An Coillín

Annual Inspection
Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

AN COILLÍN

An Coillín, Westport Road, Castlebar,
Co. Mayo

Date of Publication:
02 April 2024

ID Number: AC0080

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing mental health care / long stay

Conditions Attached:
None

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Mr Steve Jackson, General Manager, CHO2 – Mental Health Services

Inspection Team:
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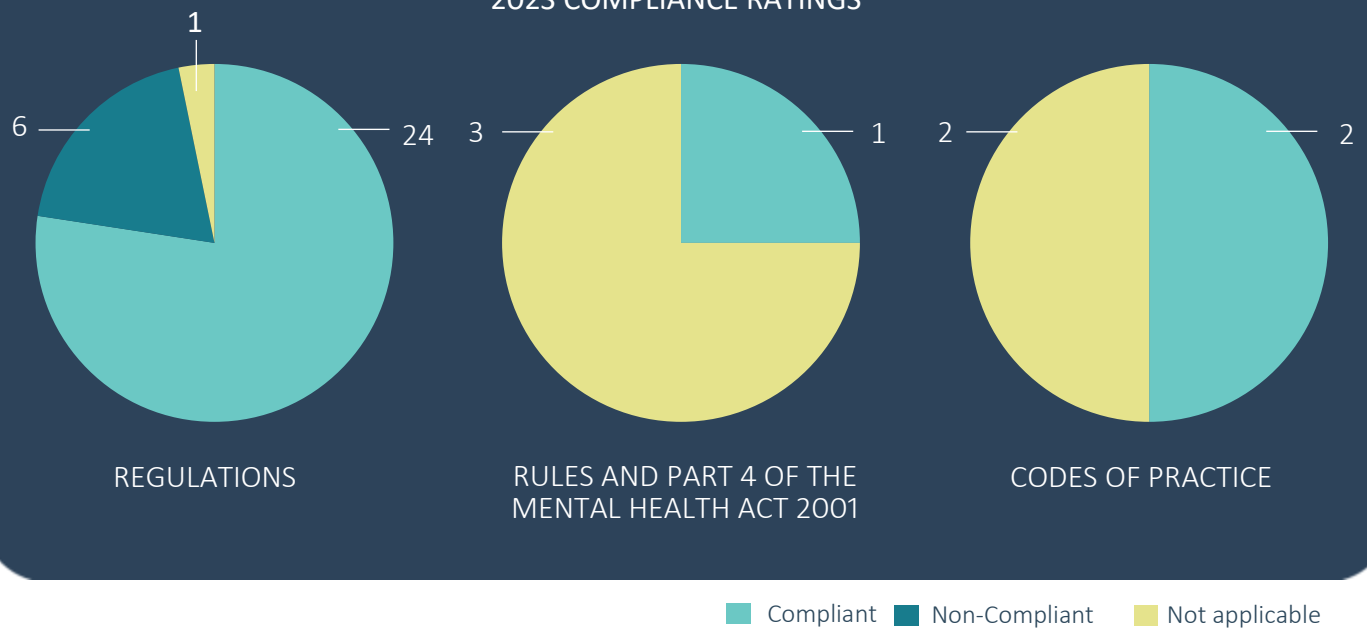
Inspection Date:
19 – 22 September 2023

Previous Inspection date:
22 – 25 March 2022

Inspection Type:
Announced Annual Inspection

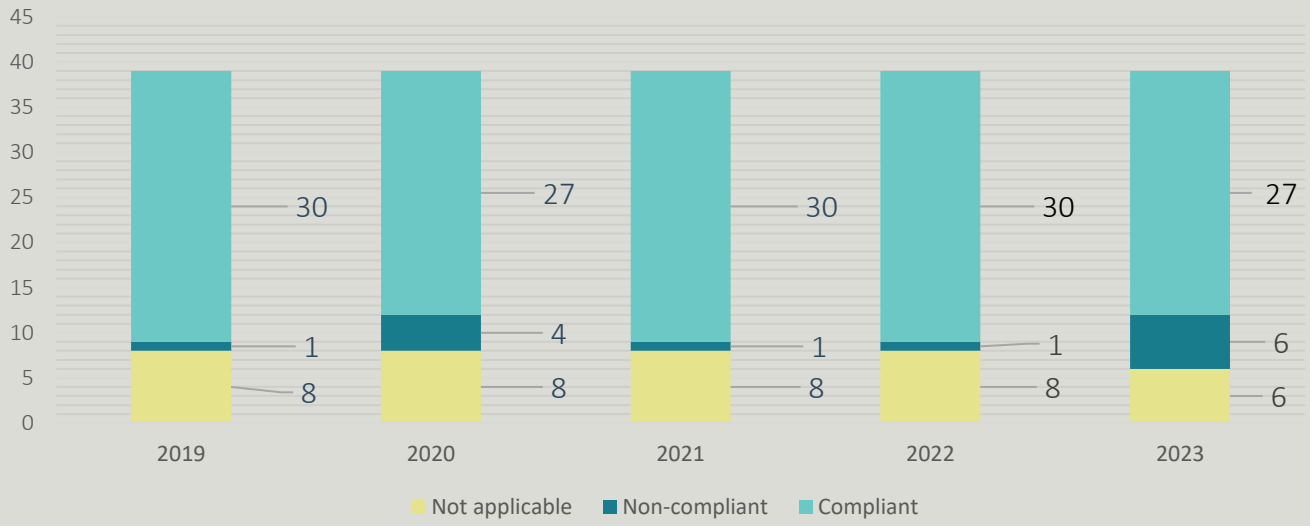
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

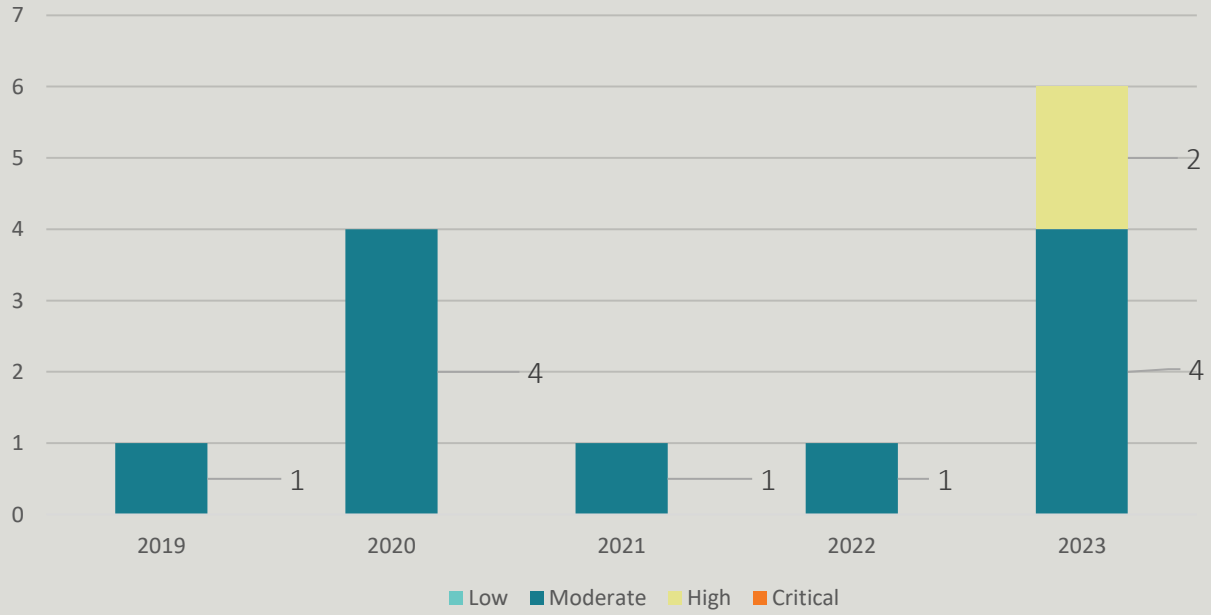
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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 — Prof Jim Lucey

In brief

An Coillín was a single-storey building, located on the Mayo University Hospital campus, in Castlebar, County Mayo. The approved centre was registered with the Mental Health Commission for the provision of continuing mental health care. All residents received care and treatment from the Rehabilitation and Recovery multi-disciplinary team. The approved centre was registered for 22 beds.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	87%	87%	97%	97%	82%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

The approved centre demonstrated that they provided safe care in the following areas:
There was an adequate number of appropriately trained nursing staff to provide safe care and treatment. All staff were trained in fire safety, safeguarding, basic life support, management of violence and aggression,

and the Mental Health Act. The ordering, storing, prescription and administration of medication was carried out in a safe manner.

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. There was a maintenance programme and there were no safety hazards in the approved centre. The appearance of the approved centre was clean at all times.

However, the approved centre contained a malodourous smell in two of the toilets. Several fire safety issues were identified including; the fact that five fire doors did not close correctly, the key for one emergency fire exit was stored some distance from the door and the magnetic lock on one fire door was broken. Ligature points were not minimised to the lowest level, based on individual risk assessment. All residents had an individual risk assessment and risk management plan that was regularly updated. Staff were aware of safeguarding procedures.

Appropriate care and treatment of residents

The approved centre demonstrated that they provided appropriate care and treatment in the following areas:
All residents had a comprehensive initial assessment on admission. Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines. Residents had access to a local General Practitioner (GP) and local hospital for assessment and any treatment required. Each resident had an individual care plan that documented the resident's needs; however one individual care plan did not identify appropriate goals for the resident, care and treatment required to meet the goals identified, or the resources required to provide the care and treatment identified. One individual care plan was not updated as indicated by the resident's changing needs, condition, and circumstances.

Residents has access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, non-consultant privachospital doctors and registered psychiatric nurses. There was a social worker and occupational therapist team, however at the time of the inspection there was no dedicated psychologist for the An Coillín approved centre. Efforts were made to fill this post, including upgrading the post to a principal specialist psychology post. Additionally, efforts were made to address the unmet psychology need with cross-cover from another psychologist. There were regular multi-disciplinary team meetings to discuss residents' care plans.

It was noted that the layout and the decoration of An Coillín was not of a consistently high standard. Some maintenance issues were observed which included: a crack in one of the window sills, a number of internal fire doors that did not close correctly, scuffed and marked flooring and some litter at the entrance to the approved centre.

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 dormitory and single room accommodation. 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.

There was evidence that residents' dignity and privacy were respected. There were privacy screens on bedroom doors, all bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. However, one dormitory did not have screening on the windows meaning it was possible to view inside the dormitory from the internal garden. No signage had been put up to alert residents and visitors of the existence of a new CCTV camera following its installation by the approved centre. Clinical files were securely stored.

Physical restraint was used in the approved centre only when less restrictive alternatives were deemed unsuitable. Neither mechanical restraint nor seclusion were used in the approved centre.

Responsiveness to residents' needs

The approved centre demonstrated that they were responsive to people's needs in the following areas:
The quality of the food at mealtimes was good and provided healthy options which were nicely presented. The was a wide variety of recreational activities available The residents were complimentary the care they received. They said that they received information on their treating teams and their individual care plans, were aware of their key workers and were able to give feedback about their care to staff.

Governance, Leadership and Accountability

The approved centre had the following governance structures and processes in place:
An Coillín was governed by the Mayo Mental Health Services. The Mayo Mental Health Services (MMHS) governance comprised of two core meetings: the MMHS Area Management Team (AMT) meeting and the MMHS Quality and Patient Safety Committee (QPSC) meeting. Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. There was a process in place to escalate incidents for further review as required. All required approved centre policies were up to date. All staff had received mandatory training. A programme of clinical audit was ongoing in An Coillín. There was a robust complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed. Established governance structures were in place and the approved centre was represented on various committees within Mayo Mental Health Services.

Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement. A peer advocacy representative met with residents in person on a weekly basis. Resident feedback to the inspection team was largely positive.

The approved centre had a reduction in its overall compliance rating from 97% in 2022 to 82% in 2023.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1) A bi-monthly therapeutic services and programmes management meeting had been established. This meeting provided a platform for all members of the MDT to bring suggestions for therapeutic and recreational activities for discussion.
2) A number of new social outings had been facilitated by social work and occupational therapy staff in the past year including the following: bowling alley, live music in the evening, cinema, beach, Christmas dinner party in local hotel and Turlough House and gardens.
3) A new Autumn-Winter preparedness plan had been developed for An Coillín, led by the Mayo Mental Health Services Infection Prevention & Control (IPC) Nurse to ensure preparedness for the winter season, in particular respiration illness and outbreak management. This included IPC, Peer Influenza Vaccination and COVID Vaccination Teams providing in-reach to An Coillín, in conjunction with the Department of Public Health.
4) The implementation of a clinical pharmacist role had resulted in a higher quality and safer service in terms of reducing medication error and promoting patient safety. The role included completion of multiple audits, weekly clinical education and participation in the MDT meeting, in addition to regular medication reviews and projects, to ensure appropriate prescribing, de-prescribing and optimisation of medication.
5) The installation of a phone charging docking station in An Coillín helped to promote independence for the residents.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

An Coillín was a single-storey building, located on the Mayo University Hospital campus, in Castlebar, County Mayo. The approved centre was registered with the Mental Health Commission for the provision of continuing mental health care. All residents received care and treatment from the Rehabilitation and Recovery multi-disciplinary team.

The approved centre was registered for 22 beds. Residents were accommodated in a combination of single en suite bedrooms and shared dormitories. Resident activity areas included a day room, a dining room, an activities room, an occupational therapy kitchen, an oratory, a visitor's room and a large enclosed garden. Despite some recent minor improvements to the premises, the overall approved centre environment did not present as a modern mental health facility; instead, it was dated and in need of significant renovation.

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

Resident Profile	
Number of registered beds	***22***
Total number of residents	**17**
Number of detained patients	3
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	16
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

An Coillín was governed by the Mayo Mental Health Services, which was part of the wider Community Healthcare West (Galway, Mayo, and Roscommon). The Mayo Mental Health Services (MMHS) governance comprised of two core meetings: the MMHS Area Management Team (AMT) meeting and the MMHS Quality and Patient Safety Committee (QPSC) meeting. Both meetings were scheduled monthly and membership included heads of disciplines and the area lead for mental health engagement.

A number of sub-committees such as the Health and Safety Committee and the Policies, Procedures, Protocols and Guidelines (PPPG) Steering Group fed into these meetings. The Therapeutic Services and Programmes and Recreational Activity group met bi-monthly and provided updates to the Operational Group. A multi-disciplinary approach was fostered within governance structures and clinical care, and an ethos of continuous quality improvement was evident. A Placement Committee Subgroup met every six weeks to discuss bed management and the relocating of residents into the community where applicable.

The approved centres registered proprietor held overall responsibility for the risk management process. The 'Multi-disciplinary Team Operational Group' monitored and updated the approved centre's risk register. This group also discussed matters relating to staff training, the reduction of restrictive practices within the approved centre and issues relating to health and safety. The Quality and Patient Safety Committee monitored and maintained the Area Mayo Mental Health Services risk register. Minutes of these meetings documented a discussion and review of any serious incidents that had taken place within the service. Complaints were also reviewed at this meeting.

Incidents in the approved centre were reviewed weekly by the multi-disciplinary team (MDT). Trends and analysis were discussed at the monthly Quality and Patient Safety Committee meetings. The AMT had overall responsibility for approving updated policies and the results of audits completed were discussed at the monthly meetings. The operational risks presented by the approved centre premises were identified as challenging by the nursing department.

Staffing shortages were highlighted as an operational risk assessment by all departments. At the time of the inspection the approved centre had a vacant psychologist post. This post had been approved and recruitment of a psychologist was due to take place imminently. The approved centre was awaiting approval for a senior occupational therapy post for An Coillin. All disciplines were involved in the programme of clinical audit.

The approved centre did not have an established system of performance appraisal in place; however, appraisals took place within each of the medical, social work, psychology and occupational therapy departments. A process of supervision was in place for all disciplines as required. Strategic goals were in place for each of the disciplines and these included: "to ensure that patients' needs are met in terms of psychosocial and physical functioning in areas of self-care, productivity, leisure and social participation" (occupational therapy), and, "to provide appropriate, effective and evidenced based continuing mental health care for patients with severe and enduring mental illness" (medical).

The voice of the service user was sought by An Coillín through opportunities such the "Comment, Compliment or Complaint" process. The area lead for mental health engagement attended management meetings relevant to the approved centre. The peer advocate in mental health visited the approved centre on a weekly basis. Residents' meetings took place on a weekly basis and these were attended by members of the MDT. A peer support worker provided an in-reach service to residents of An Coillín.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 15: Individual Care Plans	✓		✓		✓		✓		✗	Moderate
Regulation 16: Therapeutic Services	✓		✓		✓		✓		✗	Moderate
Regulation 22: Premises	✓		✓		✗	Moderate	✗	Moderate	✗	High
Regulation 25: CCTV		N/A		N/A		N/A		N/A	✗	Moderate
Regulation 26: Staffing	✗	Moderate	✗	Moderate	✓		✓		✗	Moderate
Regulation 32: Risk Management	✓		✓		✓		✓		✗	High

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

4.2 Areas that were not applicable on this inspection

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

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The inspection team met with six residents. Feedback included that residents would like more variety in terms of dessert options, that they felt safe in the approved centre and that outings from the approved centre were accommodated. Residents were familiar with the members of their MDT and had the option of attending their ICP reviews. Not all residents knew the name of their allocated key worker. Residents gave positive feedback about the availability of recreational activities and said that staff were approachable. One resident was supported to access a training course in a nearby college and another stated they would like to pursue further education with staff support.

Four residents completed and returned the Mental Health Commission 'Your Views' questionnaire. Responses were entirely positive with all respondents stating that they understood what their individual care plan (ICP) was. All four respondents were 'always' involved in goal setting for their ICPs. All four indicated that they were familiar with the members of their multi-disciplinary team and that they were 'always' able to discuss concerns or worries with a staff member. All four stated that they had space for privacy and that their privacy and dignity were respected. All respondents indicated that they could communicate freely with their family, friends, or advocate.

When asked to rate the approved centre out of 10 (with 1 being poor and 10 being excellent) three respondents included a rating. They were 8, 9 and 10 out of 10.

5.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative. The inspectors also met with the Peer Advocate in the approved centre.

The advocate's feedback indicated that most residents would prefer to have access to more personal space within the approved centre and that it was busy at times. Residents would prefer all single bedroom accommodation. The majority of residents would choose to move to more independent accommodation as part of their discharge plan and staff worked to facilitate these preferences where possible. Feedback was generally positive about the availability of activities and some residents were particularly interested in the gardening and art groups as well as other activities such as the following: boxercise, the music group and the baking group were all appreciated. Some residents enjoyed outings with their Peer Support Worker. Residents also felt supported in terms of their physical health needs such as dental visits and support in booking other necessary medical appointments.

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 Clinical Director
- Area Director of Nursing
- Registered Proprietor Nominee
- Acting ADON
- Principal Psychologist
- Dietitian Manager
- Regulatory Compliance Advisor
- Nurse Practice Development Coordinator
- Occupational Therapist
- Psychologist
- Clinical Nurse Manager 2
- Clinical Nurse Manager 3

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. SANSI assessments were undertaken on a monthly basis. The notice board in the dining room displayed information on allergens as well as the calorific values of different foods. The dietitian (in conjunction with the Clinical Nurse Specialist on Physical Health) had introduced the identification of healthier food options with a heart logo on menu options.

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. An innovative Healthy Lifestyle Skills approach had been developed in the approved centre, including the following: education about healthy food choices and implementation of the healthy heart meal plan intervention, a Smoothie group, and the promotion of activity such as a walking group, and Boxfit with input from the dietitian.

Additional recreational events to promote social and community inclusion had been held in the approved centre. These included the visit of a pet farm and a men's shed choir afternoon. Residents were also supported to attend other events, including a sports day and summer barbeque. Nursing interns had implemented Bocce (a ball sport similar to boules) at the weekends and organised weekly evening activity events. The therapeutic group programme had been expanded to include a weekly spa/beauty/sensory group to promote self-care and relaxation.

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. Mass on was held on Tuesdays and communion at the weekends. The Quran was available to residents, as was a list of relevant ministers.

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

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in March 2022.

Residents in the approved centre had access to mail, e-mail, internet, telephone, or any device for sending or receiving messages or goods, unless otherwise risk-assessed with due regard to resident' well-being, safety, and health.

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 any resident's communication at the time of communication.

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 file of one resident was examined on inspection in relation to the search process. Risk was assessed prior to the search of the resident, their property, or the environment, as appropriate to the type of search being undertaken. The resident's consent was sought prior to the search, and the request for consent and received consent were documented. 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.

The resident was 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 search, 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 the 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.

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 April 2022.

There were two sudden deaths of residents in the approved centre since the last inspection. The deaths were managed in accordance with the residents' religious and cultural practices, with dignity and propriety, and in a way that accommodated the residents' representatives, family, next of kin, and friends. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating MODERATE

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

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

INSPECTION FINDINGS

Each resident had an Individual Care Plan (ICP). Five 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 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.

Four of the ICPs inspected identified appropriate goals for the resident, as well as documenting the relevant care and treatment required for the identified goals. However, one ICP did not identify appropriate goals for the resident, care and treatment required to meet identified goals, or the resources required to provide for such care and treatment.

All ICPs were subject to six-monthly review by the MDT in consultation with the resident. However, one ICP required more frequent updates owing to the resident's changing needs and condition. As such, this ICP had not been updated as indicated by the resident's changing needs, condition, and circumstances.

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

a) **One individual care plan did not identify appropriate goals for the resident, care and treatment required to meet the goals identified, or the resources required to provide the care and treatment identified, 15.**
b) **One individual care plan was not updated as indicated by the resident's changing needs, condition, and circumstances, 15.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating MODERATE

(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 not appropriate and did not meet the assessed needs of one resident, as detailed in their individual care plan (ICP). Residents of the approved centre received nursing, medical, social work, and occupational therapy services. However, the staff grade psychology post had been vacant since March 2022. While there was some limited psychology input delivered within the approved centre, one resident was not receiving the psychology input required by their ICP. There was documentary evidence of an unmet psychology need within one resident's individual care plan.

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

The approved centre was non-compliant with this regulation because a staff grade psychology post had been vacant in since March 2022 and there was documentary evidence of an unmet psychology need within one resident's individual care plan, 16.

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 were documented and followed up with a written referral. 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 the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written, and available in the required formats to support resident's needs.

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

All bathrooms, showers, and toilets had locks on the inside of the door, except in the case of an identified risk to the resident. Where residents shared a room, bed screening 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 had access to personal space and to appropriately sized communal rooms. There was suitable and sufficient heating within the approved centre. Private and communal areas were furnished to remove excessive noise or acoustics, and the lighting in communal rooms suited the needs of residents and staff. Appropriate signage and sensory aids were provided to support resident orientation needs and sufficient spaces were provided for residents to move about, including outdoor spaces.

Hazards including hard or sharp edges and slippery floors were all minimised in the approved centre. Ligature anchor points were not minimised to the lowest practicable level at the time of the inspection.

Not all areas of the approved centre were kept in a good state of repair. The following issues were observed in the approved centre:

- An external window sill was cracked
- A number of internal fire doors did not close correctly
- Scuffed and marked flooring
- Some litter was observed at the entrance to the approved centre; this included discarded cigarette ends and drink cans.

There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment; records were maintained. At the time of inspection, the approved centre was generally clean, hygienic, and free from offensive odours; however, two toilets were noted to be malodorous.

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

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

a) **The approved centre was not kept in a good state of repair externally and internally, as an external windowsill was cracked, some fire doors did not close properly and floors were scuffed and marked. There was litter observed at the entrance of the approved centre, 22(1)(a).**
b) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, as ligature points were not minimised to the lowest practicable level, 22(3).**
c) **The approved centre was not consistently free from offensive odours, as two toilet areas were noted to be malodorous, 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, five of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident had 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; the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident; and the Nursing and Midwifery Board of Ireland (NMBI) registration number or PIN of every nurse prescriber 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 was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating MODERATE

(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 approved centre did not display clear signage in prominent positions where CCTV cameras or other monitoring devices were utilised. As a result, the approved centre's use of CCTV and any other monitoring system was not disclosed to residents or residents' representatives by way of a sign indicating its use.

The existence and usage of all CCTV was disclosed to the Mental Health Commission at the time of the inspection. 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 non-compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that CCTV was clearly labelled and its use evident, 25(1)(b).**
b) **The registered proprietor did not ensure that the existence and usage of CCTV was disclosed to residents and their representatives, 25(2).**

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 operational policy and procedures in relation to staffing. The policy was last reviewed in June 2021. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements. An appropriately qualified staff member was on duty and in charge at all times.

The approved centre had one multi-disciplinary team. The disciplines included psychiatry, nursing, occupational therapy, and social work staff. The numbers and skill mix of staffing were not sufficient to meet resident needs at the time of the inspection as there was no psychologist on the team.

A physiotherapist, an art therapist, a peer support worker, a physical health nurse, and a pharmacist also visited the approved centre.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Not all staff were trained in Basic Life Support and the Management of Violence and Aggression. However, the three staff members whose training was out of date were booked into refresher courses within 10 days of the inspection. The approved centre had a comprehensive training schedule and a time bound plan to address the mandatory training needs of staff. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory areas.

Staff Training Table								
Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (24)	23*	96%	24	100%	22*	92%	24	100%
Medical (2)	2	100%	2	100%	2	100%	2	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (1)	1	100%	1	100%	1	100%	1	100%

*Training refresher courses for outstanding staff were scheduled within 10 days of the annual inspection.

The approved centre was non-compliant with this regulation because the skill mix was not appropriate to the assessed needs of the residents due to the fact that there was no psychologist on the multi-disciplinary team, 26 (2).

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in 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 applicable 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 where 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

NON-COMPLIANT

Risk Rating HIGH

(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. The policy addressed all requirements of the regulation including:

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

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

Health and safety risks were identified, assessed, reported, monitored, and documented within the risk register as appropriate. However, not all identified health and safety risks were treated appropriately: five sets of fire doors in the approved centre did not close correctly at the time of the inspection. In one case, one of the two doors of an internal fire door was not functioning properly as it did not release from its magnetic lock during a fire drill. In the case of one locked fire exit, the key was kept some distance from the fire door. This meant that it would not be possible to open the fire door immediately if 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 anonymised at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because five sets of fire doors were not closing correctly, one set did not release from its magnetic lock during a fire drill and it was not possible to open one fire exit from inside the approved centre. Therefore, precautions were not in place to control for all identified health and safety risks, 32 (2)(b).

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

- The names of the medications prescribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of 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 2021: 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 had been reviewed in January 2023, and addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

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

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

Evidence of Implementation: The clinical files of three residents that had been physically restrained were examined on inspection. Each of these episodes of restraint had taken place in 2022, prior to the introduction of the new code of practice on physical restraint. Physical restraint was used in rare, exceptional circumstances and in the best interest of the residents. Physical restraint was only used after all alternative interventions had been considered. The use of physical restraint was based on risk assessment and cultural and gender sensitivity were demonstrated.

The episodes of physical restraint were initiated by a registered medical practitioner (RMP), registered nurse (RN), or other members of the multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated member of staff was responsible for leading the restraint and for monitoring the head and airway of the residents. 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 was completed no later than three hours after the start of each episode.

The orders for physical restraint lasted for a maximum of 30 minutes. The clinical practice forms 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 CP within 24 hours. There was evidence that the residents had been informed of reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint.

As soon as practicable and with the residents' consent, the residents' next of kin or representative were informed of the use of physical restraint, and this was recorded in the clinical file. Where the next of kin or representative was not informed, the justification for this was recorded in the clinical file.

There was evidence that staff were aware of relevant considerations in individual care planning pertaining to the resident's needs and requirements in relation to the use of physical restraint. Where applicable, special consideration was given when restraining a resident who was known by the staff involved in physical restraint to have experienced physical or sexual abuse. Where practicable, same sex staff members were present during the physical restraint episodes. Completed clinical practise forms were placed in the residents' clinical files.

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

The approved centre was compliant with this code of practice.

Admission, Transfer and Discharge

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 been completed on the implementation of and adherence to the admission, transfer, and discharge policies.

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and other risks, and documented communications with the relevant healthcare

provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT), and family or representative, where appropriate.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan, and informational needs. The discharge was coordinated by the key worker. 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 15: Individual Care Plan					
Reason ID : 10004497		**One individual care plan did not identify appropriate goals for the resident, care and treatment required to meet goals identified, or the resources required to provide the care and treatment identified, 15.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified ICP was reviewed and updated to reflect appropriate goals, care and treatment requirements of the resident.	Quarterly audits of regulation 15.	Yes	30/09/2023	Area Director of Nursing, Executive Director, Occupational Therapy Ma Principal Social Worker & Principal Psychologist.
Preventative Action	An MDT working group has been established to review and develop a Recovery Individual Care Plan document. Most recent audit completed on 27th Dec 2023.	Quarterly audits of regulation 15.	Yes	30/06/2024	Area Director of Nursing, Executive Director, Occupational Therapy Ma Principal Social Worker & Principal Psychologist.
Reason ID : 10004498		**One individual care plan was not updated as indicated by the resident's changing needs, condition, and circumsta 15.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified ICP was reviewed and updated to reflect the changing needs, conditions and circumstances of the resident.	Quarterly audits of regulation 15.	Yes	30/09/2023	Area Director of Nursing, Executive Director, Occupational Therapy Ma Principal Social Worker & Principal Psychologist.
Preventative Action	An MDT working group has been established to review and develop a Recovery Individual Care Plan document.	Quarterly audits of regulation 15.	Yes	30/06/2024	Area Director of Nursing, Executive Director, Occupational Therapy Ma Principal Social Worker & Principal Psychologist.

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10004491		**The approved centre was non-compliant with this regulation because a staff grade psychology post had been vacant in since March 2022 and there was documentary evidence of an unmet psychology need within one resident's individual care plan, 16.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff grade psychology post was advertised on the HSE national staff grade psychology panel. It was unable to be filled due to lack of expression of interest. The post was then upgraded to a principal specialist psychology post. This was done in an effort to fill the post, address the psychology needs in An Coillin, and help meet the governance requirements for psychology within the Adult Mental Health Service in Mayo. This was approved and was with the recruitment service to begin the recruitment process at the time of the inspection. This has been affected by the recent recruitment embargo. In the interim, psychology cross cover has been	Annual audit of Reg 16 and ongoing monitoring by Principal Psychologist	Currently impacted by HSE recruitment embargo.	31/07/2024	Principal Psychologist & Business Manager

	provided where possible. This has included providing group interventions to maximise the number of residents that could be seen by psychology. A psychology group was delivered between January and March 2023 and a new psychology group has commenced in February 2024. Psychology cross cover has also included completion of assessments, interventions and consultation on cases since the initial post was vacated in March 2022. The unmet psychology need for one resident that was identified in their ICP has since been met with the undertaking of a neuropsychological assessment.				
Preventative Action	Referral for psychology can be made to the Principal Psychology Manager who will then delegate the referral to a psychologist in the psychology	Annual audit of Reg 16 and ongoing monitoring by Principal Psychologist	Currently impacted by HSE recruitment embargo.	31/07/2024	Principal Psychologist & Business Manager

	department within the current capacity of the service.				

Regulation 22: Premises					
Reason ID : 10004492		**The approved centre was not kept in a good state of repair externally and internally, as an external windowsill was cracked, some fire doors did not close properly and floors were scuffed and marked. There was litter observed at the entrance of the approved centre, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All Fire doors were serviced and repaired to ensure they close & release properly. The premises audit and the schedule of maintenance for 2024 was completed on 22nd Feb. Internal and external painting of the unit agreed to be completed in 2024. Awaiting quotas from external contractors. Funding will be made available. Phased replacement of flooring in corridors and bedrooms agreed. Awaiting quotas from external contractors. Funding will be made available. The entrance to the Approved Centre now included in the cleaning schedule and is attended to twice daily by Contracted Cleaners. Multi Task Attendants check the area frequently	Annual maintenance audit with 3 monthly reviews and updates involving Nurse management, Infection Prevention and Control (IPC) Nurse, Maintenance Manager and Business Manager.	Yes – but dependant on availability of external contractors.	30/06/2024	Business Manager, Nurse Management & Maintenance Manager.

	throughout the day and clear any rubbish that has been discarded.				
Preventative Action	Cleaning schedule in place and overseen by Infection Prevention Control Nurse and the Contract Cleaners Supervisor. Regular walk around by nurse managers. Any identified maintenance issues reported to Maintenance department. Continue to review and update Premises audit involving key stakeholders. Reviewed and updated audit findings 3 monthly.	Annual maintenance audit with 3 monthly reviews and updates with Nurse management, IPC, Maintenance Manager and Business Manager.	Yes – but dependant on availability of external contractors.	30/06/2024	Business Manager, Nurse Management & Maintenance Manager.
Reason ID : 10004493		**The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, as ligature points were not minimised to the lowest practicable level, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Following completion of ligature audit all identified ligature anchor points were risk rated and action plans developed. A number of identified ligatures have been reduced. For example: reduced ligature wardrobe and reduced ligature	Annual Ligature audit completed as per the HSE Mental Health Services: Ligature Risk-Reduction Policy and Audit Tool. Quarterly reviews and updates by Ligature Reduction Group.	Yes	31/07/2024	Business Manager, Nurse Management & Maintenance Manager.

	lockers installed in all bedrooms. The Ligature Reduction Group review and update the ligature reduction plan 3 monthly or more frequently if required.				
Preventative Action	Annual ligature audit as per National Ligature Risk Reduction Policy and Ligature Risk Reduction Audit Tool with quarterly reviews utilised to reduce ligature to the lowest practicable level. Most recent ligature reduction group meeting held on 13th Feb 2024 and plan updated.	Annual Ligature Audits with quarterly reviews and updates.	yes	30/04/2024	Business Manager, Nurse Management & Maintenance Manager.
Reason ID : 10004494		**The approved centre was not consistently free from offensive odours, as two toilet areas were noted to be malodorous, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The identified toilets were cleaned and ventilated. A cleaning schedule is in place overseen by Infection Prevention Control Nurse and the Contract Cleaners Supervisor. The identified toilet area highlighted and have increased cleaning frequency in place.	Monthly cleaning audit by IPC Nurse and cleaning manager.	Yes	05/09/2024	Business Manager, Nurse Management & Maintenance Manager.

Preventative Action	Frequent walk around by nursing and cleaning staff. Plan to upgrade extract fans in toilet areas to assist with ventilation.	Monthly cleaning audits by IPC Nurse and cleaning manager.	yes	30/06/2024	Maintenance manager, Business Manager, Nurse Management.

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10004499		**The registered proprietor did not ensure that CCTV was clearly labelled and its use evident, 25(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Clear signage was displayed in prominent positions where the CCTV camera is located during inspection. Mayo Mental Health Service CCTV Policy updated to include An Coillin.	Annual audit of Regulation 25	Yes	05/09/2023	Nurse Management
Preventative Action	Annual audit of regulation 25. Regular walk around by nurse managers to ensure signage is in place and clearly visible.	Annual audit of Regulation 25	Yes	30/06/2024	Nurse Management
Reason ID : 10004500		**The registered proprietor did not ensure that the existence and usage of CCTV was disclosed to residents and their representatives, 25(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Clear signage now displayed in prominent positions in the Approved Centre	Annual audit of Regulation 25	Yes	05/09/2023	Nurse Management
Preventative Action	Annual audit of regulation 25. Regular walk around by nurse managers to ensure signage is in place.	Annual audit of Regulation 25	Yes	30/06/2024	Nurse Management

Regulation 26: Staffing

The approved centre did not provide acceptable Corrective and Preventative Action Plans (CAPAs) within the required timeframe. The approved centre will be required to provide acceptable CAPAs and the Commission will follow up in relation to same and will escalate accordingly.

Regulation 32: Risk Management Procedures					
Reason ID : 10004495		**Five sets of fire doors were not closing correctly, one set did not release from its magnetic lock during a fire drill and it was not possible to open one fire exit from inside the approved centre. Therefore, precautions were not in place to control for all identified health and safety risks, 32 (2)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The doors in question were serviced and repaired to ensure they close and release correctly. Monthly visual check of fire doors by person in charge commenced as per the Fire Safety Register. Inspection of fire doors 6 monthly by maintenance department.	Annual maintenance audit with 3 monthly reviews and updates with Nurse management, IPC, Maintenance Manager and Business Manager.	Yes	31/10/2023	Business Manager, Nurse Management & Maintenance Manager.
Preventative Action	A Fire Safety Management Plan is in place within the Approved Centre which includes the following: Fire Protection equipment, fire evacuation and training, testing/service arrangement for firefighting equipment & emergency lighting, fire detectors/alarm systems and unit equipment checks.	Audit of regulation 22 & regulation 32. Fire Safety Register.	Yes	29/02/2024	Business Manager, Nurse Management & Maintenance Manager.

Appendix 2: Background to the inspection process

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

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

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

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

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

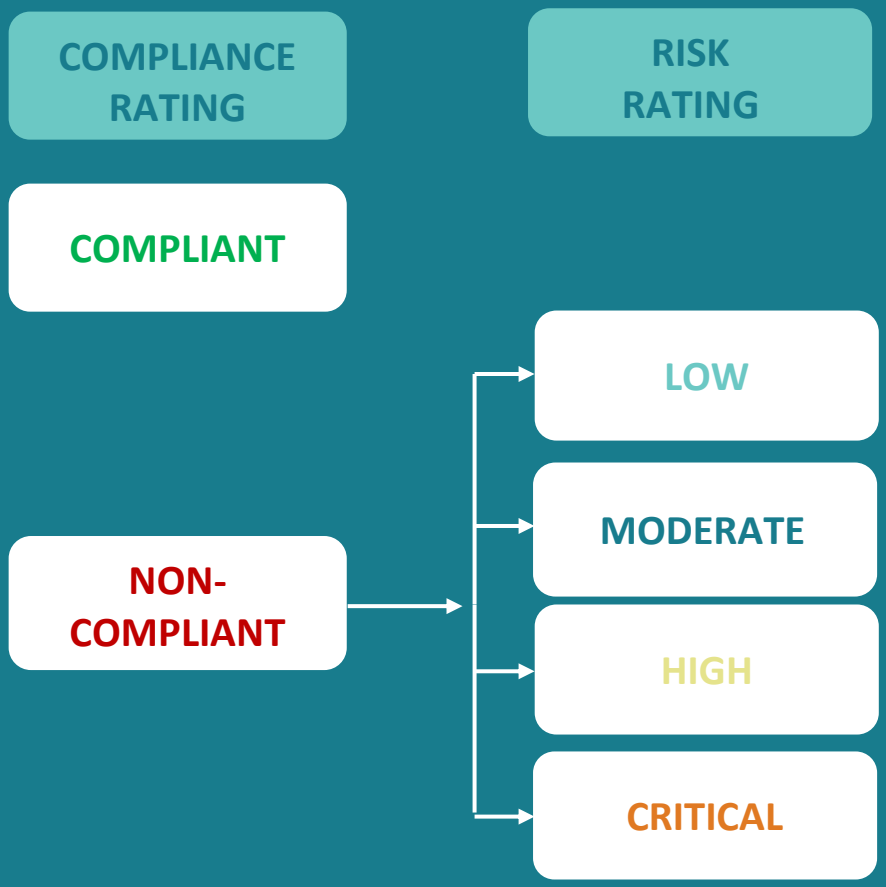
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

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

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.