Department of Psychiatry, Connolly Hospital

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, CONNOLLY HOSPITAL

Blanchardstown, Dublin 15.

Date of Publication:
1 May 2023

ID Number: AC0133

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care

Conditions Attached:
Yes

Most Recent Registration Date:
7 December 2021

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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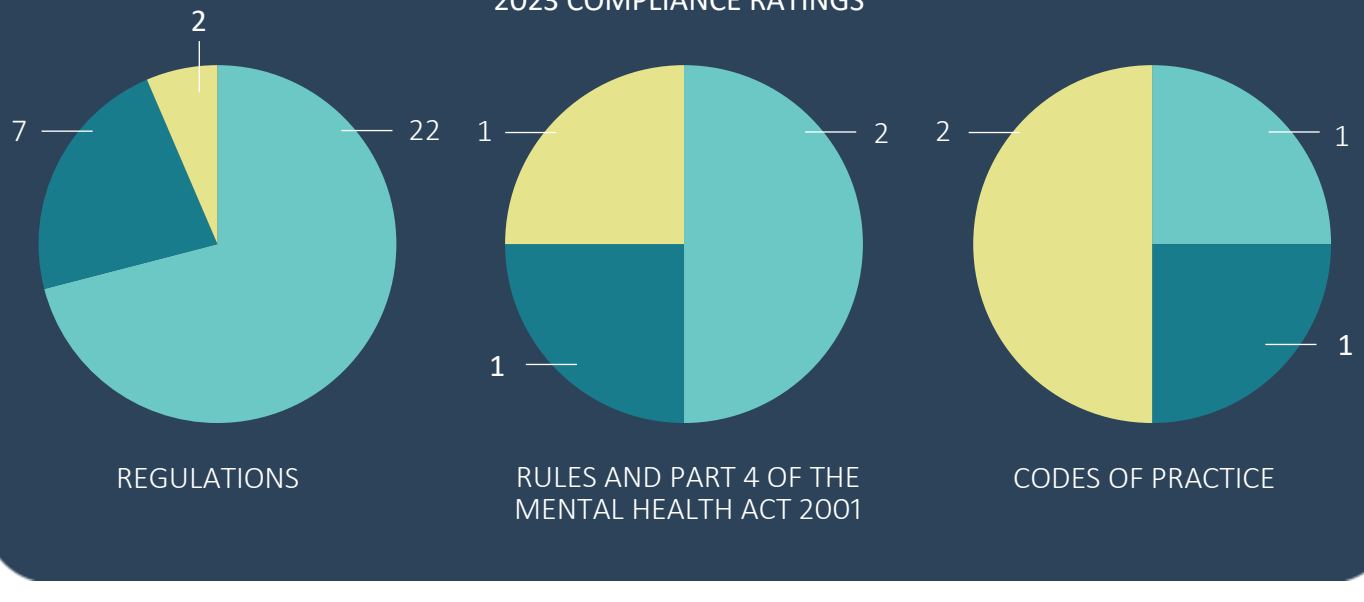
Inspection Date:
1 – 4 August 2023

Previous Inspection date:
18 – 21 October 2022

Inspection Type:
Announced Annual Inspection

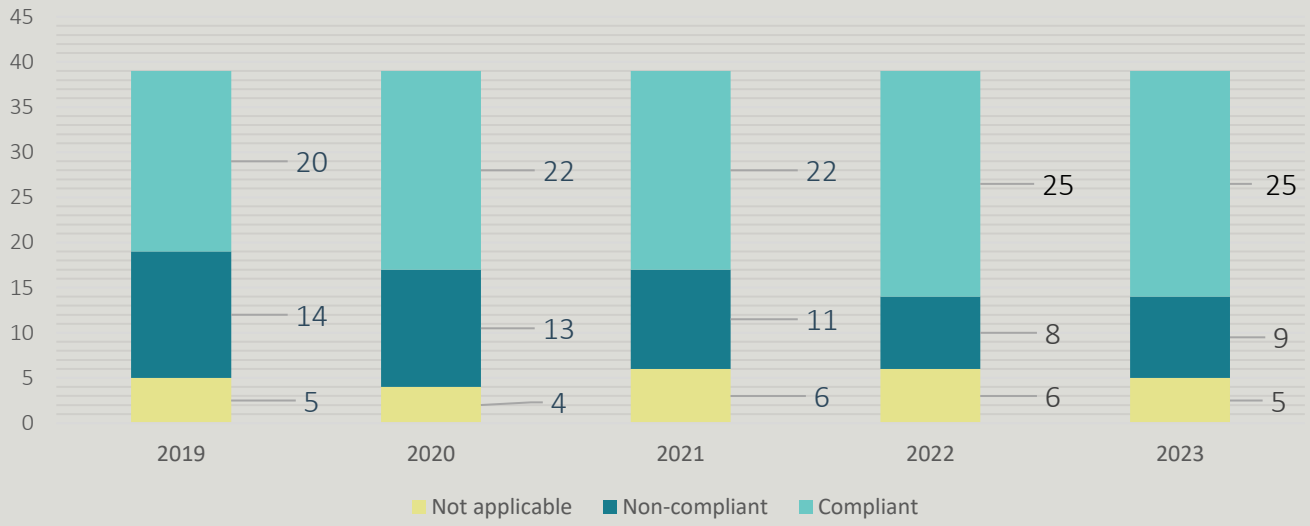
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

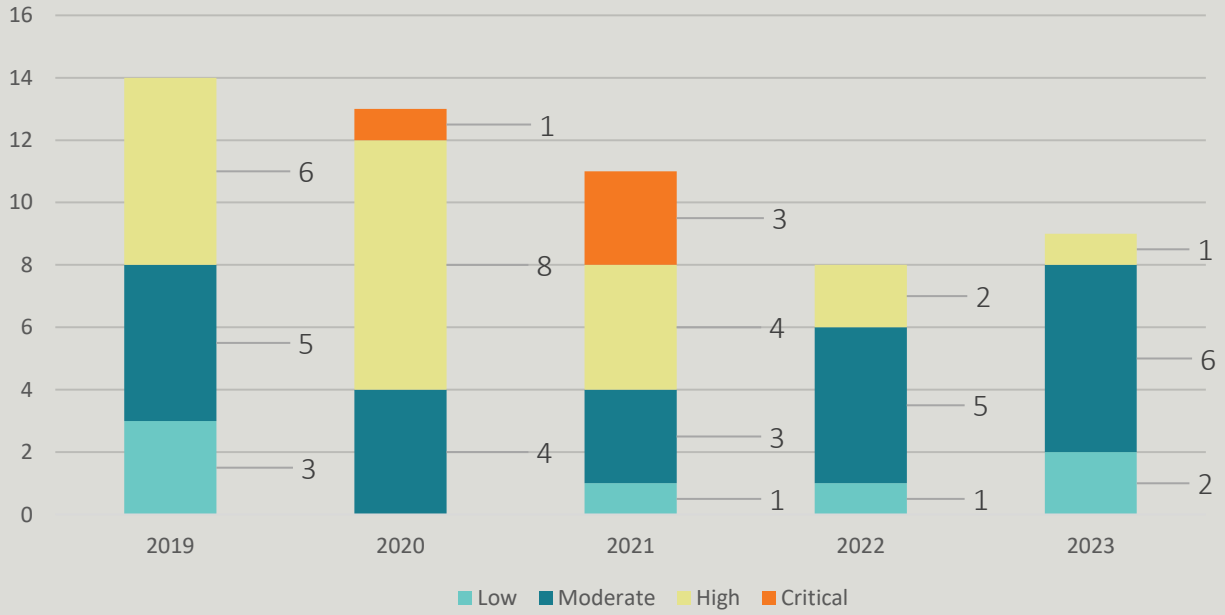
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

In brief

The Department of Psychiatry (DOP) was located on the lower ground floor of Connolly Hospital, Blanchardstown. Nine consultant led teams based in four catchment areas, Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. This comprised of two rehabilitation teams and seven community mental health teams. The liaison psychiatry service, within Connolly Hospital Blanchardstown, also had admitting rights to the approved centre. The approved centre had a bed capacity of 47 and 47 residents were accommodated at the time of the inspection.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	59%	63%	67%	76%	74%

Conditions to registration

There were two conditions attached to the registration of this approved centre at the time of inspection

Conditions	Findings
Condition 1: *The approved centre must implement the Quality Improvement Plan submitted to the Mental Health Commission by the service on 20 September 2021. The approved centre shall submit updates in a form and frequency specified by the Commission. The updates must include detail on the governance arrangements relating to how improvements are being overseen and sustained on a continuing basis.*	The approved centre was not in breach of Condition 1.
Condition 2: *To ensure adherence to Regulation 26(4): Staffing, the approved centre shall implement a plan to ensure all healthcare professionals working in the approved centre are up-to-date in mandatory training areas. The approved centre shall provide a progress update on staff training to the Mental*	The approved centre was not in breach of Condition 2 and the approved centre was non-compliant with Regulation 26: Staffing at the time of inspection.

Health Commission in a form and frequency prescribed by the Commission.	

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:

- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*:** There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Access to essential information*:** The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Infection control*:** Current national infection control guidelines were followed.

However:

- ***Cleanliness:*** The inside of the approved centre was clean, hygienic and free from offensive odours but the outside garden area for the High Dependency Unit was dirty and poorly maintained. The ground and the sides of the shelter area were in need of cleaning and the garden beds had been neglected.
- ***Mandatory training:*** Not all staff were trained in fire safety, basic life support, and the management of violence and aggression.
- ***Numbers of staff:*** The number of psychology staff in the approved centre was not sufficient to meet resident needs. The approved centre had a designated senior psychologist, however one staff grade psychology post was vacant since May 2023.
- ***Ligature points:*** were not minimised to the lowest practicable level, based on risk assessment.

Appropriate care and treatment of residents

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

- ***Initial assessments**:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment**:* Each resident had a physical examination on admission.
- ***Access to other medical services:*** Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Individual Care Plan**:* There were a number of deficits in the care planning process in the sample of files (10) inspected.
    a) One individual care plan was not developed by the multi-disciplinary team following a comprehensive assessment within seven days of admission, as only medical staff were in attendance for the development of the initial care plan.
    b) One individual care plan did not include an appropriate intervention for a goal identified.
    c) Two individual care plans were not reviewed by the multi-disciplinary team on a weekly basis, as required for an acute setting.
- ***Physical assessment**:* The resident's nutritional status and dental health state was not documented on the six-monthly assessment of one resident, which meant this resident did not receive an adequate six-monthly general health assessment.
- ***Therapeutic Services and Programmes:*** All of the approved centre's therapeutic services and programmes were directed towards restoring and maintaining the optimal levels of physical and psychosocial functioning of each resident, with the exception of one to one psychology. Eight residents were waiting for psychology assessment or intervention. One resident had been waiting for more than four weeks for a psychology assessment.

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:*** Residents were accommodated within two 21-bedded wards: Ash Ward and Pine Ward. The wards consisted of three single rooms, three double rooms and three four-bedded rooms. A High Dependency Unit (HDU), located between both wards, accommodated five residents.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.

- ***Privacy and dignity:*** Residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. There were areas where the residents could go if they wanted privacy as well as areas for socialising. Clinical files were securely stored.
- ***Use of restrictive practices: Use of restrictive practices: Rights based Care: Seclusion*** was used in the approved centre only when less restrictive alternatives were deemed unsuitable. There were a number of deficits in the approved centre's seclusion processes in the sample (3) seclusion episodes inspected:

a) In one of the three episodes of seclusion inspected, the resident's representative was not informed of the seclusion episode and there was no record in the clinical file or on the register of seclusion to explain why this communication did not occur.
b) In three episodes of seclusion where searches were undertaken, the outcome of the searches were not documented in the clinical files.
c) In one of the episodes of seclusion inspected, the resident was not informed of the ending of seclusion.

- ***Use of restrictive practices: Rights based Care: Physical Restraint:*** There were a few deficits in the physical restraint process in the sample (3) of physical restraint episodes inspected:
  (a) The resident's individual care plan was not updated to reflect the outcome of the debrief, in particular the resident's preferences in relation to restrictive interventions going-forward, on two occasions.
  (b) There was no documentary evidence that one staff member involved in physical restraint had read and understood the policy.
- ***Rights-based care:*** There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Rights-based care:*** Consent of the resident was not always sought, as resident consent was not documented for one search of a resident which was undertaken.
- ***Privacy and dignity:*** Not all searches were undertaken with due regard to the resident's dignity, privacy and gender, as one search form did not document if there was a minimum of two staff in attendance when the resident was being searched.
- ***Residents Property***: All residents had access to either a locker or wardrobe, but not all residents had access to both, which meant that residents were not consistently supported to securely manage their own property.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Residents were supported to attend Mass locally and other faiths could be accommodated on an individual needs basis.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Included board games, books, DVDs, table tennis, and TVs. Residents from Pine and Ash wards had access to a large internal garden for walks. Residents in the High Dependency Unit had access to a smaller secure garden area.
- ***Residents' feedback:*** The residents were complimentary about the care they received and described the accommodation as adequate. 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. Some residents reported that there were not enough activities on the wards and two residents found the food portions small. Most of the residents described feeling safe 'sometimes' within the approved centre. *(Please refer to section 5.1 for all resident feedback).*

However:

- ***Environment: Ventilation:*** The approved centre was not adequately ventilated, as none of the bedroom windows could be opened.
- ***Environment: Furnishings:*** All residents had access to either a locker or wardrobe, but not all residents had access to both.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The Dublin North City Mental Health Services (DNC MHS) Management Team were responsible for the overall governance and operation of the approved centre, with the exception of Estates/Fire Maintenance, and separately cleaning and catering staff on one of the wards, which was provided for by Connolly Hospital. The DNCMHS Management Team met on a monthly basis.
- ***Leadership:*** The DNC MHS governance process encompassed a monthly Area Management Team Meeting; attendees included the service manager and heads of disciplines. The Area Management Team Meeting was supplemented by a monthly senior management Quality and Safety Committee Meeting. Within the approved centre, governance was enhanced by a local multi-disciplinary Compliance Meeting. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development.
- ***Restrictive practices reduction:*** The service had developed and implemented a policy on the reduction of restrictive practice. The registered proprietor had appointed a senior manager responsible for the approved centre's reduction in restrictive practice. The approved centre was

compliant with the Rule Governing Mechanical Restraint and it was not compliant with the Code of Practice on Physical Restraint and the Rules Governing the Use of Seclusion.

- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. There was a local risk register. Risks identified by the heads of discipline had been appropriately escalated to the DNC MHS risk register, where applicable.
- ***Quality improvement:*** The approved centre had implemented three quality initiatives since the last inspection, including firstly RAID (Reinforce Appropriate Implode Disruptive) training for staff: a positive psychology approach for managing people who exhibit challenging behaviour. Secondly, the Establishment of an Individual Care Plan (ICP) working group and the development of new Individual Care Plan (ICP) and restrictive practice posters, and thirdly the introduction of nursing tobacco free champions: this initiative also included the provision of psycho-education sessions for service users.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings which fed into the compliance meeting if issues were escalated, suggestion boxes, and engagement with the complaints, compliments and feedback process were the principal mechanisms for resident and carer involvement in the process of quality improvement. The service user experience was discussed at the DNC MHS Quality and Safety Committee Meeting.
- ***Advocacy services:*** An advocate from the Peer Advocacy in Mental Health visited the approved centre regularly and spoke with residents.
- ***Regulatory compliance and engagement:*** The approved centre had two conditions on its registration. The approved centre has had an average compliance rate of 70% over the last 4 years. Compliance has decreased by 2% since last year when it was 76% (2022) to this year: 74% (2023). The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Staff training:*** Not all staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health 2001.
- ***Regulatory compliance and engagement:*** The approved centre was not compliant with nine areas of this inspection in 2023.
- ***Risk - Numbers of staff:*** The number of psychology staff in the approved centre was not sufficient to meet resident needs. The approved centre had a designated senior psychologist, however one staff grade psychology post was vacant since May 2023.
- ***Risk - Ligature points:*** were not minimised to the lowest practicable level, based on risk assessment.
- ***Clinical governance:*** There were areas where clinical governance needed improvement i.e. the non-occurrence of two residents receiving an individual care plan weekly review by the MDT, therapeutic services and programmes were not directed towards achieving optimal levels of physical and psychosocial functioning of residents, and the restrictive practices processes within the use of physical restraint and seclusion had deficits.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

- Introduction of RAID (Reinforce Appropriate Implode Disruptive) training for staff. RAID training was a positive psychology approach for managing people who exhibit challenging behaviour.

- Establishment of an Individual Care Plan (ICP) working group and the development of new Individual Care Plan (ICP) and restrictive practice posters.

- Introduction of nursing tobacco free champions; this initiative also included the provision of psycho-education sessions for service users.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry (DOP) was located on the lower ground floor of Connolly Hospital, Blanchardstown. The approved centre had a designated entrance, from the ground floor of the main hospital via staircase or lift. Access to the approved centre was by swipe card or by request, which was facilitated by security staff.

The approved centre's main corridor provided access to the wards and an occupational therapy department, which included a recreational room, an arts and crafts room, a relaxation room, an occupational therapy kitchen and a garden. A family room, a tribunal room and staff offices were also located on the main corridor. The approved centre was registered for 47 beds with the Mental Health Commission. Residents were accommodated within two 21 bedded wards; Ash ward and Pine ward. The wards consisted of three single rooms, three double rooms and three four-bedded rooms. Residents in Ash ward and Pine ward had shared access to a large courtyard, with raised flower beds and colourful garden furniture. Both wards had three small multi-purpose day rooms and a dining room. A High Dependency Unit (HDU), located between both wards, accommodated five residents. HDU consisted of a day room/dining room and an external courtyard, which required maintenance at the time of the inspection. The approved centre's seclusion facility was located within the HDU.

Nine consultant led teams based in four catchment areas, Blanchardstown east and west, Finglas and Cabra, admitted residents to the approved centre. This comprised of two rehabilitation teams and seven community mental health teams. The liaison psychiatry service, within Connolly Hospital Blanchardstown, also had admitting rights to the approved centre.

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

Resident Profile	
Number of registered beds	***47***
Total number of residents	**47**
Number of detained patients	23
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	6
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of the Dublin North City and County Healthcare Organisation. Dublin North City Mental Health Services (DNC MHS) were responsible for the overall management and governance of the approved centre. However, this did not include estates or fire management, along with cleaning and catering staff for one of the wards, which were provided by Connolly Hospital.

The DNC MHS governance process encompassed a monthly Area Management Team Meeting; attendees included the service manager and heads of disciplines. Agenda items included: finance, human resources and staff training, service plans and updates, quality and patient safety, key performance indicators and capital/minor developments. The Area Management Team Meeting was supplemented by a monthly senior management Quality and Safety Committee Meeting. This meeting was a forum to discuss issues such as service user and staff experience, quality indicators and outcome measures and risk management. However, Quality and Safety Committee meetings were not held in April or May 2023. Within the approved centre, governance was enhanced by a local multi-disciplinary Compliance Meeting. This meeting facilitated discussion on regulatory issues, quality initiatives, policies and local operational issues. The Compliance Meeting was supported by various committees and meetings which encompassed an Incident Review Committee.

There was an organisational chart to identify the leadership and management structure and the lines of authority and accountability within the approved centre. The CHO DNC MHS General Manager was the Approved Centre's Registered Proprietor nominee. There were formal and informal structures and processes in place for measuring and encouraging staff performance and personal development. Residents within the approved centre had access to medical, nursing, social work, psychology, and occupational therapy disciplines. At the time of the inspection, the number of psychologists was not sufficient to meet resident needs. While the approved centre had a designated senior psychologist, one staff grade psychology post was vacant since May 2023. The approved centre had recently obtained approval to augment the vacant staff grade psychology post to a senior grade. A psychology assistant was due to commence work within the approved centre in September 2023. Not healthcare staff within the approved centre had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression.

The person with responsibility for risk was identified and known by all staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre to ensure their effective implementation. The multi-disciplinary team was involved in the development, implementation, and review of individual risk management processes. Incidents were recorded and risk-rated on the National Incident Report Form (NIRF). Incidents were reviewed to identify any trends or patterns occurring in the service at the approved centre's Incident Review Committee. Risks identified by the heads of discipline had been appropriately escalated to the DNC MHS risk register, where applicable. This included the following: violence and aggressive behaviour, inability of staff to attend mandatory training, ligature points and limited staff resources. The DNC MHS risk register was reviewed regularly at the Quality and Safety Committee Meeting, with updates discussed at the Area Management Team Meeting.

The approved centre had two conditions attached to its registration with the Mental Health Commission for the provision of acute adult mental health care. Not healthcare staff within the approved centre had

completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. However, the approved centre was implementing a plan to ensure that all healthcare professionals were up to date in their mandatory training. It was evident from this inspection that the approved centre was committed to the implementation of their Quality Improvement Plan. Significant work had been completed to address previous non-compliances in relation to Regulation 22 Premises. Since the last annual inspection in October 2022, the approved centre had been painted, with new flooring throughout. The approved centre had obtained major capital funding for a windows and carpentry project, in which work was due to commence by the end of the year. The project plans addressed issues regarding Regulation 8 Personal Property and Possessions and Regulation 22 Premises, which incorporated ligature reduction works.

The approved centre had a variety of mechanisms in place to capture the service user experience. Regular community meetings were held and the minutes of these were kept. Issues arising from the community meetings were escalated to the Compliance Meeting. Residents' feedback was also obtained via the complaints, compliments, and feedback process, which was displayed throughout the approved centre. An advocate from the Peer Advocacy in Mental Health visited the approved centre regularly and spoke with residents. The service user experience was discussed at the DNC MHS Quality and Safety Committee Meeting. While Service User Reform was a standing agenda item of the DNC MHS Area Management Team meeting, there had been no update for several months; the inspection team was informed that an Area Lead for Mental Health Engagement was due to start.

The Mental Health Commission's updated Rules governing the use of Mechanical Restraint, the Rules governing the use of Seclusion and the Code of Practice on the Use of Physical Restraint were implemented on 1st January 2023. In response to this, the approved centre had a new Restrictive Practice Reduction Policy and the Registered Proprietor had appointed a named Senior Manager who was responsible for the approved centre's reduction of restrictive practices. The approved centre established a Restrictive Practices Oversight Committee, in which all restrictive practices were reviewed. The Rules governing the use of Mechanical Restraint was deemed compliant. However, both the Rules governing the use of Seclusion and the Code of Practice were found to be non-compliant; with moderate risk ratings.

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 8: Residents' Personal Property and Possessions	✓		✓		✗	High	✓		✗	Low
Regulation 13: Searches	✗	Moderate	✓		✓		✓		✗	Moderate
Regulation 15: Individual Care Plan	✗	High	✗	High	✓		✗	Moderate	✗	Moderate
Regulation 16: Therapeutic Services and Programmes	✗	Moderate	✓		✓		✓		✗	Moderate
Regulation 19: General Health	✓	High	✓	High	✗	Critical	✗	Moderate	✗	Low
Regulation 22: Premises	✗	Low	✗	High	✗	High	✗	High	✗	High
Regulation 26: Staffing	✗	Moderate	✗	High	✗	Critical	✗	Low	✗	Moderate
Rules Governing the Use of Seclusion	✗	Low	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate
Code of Practice on the Use of Physical Restraint in Approved Centres	✗	High	✗	High	✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As the approved centre did not provide an ECT service, this rule was not applicable
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

The inspection team spoke with six residents. Most of the residents were complimentary of the staff, with one resident describing the nursing staff as 'fantastic'. Residents reported that they knew their multi-disciplinary team (MDT) and were aware of their individual care plan (ICP). Residents described their accommodation as adequate. One resident reported that they felt 'listened to' and that they 'felt safe'. However, some residents reported that there weren't enough activities on the wards. Two residents stated that food portions were small, with one resident reporting that snacks such as yogurts and crackers were limited. Some of the residents raised specific concerns regarding their individual care and treatment; the inspection team discussed these issues with the relevant nursing staff, with the residents' consent.

The inspection team received 16 completed service user experience questionnaires. On a scale of 1 – 10, with 1 being poor and 10 being excellent, 13 residents rating of their overall experience of their care and treatment ranged between 1 and 10, with an average score of 5. Some of the residents commented that there weren't enough activities (including talk therapies), that the evening meal wasn't nutritious and that waiting to see the doctors was hard. Not all of the residents reported that they understood their individual care plan (ICP). Most of the residents described feeling safe 'sometimes' within the approved centre.

5.2 Advocacy

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

Positive aspects of the service included:

- Most of the resident were happy with the care that they received
- Residents commented positively on the service that they received from their social workers and occupational therapists
- Residents stated that their physical health was cared for, including any dietary requirements
- Residents reported that they were listened to and that their concerns were taken seriously
- Residents stated that they were provided with information on their medications

Areas in need of improvement:

- Delayed discharges due to a lack of suitable accommodation.
- Over-reliance on medication to treat mental health illness.
- Some residents were not aware of their individual care plan (ICP) or key nurse.
- Some residents who were secluded described this as a very traumatic experience.
- Some residents commented that there were too many acutely unwell residents within the approved centre and that this impacted negatively on their recovery.
- Residents reported that they would like information and recovery techniques to deal with illnesses such as depression, bipolar disorder, schizophrenia and anxiety disorders.

6.0 Feedback Meeting

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

- Clinical Director
- General Manager / Registered Proprietor Nominee
- Service Manager
- Assistant Director of Nursing x2
- Clinical Nurse Manager III
- Area Director of Nursing
- Principal Social Worker
- Occupational Therapy Manager
- Principal Psychologist Nominee
- Clinical Nurse Manager II

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 a 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. Nursing staff assessed residents' needs on admission and referrals were made to the dietitian where necessary. Residents also had access to a private dietitian and speech and language therapist.

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. Food was cooked in the main Connolly Hospital kitchen. There were proper facilities for the refrigeration, storage, preparation, 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. New clothing for both males and females was available in a variety of sizes and colours. 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

NON-COMPLIANT

Risk Rating Low

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in July 2023. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. There were secure property rooms available in all the three units, which contained individually named boxes for each resident to store personal property.

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 not consistently 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. On Ash ward, there were seven bedrooms with wardrobes only and one bedroom with a locker only. In Pine Ward, there were two bedrooms with lockers only and six with wardrobes only. At the time of inspection, a plan of works was in place for the installation of new wardrobes by the end of the year.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that provisions were made for the safe-keeping of all personal property; not all residents had access to both a locker and a wardrobe, 8(6).

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents had access to board games, books, DVDs, table tennis, and TVs. Residents from Pine and Ash wards had access to a large internal garden for walks. Residents in the High Dependency Unit had access to a smaller secure garden area.

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. All religious requests were facilitated where practicable, and could be arranged via the chaplain in Connolly Hospital Blanchardstown.

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 September 2020.

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 visiting children.

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 October 2021.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. In Pine ward, residents had use of their own mobile phones, access to Wi-Fi, and access to an electronic tablet and portable phone. In Ash ward, residents had access to their own devices, as well as Wi-Fi, tablets, portable phones and nurses' station phone. In the High Dependency Unit, residents had access to their own devices, portable ward phone, and tablet.

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. At the time of inspection, one resident had a restriction on their communication and this was recorded in the clinical file.

The approved centre was compliant with this regulation.

Regulation 13: Searches

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The clinical files of three residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. For two of the searches examined, resident consent was sought and the request for consent and received consent were documented. However, for the third search, there was no documented record to indicate that consent was sought.

General written consent was sought for routine environmental searches. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

Residents were informed by those implementing the search of what was happening during the search, and why. A written record, which included the reason for the search, the names of both staff members who undertook the search, and details of who was in attendance, was available for two of the searches. For one search, however, no search form was completed, and clinical notes did not report who undertook

the search or in who was in attendance. In the absence of a search form or written record in the clinical file, it was not possible to ascertain if two staff were in attendance at all times during this search.

A written record was kept of all environmental searches. Policy requirements were implemented when illicit substances were found as a result of a search.

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

a) **The registered proprietor did not ensure that the consent of the resident was always sought, as consent was not documented for one search, 13(4).**
b) **The registered proprietor did not ensure that all searches were undertaken with due regard to the resident's dignity, privacy and gender, as one search did not document if there was a minimum of two staff in attendance, 13(7).**

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, which was last reviewed in May 2021, and a policy relating to the sudden death of a resident, which was last reviewed in March 2021.

As there had been no death of a resident since the last inspection, this regulation was assessed on the policy requirement alone.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

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). Ten ICPs were inspected. All ICPs were a composite set of documentation. Specific space and sections were allocated for needs, goals, treatment, care, resources required, and reviews.

Not all the ICPs were developed by the multi-disciplinary team (MDT) following comprehensive assessment within seven days of admission. For one ICP, only medical staff were in attendance for the development of the initial care plan.

The ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate. The ICPs were stored within the clinical file, were identifiable and uninterrupted, and were not amalgamated with progress notes.

ICPs identified appropriate goals for the resident. For nine ICPs, the care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. All ICPs identified the resources required to provide the care and treatment identified.

ICPs were mostly subject to appropriate review by the MDT in consultation with the resident. However, two ICPs had their reviews postponed for a week due to a bank holiday. This left a gap of two weeks between review, putting them outside the weekly timeframe required for an acute setting.

The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

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

a) **One individual care plan was not developed by the multi-disciplinary team following comprehensive assessment within seven days of admission, as only medical staff were in attendance.**

b) One individual care plan did not include an appropriate intervention for a goal identified.
c) Two individual care plans were not reviewed by the multi-disciplinary team on a weekly basis, as required for an acute setting.

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 appropriate and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The occupational therapy (OT) department consisted of an OT kitchen for assessments, a large group room with an interactive white board, an art room and 'my space' room which was co-created with service users two years previously. Group programmes changed dynamically based on the needs of the cohort. At the time of inspection, leisure and socialisation groups were running for residents of Pine and Ash wards. An open-access exercise group was facilitated by a fitness instructor on Thursdays. These groups were run separately or as one-to-one sessions for residents in the High Dependency Unit.

All of the approved centre's therapeutic services and programmes were directed towards restoring and maintaining the optimal levels of physical and psychosocial functioning of each resident, with the exception of one to one psychology. There was one psychologist in the approved centre at the time of inspection, and one vacant psychology post. At the time of the inspection, eight residents were waiting for psychology assessment or intervention. One resident had been waiting for more than four weeks for a psychology assessment.

The approved centre was non-compliant with this regulation because eight residents were waiting for psychology assessment or intervention and one resident had been waiting for more than four weeks for a psychology assessment, 16(2).

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 March 2021. The clinical file of one resident who had been transferred from the approved centre was inspected. As it was an emergency transfer, communication between the approved centre and the receiving facility was 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

NON-COMPLIANT

Risk Rating Low

(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. There was an emergency trolley and Automated External Defibrillator (AED) available in both Pine and Ash wards with access to both for the High Dependency Unit. In the event of an emergency, the crash team from the main hospital would respond. 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, medication review, and body mass-index, weight, and waist circumference. However, nutritional status (diet and physical activity, including sedentary lifestyle) and dental health were not recorded on the six-monthly health assessment of one resident. 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 non-compliant with this regulation because the nutritional status and dental health was not documented on the six-monthly assessment of one resident, 19 (1)(b).

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was appropriate to and supportive of the dignity and privacy of the residents. Residents were called by their preferred names, staff appearance and dress 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.

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and bedrooms. Rooms were not ventilated. The windows in bedroom areas could not be opened to allow a flow through of air. At the time of inspection, a plan was established to replace all windows in the approved centre, with installation due to begin by the end of the year.

All private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

Sufficient spaces were provided for residents to move about, including outdoor spaces. Residents in Ash and Pine wards had shared access to a large courtyard garden, which was well maintained. The garden included colourful furniture and raised garden beds. Residents in the High Dependency Unit (HDU) had access to a smaller garden area.

Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or rough surfaces, were minimized in the approved centre. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

The approved centre was kept in a good state of repair externally and internally. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than

43°C. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Current national infection control guidelines were followed.

Internally, the approved centre was clean, hygienic and free from offensive odours. Externally, however, the ground paving in the HDU garden was dirty and in need of power hosing, as were the sides of the shelter area, which were unkempt and covered in dirt and moss. The two garden beds in this garden were neglected and almost bare, with exception of two plants and weeds.

The approved centre provided a sufficient number of toilets and showers for residents, with at least one assisted toilet per floor. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs. However, not all bedrooms were furnished to support resident independence and comfort, as some bedrooms did not have a wardrobe and a bedside locker in which to store belongings. There were plans in place for carpentry works to address this issue.

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

a) **The registered proprietor did not ensure that the HDU garden was clean, 22(1)(a).**
b) **The registered proprietor did not ensure that the premises were adequately ventilated, as none of the bedroom windows could be opened, 22(1)(b).**
c) **The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings, as not all resident bedrooms were furnished with a wardrobe and bedside locker, 22(2).**
d) **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, based on risk assessment, 22(3).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including the following: a record of any allergies or sensitivities to medications, including if the resident has none; the frequency of administration, including the minimum dose interval for 'as required' (PRN) medication; a record of all medications administered to the resident; clear records of the date of discontinuation for each medication; 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. 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, and Scheduled 2 and 3 controlled drugs were secured separately from other medications to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in November 2020. The approved centre also had a Health and Safety Statement, last reviewed in April 2023.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating MODERATE

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

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

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

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

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

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

INSPECTION FINDINGS

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

Residents within the approved centre had access to medical, nursing, social work, psychology, and occupational therapy disciplines. However, the number of psychology staff in the approved centre was not sufficient to meet resident needs. While the approved centre had a designated senior psychologist, one staff grade psychology post was vacant since May 2023. As a result, at the time of the inspection, eight residents were waiting for psychology assessment or intervention; one resident had been waiting for more than four weeks. The approved centre had recently obtained approval to augment the vacant staff grade psychology post to a senior grade. Furthermore, a psychology assistant was due to commence work within the approved centre in September 2023.

An appropriately qualified staff member was on duty at all times. All healthcare staff were trained in the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. Not all healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression. The following table gives a breakdown of the numbers of 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 (50)	47	97%	50	100%	44	88%	50	100%
Consultant Psychiatrist (11)	5	63%	4	27%	10	90%	11	100%
Medical (17)	15	83%	17	100%	17	100%	17	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (8)	8	100%	7	88%	8	100%	8	100%
Psychologist (4)	1	25%	4	100%	4	100%	4	100%

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

a) **The number of psychology staff in the approved centre was not sufficient to meet resident needs. While the approved centre had a designated senior psychologist, one staff grade psychology post was vacant since May 2023, 26(2).**
b) **Not all healthcare staff had completed mandatory training in Basic Life Support, Fire Safety, and the Management of Violence and Aggression, 26(4).**

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in January 2021, 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 unauthorized 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 May 2021, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

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

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

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had an Incident Reporting and Management Policy (last reviewed in May 2021), a Clinical Risk Assessment and Management Policy (last reviewed in October 2021), an Additional Risk Management Procedures Policy (last reviewed in October 2021), and a Health and Safety Statement (last reviewed in April 2023). Together, these policies incorporated all the policy requirements for this 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 and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

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

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with two conditions to registration attached. The certificate was displayed prominently in the main hall of the approved centre.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was last reviewed in March 2023. It included all the policy-requirements for this rule.

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

The policy and procedures for training all staff involved in seclusion documented who would receive training, the identification of appropriately qualified persons to give the training, and the areas to be addressed within the training programme.

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

Monitoring: A multi-disciplinary review and oversight committee was established to analyse every episode of seclusion in detail.

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

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

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

Upon commencement of each episode of seclusion, a Seclusion Care Plan for the resident was developed by a RN.

There was a medical examination of the resident by a RMP as soon as practicable, and no later than two hours after the commencement of each episode. The examination included an assessment and record of any physical, psychological, or emotional trauma caused to the resident as a result of the seclusion. Where the CP ordered the continued use of seclusion, they advised the duration of each order. Seclusion orders were not made for any period of time longer than four hours from the commencement of each seclusion episode. The orders of the CP confirmed that there were no other less restrictive ways available to manage the residents' presentation.

The CP undertook a medical examination of the residents and signed the seclusion register within 24 hours of the commencement of each episode. In two of the seclusion episodes, the residents' representatives were informed of the seclusion, in accordance with their wishes and individual care plans (ICPs), and this was recorded in the clinical files. In respect of the third, however, the seclusion register indicated that the representative was not informed, but no explanation for this was recorded in either the seclusion register or the clinical file.

Searches were undertaken in all three episodes of seclusion inspected. Bodily searches were undertaken in the presence of more than one staff member, and respected the right of the resident to dignity, bodily integrity and privacy. Gender and cultural sensitivity and the preferences of the resident were respected. However, in all three instances, the outcome of the search was not documented in the clinical file, and the search form was not completed as per the approved centre's policy.

Monitoring of the Resident: The residents placed in seclusion were kept under direct observation by an RN for the first hour following the initiation of seclusion. After the first hour, an RN kept the residents under continuous observation and remained within sight and sound of the seclusion room throughout the episode. A comprehensive written record of the resident was made by the RN every 15 minutes.

Ending of Seclusion: In one of the episodes of seclusion inspected, the resident was not informed of the ending of seclusion. An in-person debrief followed each episode. This occurred within two working days of the episode, unless it was the preference of the resident to have the debrief outside of this timeframe. The debrief was person-centred, gave the residents the opportunity to discuss the seclusion with

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

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

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

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

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

a) **In one of the three episodes of seclusion inspected, the resident's representative was not informed of the seclusion episode and there was no record in the clinical file or on the register of seclusion to explain why this communication did not occur, 3.12(a).**
b) **In three episodes of seclusion where searches were undertaken, the outcome of the searches were not documented in the clinical files, 4.4.**
c) **In one of the episodes of seclusion inspected, the resident was not informed of the ending of seclusion, 7.3.**

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of mechanical restraint. The policy was last reviewed in May 2023.

Training and Education: All staff who had participated, or may participate, in the use of mechanical restraint had received appropriate training in its use, and in the related policies and procedures. There was a record of training attendance.

Monitoring: The approved centre had established a multi-disciplinary (MDT) review and oversight committee to undertake a detailed analysis of every episode of mechanical restraint. The committee met on a quarterly basis to:

- Determine if there was compliance with the rules on the use of MR, for each episode reviewed.
- Determine if there was compliance with the approved centre's own policies and procedures relating to MR.
- Identify and document any areas for improvement.
- Identify the actions, the persons responsible, and the timeframes for completion of any actions.
- Produce a report following each meeting of the review and oversight committee.

Evidence of Implementation: One episode of mechanical restraint (MR) was examined on inspection. MR was used to address an identified clinical need or risk. It was only used when less restrictive alternatives were not deemed suitable. A risk assessment of the safety and suitability of the MR for the resident was undertaken which specified the monitoring arrangements and frequency to be implemented during its use. A copy of the risk assessment, and a record of the monitoring of the resident, were available.

The multi-disciplinary team (MDT) developed a plan of care for the resident which included information on attempts to reduce or eliminate the use of restraint for the resident. MR was ordered by a registered medical practitioner (RMP), under the supervision of the consultant psychiatrist (CP) responsible for the care and treatment of the person or the duty CP.

The clinical file contained a contemporaneous record that specified:

- That there was an enduring risk of harm to self or others.
- That less restrictive alternatives had not been successful.
- The type of mechanical restraint.
- The situation where MR was being applied.
- The duration of the restraint.
- The duration of the order.
- The review date.

The register proprietor notified the Mental Health Commission about the use of MR for enduring risk to self and others in the specified format, and within the timeframes set by the Mental Health Commission.

The approved centre was compliant with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

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

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating MODERATE

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

INSPECTION FINDINGS

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

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

The approved centre had a written policy on the reduction of physical restraint. It included all the policy requirements for this code of practice.

Training and Education: The written record did not indicate that all staff involved in the use of physical restraint had read and understood the policy, as one signature was absent from the list. A record of attendance at training was maintained.

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

Evidence of Implementation: Three episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered practical nurse (RPN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there were no other less restrictive methods available to manage the residents' presentation. The consultant psychiatrist (CP) was notified as soon as was practicable and this was documented in the clinical flies. A physical examination of the residents had been completed no later than two hours after the start of each episode of restraint.

The orders for physical restraint did not exceed a duration of 10 minutes. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode, and signed by the CP within 24 hours. The residents were informed of the reasons for the physical restraint, and the circumstances which would lead to its discontinuation. This was recorded in the clinical file as soon as was practicable.

In accordance with the resident's wish and their individual care plan (ICP), the resident's representative was informed of the restraint as soon as was practicable. Where it was the resident's wish that their representative was not informed of the restraint, no such communication occurred outside the course of that necessary to fulfil legal and professional requirements. The Mental Health Commission was notified

of the start time and date, and the end time and date, of each episode of physical restraint in the correct format and within three days of each episode.

Staff members of the same gender were present at all times during the episodes of physical restraint. The residents were continuously assessed throughout the uses of restraint to insure their safety, and this was documented.

Ending Physical Restraint: The physical restraint in each instance was ended by the person who had lead it. The residents were given the opportunity to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. The debrief included a discussion regarding the residents' preferences in the event of a restrictive intervention being required in the future (noting which restrictive intervention they would not like to be used.)

In respect of two episodes, the resident's ICP was not updated to reflect the outcome of the debrief - in particular, with reference to the person's preferences in relation to restrictive interventions going forward. In respect of the third episode, the resident's ICP was updated.

There was a record of all attendees who were present at the debrief and this was included in the clinical file. Appropriate emotional support was provided to the residents following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

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

Clinical Governance: Each episode of physical restraint was reviewed by the members of the MDT involved in the resident's care and treatment and documented in the clinical files within five working days of the date of restraint. The MDT review, including recorded actions decided upon and follow-up plans to eliminate or reduce interventions for the resident, was documented.

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

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

(a) The resident's individual care plan was not updated to reflect the outcome of the debrief, in particular the resident's preferences in relation to restrictive interventions going forward, on two occasions, 5.5.

(b) There was no documentary evidence that one staff member involved in physical restraint had read and understood the policy, 7.2(b).

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in November 2020, included all of the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in March 2021, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in May 2021, 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, discharge and 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, and all other relevant information. A key worker system was in place, full physical examination carried out, and a family member or carer was involved in the admission process with the resident's consent.

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

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

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

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs. The discharge was coordinated by the key worker. The preliminary discharge summary was sent to the relevant healthcare. 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; and risk issues such as signs of relapse. Family members, carers or 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 08: Residents' Personal Property and Possessions					
Reason ID : 10004551		**The registered proprietor did not ensure that provisions were made for the safe-keeping of all personal property; not all residents had access to both a locker and a wardrobe, 8(6).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review was completed of all residents' beds and access to a locker or wardrobe was provided.	All residents have access to either a locker and/or wardrobe to store personal belongings, observed through quality and safety workarounds. All residents are able to store property in patient private property room observed through quality and safety workarounds.	This has been achieved.	22/12/2023	ADON CNM III CNM 11 Service Manager
Preventative Action	Funding has been approved for an Furniture Programme of Works, which includes lockers and wardrobes for each resident.	Furniture Programme of Works Tracker; Meetings with Maintenance; DOP Compliance Committee; Quality and safety walkarounds	Achievable	28/03/2025	ADON, Nurse Managers, Service Manager, Maintenance

Regulation 13: Searches					
Reason ID : 10004569		**The registered proprietor did not ensure that the consent of the resident was always sought, as consent was not documented for one search, 13(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ensured all staff were aware of the policy and procedure regarding searches in the DOP. Quality and Safety Walkabout include Search regulation 13 on the checklist.	Quarterly Quality and Safety Walkabout. Annual Audit. Compliance Committee	Achievable and Realistic	29/12/2023	Clinical Director ADON CNM111 CNM11.
Preventative Action	Searches regulation to be added to the Quality and Safety Walkabout checklist. Search Regulation 13 discussed at Monthly Compliance Committee meeting where all members of the MDT attend and any recent searches will be discussed. Policy reviewed under JSF 2024 and all staff will sign to evidence that they have read and understood the Policy and Procedure on searches.	Quarterly Quality and Safety Walkabout. Annual Audit Monthly Compliance Meeting.	Achievable and realistic	27/09/2024	Clinical Director ADON CNM111 CNM11.

Reason ID : 10004570		The registered proprietor did not ensure that all searches were undertaken with due regard to the resident's dignity, privacy and gender, as one search did not document if there was a minimum of two staff in attendance, 13(7).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ensured all staff were aware of the policy and procedure regarding searches in the DOP. Quality and Safety Walkabout include Search regulation on the checklist.	Quarterly Quality and Safety Walkabout. Annual Audit.	Achievable and Realistic	29/12/2023	Clinical Director ADON CNM111 CNM11.
Preventative Action	Searches Regulation 13 to be added to the Quality and Safety Walkabout checklist. Search regulation discussed at Monthly Compliance Committee meeting where all members of the MDT attend and any recent searches will be discussed. Policy reviewed under JSF 2024 and all staff will sign to evidence that they have read and understood same.	Quarterly Quality and Safety Walkabout. Annual Audit Monthly Compliance Meeting.	Achievable and realistic	27/09/2024	Clinical Director ADON CNM111 CNM11.

Regulation 15: Individual Care Plan					
Reason ID : 10004571		**One individual care plan was not developed by the multi-disciplinary team following comprehensive assessment within seven days of admission, as only medical staff were in attendance.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team involved made aware of the lack of MDT input into ICP for one service user.	Monthly ICP audits.	Achievable and realistic	29/12/2023	Clinical Director
Preventative Action	ICP MDT training day delivered on the 20th of Nov 2023. ICP included into the Quartly Quality and Safety walkabout. Writing a person centred individual care plan guidance document was created and circulated to all members of the MDT. Training sessions delivered. to NCHDs at induction. A new ICP committee established in the DOP to review and create a new ICP document.	Monthly ICP Audits. Monthly Compliance Committee meetings. Quarterly Quality and Safety Walkabout.	Achievable and realistic	27/09/2024	All Heads of Disciplines.
Reason ID : 10004572		**One individual care plan did not include an appropriate intervention for a goal identified.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Team involved made aware of the lack of an appropriate intervention.	Monthly ICP audits.	Achievable and realistic	29/12/2023	Clinical Director
Preventative Action	ICP MDT training day delivered on the 20th of Nov 2023. ICP included into the Quartly Quality and Safety walkabout. Writing a person centred individual care plan guidance document was created and circulated to all members of the MDT. Training sessions delivered. to NCHDs at induction. A new ICP committee established in the DOP to review and create a new ICP document.	Monthly ICP Audits. Monthly Compliance Committee meetings. Quarterly Quality and Safety Walkabout.	Achievable and realistic	27/09/2024	All Heads of Disciplines.
Reason ID : 10004573		**Two individual care plans were not reviewed by the multi-disciplinary team on a weekly basis, as required for an acute setting.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team involved made aware of frequency required for reviews of all ICPS.	Monthly ICP audits.	Achievable and realistic	29/12/2023	Clinical Director
Preventative Action	ICP MDT training day delivered on the 20th	Monthly ICP Audits. Monthly Compliance	Achievable and realistic	27/09/2024	All Heads of Disciplines.

	of Nov 2023. ICP included into the Quartly Quality and Safety walkabout. Writing a person centred individual care plan guidance document was created and circulated to all members of the MDT. Training sessions delivered. to NCHDs at induction. A new ICP committee established in the DOP to review and create a new ICP document	Committee meetings. Quartly Quality and Safety Walkabout.			

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10004552		**Eight residents were waiting for psychology assessment or intervention and one resident had been waiting for more than four weeks for a psychology assessment, 16(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Second Senior Psychologist has been recruited.	Reduction in waiting times for Psychology Assessments and Waiting times	This has been achieved	29/03/2024	Senior Psychologist
Preventative Action	Referrals are reviewed weekly and through MDT to triage and identify priorties.	Wait times for Psychological intervention reviewed at weekly MDT ICPs and referral meeting	Achievable	29/03/2024	Senior Psychologist

Regulation 19: General Health					
Reason ID : 10004574		**The nutritional status and dental health was not documented on the six-monthly assessment of one resident, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team involved made aware of the need for nutritional status and dental health of resident involved.	Monthly compliance Meeting. Quarterly Quality and Safety Walkabouts.	Achievable and realistic	29/12/2023	Clinical Director.
Preventative Action	General Health Policy circulated to all members of the MDT. Regulation 19 General Health added to the Quarterly Quality and Safety Walk rounds. This includes nutrional and dental health.	Monthly compliance Meeting. Quarterly Quality and Safety Walkabouts	Achievable and realistic	29/03/2024	Clinical Director.

Regulation 22: Premises					
Reason ID : 10004553		**The registered proprietor did not ensure that the premises were adequately ventilated, as none of the bedroom windows could be opened, 22(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is a system to audit the premises and programme of Major and Minor Works and action is taken to address any improvements required. The Windows Programme of Works are in the final stages of implementation, works due to commence in latter half of 2024.	Regular meetings with Estates and MDT and readiness/preparedness plans in development. Annual Premises Audit is completed to identify opportunities to improve the premises.	Achievable	26/07/2024	MDT members; Service Manager; Maintenance
Preventative Action	Windows Programme of Works have been agreed with works to begin in May 2024.	Regular MDT - Maintenance meetings, Compliance Committee, QSWRs	Achievable	28/03/2025	All MDT members; Service Manager; Maintenace;
Reason ID : 10004554		**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, based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	There is a system to audit the premises, including ligature audit and action is taken to address any	Annual Ligature Audit.	Achievable and Realistic	29/03/2024	ADON CNM3 CNM2 Staff Nurses

	improvements required. Ligature audit has identified high risk ligature points. Compensatory factors such as staffing levels, observations and risk assessments have been completed. Ligature Audit has been shared with all members of MDT in order to inform risk assessment and management plan. Introduction of Observation policy where MDT must include an awareness of environmental risks when ascertaining the level of observations required for service user of high risk				
Preventative Action	An updated Programme of Furniture works is scheduled for Q 2 2024 to address ligature reduced carpentry work.	Ligature Audit will demonstrate reduction in ligatures.	Achievable and realistic	27/12/2024	ADON CNM3 CNM2 Service Manager.

	Repeat Ligature Audit 2024 will be conducted and reviewed and discussed at compliance committee meeting DOP. Introduction of Observation policy where MDT must include an awareness of environmental risks when ascertaining the level of observations required for service user of high risk.				
Reason ID : 10004555		**The registered proprietor did not ensure that the HDU garden was clean, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	HDU garden was cleaned by contracted staff. An updated cleaning schedule with cleaning providers has been confirmed.	Quality and safety walk around. Monthly Audits from Cleaning providers.	Achievable and Realistic	29/12/2023	Service Manager
Preventative Action	Funding has been approved to upgrade the HDU garden. Funding has been made available for power washing.	Design brief will be completed. HDU garden upgrade will be documented and can be observed through monthly quality and safety walkarounds.	Achievable and realistic	27/09/2024	Service Manager; MDT

		Compliance Committee meeting			
Reason ID : 10004556		**The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings, as not all resident bedrooms were furnished with a wardrobe and bedside locker, 22(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A review was completed of adequate furnishings to include all residents' beds and access to a locker or wardrobe was provided.	100% of residents have access to either a locker and/or wardrobe to store personal belongings, observed through quality and safety walkarounds. 100% of residents are able to store property in patient private property room observed through quality and safety walkarounds.	This has been achieved.	29/12/2023	ADON CNM III CNM11 Service Manager
Preventative Action	Funding has been approved for Furniture Programme of Works, there will be an upgrade of each ward and will include provision for lockers and wardrobes for each resident.	Regular meeting with contractor and maintenance; Compliance Meeting; Quality and safety walkarounds.	Achievable and realistic	28/03/2025	MDT, Service Manager, Maintenance

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10004575		**The resident's individual care plan was not updated to reflect the outcome of the debrief, in particular the resident's preferences in relation to restrictive interventions going forward, on two occasions, 5.5.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team involved informed of the deficit of the residents ICP not being updated post debrief and following restrictive practice.	Restrictive practice Audits. These occur on each and every episode of restrictive practice.	Achievable and realistic	29/12/2023	All heads of disciplines.
Preventative Action	Review of every episode of restrictive practice which reports to Quarterly oversight committee. Education sessions for all members of the MDT.	Restrictive practice Audits. These occur on each and every episode of restrictive practice.	Achievable and realistic	29/03/2024	All heads of disciplines.
Reason ID : 10004576		**There was no documentary evidence that one staff member involved in physical restraint had read and understood the policy, 7.2(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All members of staff made aware of the restrictive practice policy. Signature bank updated to reflect same.	Annual review	Achievable realistic	29/12/2023	All heads of disciplines.
Preventative Action	All new members of staff to be made aware of the restrictive practice	Annual review	Achievable realistic	28/12/2024	All heads of disciplines.

	policy. Signature bank updated to reflect same.				

Rules Governing the Use of Seclusion					
Reason ID : 10004577		**In one of the three episodes of seclusion inspected, the resident's representative was not informed of the seclusion episode and there was no record in the clinical file or on the register of seclusion to explain why this communication did not occur, 3.12(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team made aware of the requirement to include documentary evidence that residents representative has been informed of any episode of restrictive practice. If not that the reason is also documented.	Restrictive practice Audits. These occur on each and every episode of restrictive practice.	Achievable and Realistic	29/12/2023	All heads of Discipline.
Preventative Action	Education sessions for all members of the MDT. All members of staff to be made aware of the restrictive practice policy. Signature bank updated to reflect same.	Annual review	Achievable and realistic	27/09/2024	All heads of disciplines.
Reason ID : 10004578		**In three episodes of seclusion where searches were undertaken, the outcome of the searches were not documented in the clinical files, 4.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team made aware of the incident where a search of a service user occurred and	Restrictive practice Audits. These occur on each and every	Achievable and realistic	29/12/2023	All heads of disciplines.

	the requirement of documentation in the clinical file.	episode of restrictive practice			
Preventative Action	All members of staff to be made aware of the restrictive practice policy. Signature bank updated to reflect same. Review of the Seclusion core care plan to include a section regarding searches, including resident's feedback in relation to dignity and privacy.	Restrictive practice Audits. These occur on each and every episode of restrictive practice	Achievable and realistic	27/09/2024	All heads of disciplines.
Reason ID : 10004579		**In one of the episodes of seclusion inspected, the resident was not informed of the ending of seclusion, 7.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Team made aware of the incident where a resident was not informed of the ending of seclusion. Policy circulated to all heads of disciplines. Education sessions for all members of the MDT on documentation	Restrictive practice Audits. These occur on each and every episode of restrictive practice	Achievable and Realistic	29/12/2023	All heads of Discipline.
Preventative Action	All members of staff to be made aware of the restrictive	Restrictive practice Audits. These occur on each and every	Achievable and realistic	27/09/2024	All heads of disciplines.

	practice policy. Signature bank updated to reflect same.	episode of restrictive practice			

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.

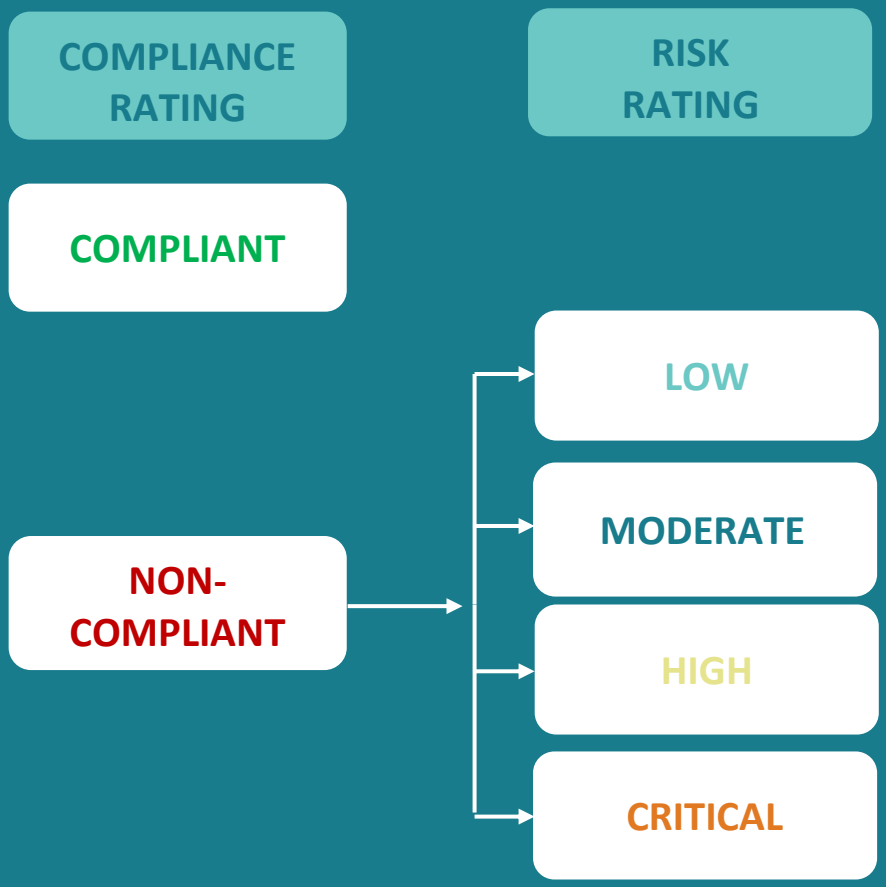
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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