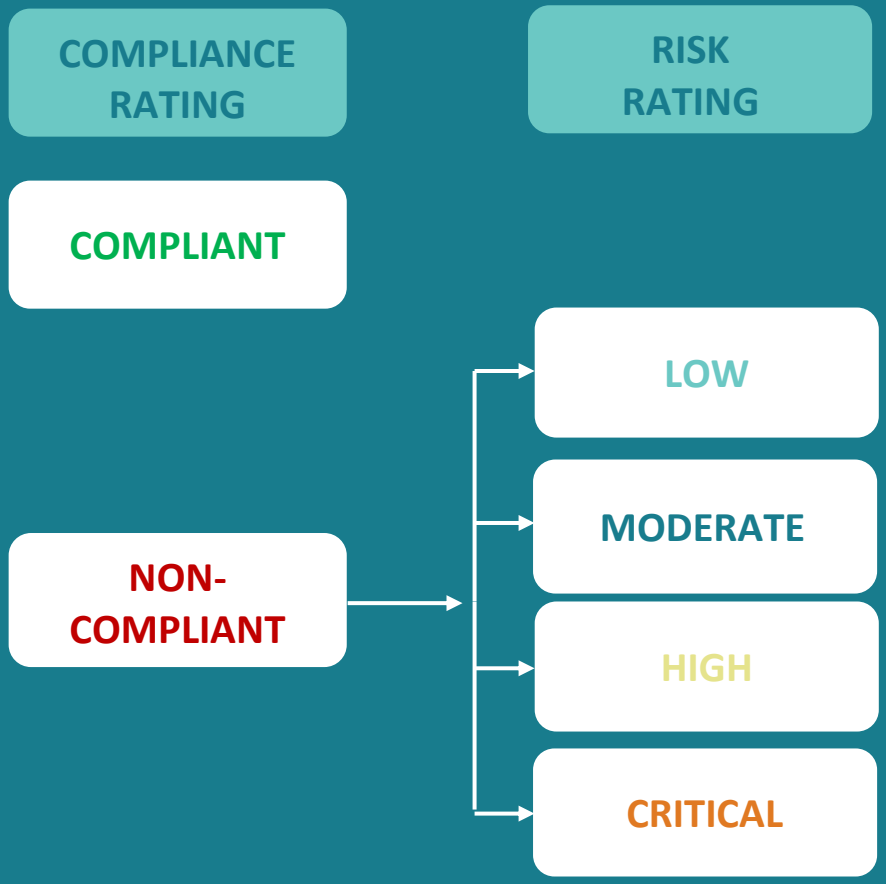
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

## COMPLIANCE AND RISK RATINGS

**The following ratings are assigned to areas inspected:**

**COMPLIANCE RATINGS are given for all areas inspected.**
**RISK RATINGS are given for any area that is deemed non-compliant.**




The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.