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Admission Ward & St Edna's Ward, St Loman's Hospital

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

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mental health commission

ADMISSION WARD & ST EDNA'S WARD, ST LOMAN'S HOSPITAL

Devlin Road, Mullingar, Co. Westmeath

Date of Publication: 24th May 2024

ID Number: AC0139

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Continuing Mental Health Care / Long Stay
Psychiatry of Later Life
Other: Community and Alcohol Drug Service

Conditions Attached:
None

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Claire Donnelly, General Manager, Mental Health Services, HSE MLM CHO

Inspection Team:
Susan O'Neill, Lead Inspector
Aoife Gallaher
Barbara Murphy
Martin McMenamin
Siobhan Dinan

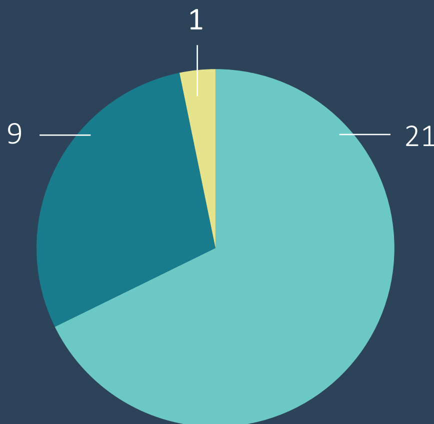
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
14 – 17 November 2023

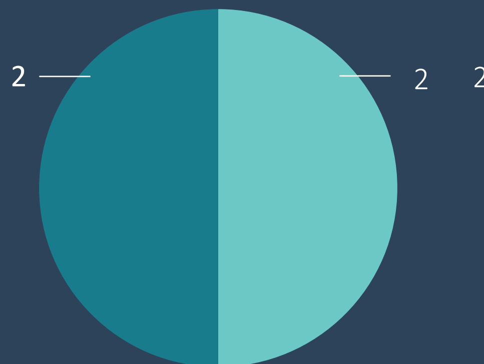
Previous Inspection date:
10 – 13 May 2022

Inspection Type:
Announced Annual Inspection

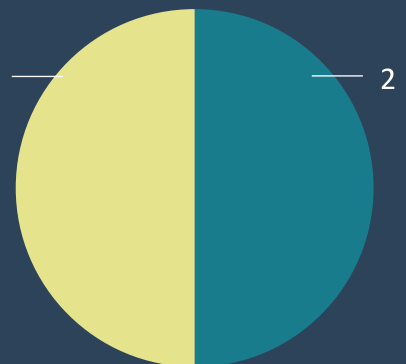
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



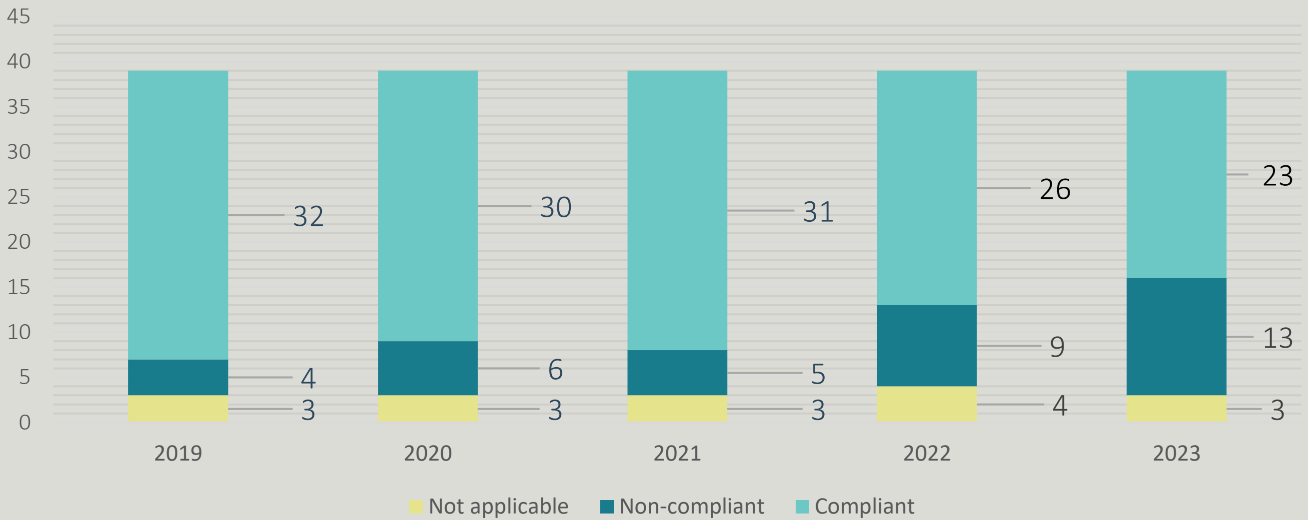
CODES OF PRACTICE

Compliant ■ Non-Compliant ■ Not applicable

RATINGS SUMMARY 2019 – 2023

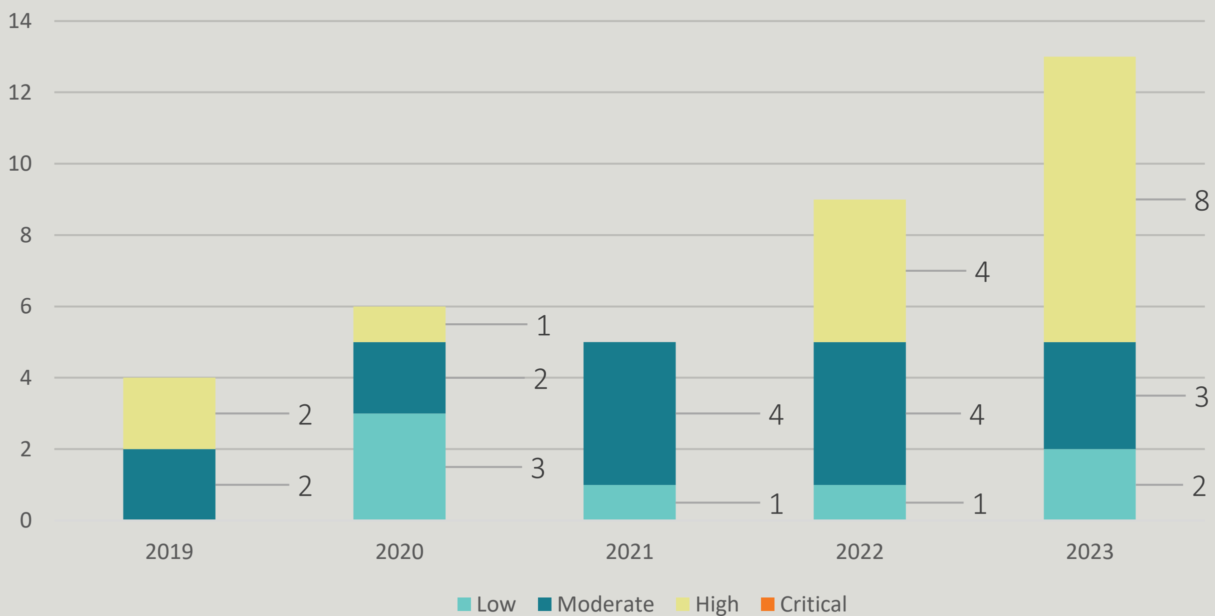
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Professor James V Lucey

In brief

The approved centre was located on the grounds of St. Loman's Hospital in Mullingar, Co. Westmeath and provided acute adult mental health care services as well as continuing mental health care, long stay, psychiatry of later life, community and alcohol or drug services. Sleeping accommodation was mostly single en suite bedrooms with some two-bed dormitory-style accommodation. The approved centre was registered for 44 beds, of which 24 were occupied. Admissions were referred from eight community mental health teams, including four general adult teams and four specialist teams.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	89%	83%	86%	74%	64%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.

- ***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 in place.
- ***Infection control***: The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

However:

- ***Fire safety:*** A fire door was not operational and fire drills had not been carried out on a regular basis.
- ***Number of registered nurses in the approved centre***: Nursing staff numbers were not always maintained at the required levels every day.
- ***Mandatory training:*** Not all staff were trained in fire safety, basic life support or the management of violence and aggression.
- ***Medication safety:*** The ordering, storing and administration of medication was carried out in a safe manner, but the prescription of crushed medicines was not practised appropriately.
- ***Ligature anchor points:*** Ligature points were not all minimised to the lowest level, based on individual risk assessment.

Appropriate care and treatment of residents

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

- ***Physical assessment****:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, psychologists, occupational therapists and social workers. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line with residents' individual care plan, and included an exercise group, a peer education group, a music group, a gardening group facilitated by the local education training board, and a cognitive remediation group.
- ***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:

- ***Appropriateness of environment:*** The approved centre was not in good structural and decorative condition as some painting, power-housing and reflooring were needed in some areas.
- ***Initial assessments****:* Not all residents had a comprehensive initial assessment on admission.

- ***Transfers:*** Full and complete written information was not sent with a resident who was transferred from the approved centre to another facility. A mitigating factor was that staff accompanied the resident.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) that documented the resident's needs but not all ICPs identified the resources required to provide the care and treatment needed, nor were all ICPs reviewed and updated by the multi-disciplinary team in consultation with the resident.
- ***Access to other medical services:*** Residents did not have non-urgent access to a dietitian.
- ***Staffing:*** The approved centre did not have a dedicated pharmacist for the service.

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:*** At the time of inspection, residents were accommodated in mostly single en suite bedrooms with some two-bed dormitory-style accommodation.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There were privacy screens on bedroom doors and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Privacy and dignity:*** Some toilets did not have locks and neither of the visitors' rooms had privacy screening on the doors.
- ***Use of restrictive practices:*** The oversight committees did not produce reports following each meeting for either mechanical restraint, physical restraint or seclusion among the sample episodes inspected.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all

resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Residents were supported to attend Mass locally and had access to a priest and a multi-faith chaplain.
- ***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***: The approved centre provided residents with a range of recreational activities, including books, boardgames, jigsaws, arts and crafts, television and music as well as outings, a movie club and gardening.
- ***Residents' feedback:*** The residents were complimentary about the environment and the care they received. They appreciated the food and found the group activities useful. Staff were praised for being very approachable. The premises was found to be clean and comfortable.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was part of the Midlands Louth Meath Community Healthcare Organisation.
- ***Leadership:*** The approved centre was governed by the Longford/Westmeath Mental Health Services Catchment Management Team (CMT), which met monthly. A Quality and Patient Safety (QPS) committee also met monthly. Clear lines of reporting and responsibility were evident within each of the disciplines.
- ***Clinical governance:*** Clinical governance meetings were conducted every month and reported into the CMT as appropriate. These meetings were attended by nursing management and various senior clinicians.
- ***Restrictive practices reduction:*** The approved centre had written policies on the reduction of enduring mechanical restraint, physical restraint and the use of seclusion.
- ***Risk:*** The approved centre had a local risk management policy which outlined risk and incident management processes. Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement.
- ***Complaints:*** A complaints process was 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, suggestion boxes, and engagement with the complaints

process were the principal mechanisms for resident and carer involvement in the process of quality improvement.

- ***Advocacy services:*** A peer advocacy representative was in place in the approved centre and attended the approved centre weekly to meet with residents.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last four years of 77%. Its compliance rate in this year was a 10% decrease from the previous year, which in turn had been a 12% decrease from the year before. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Two single bedrooms, one on each unit, were redesigned and refurbished to accommodate residents who may be living with disability.

2. Parts of the approved centre were refurbished and new furnishings were acquired. Examples included the following:

   a) Revarnishing of wood floors
   b) Replacement of sections of floor coverings
   c) Painting on both units
   d) Acquisition of new chairs, couches, coffee tables, dining room furniture, and soft furnishings.

3. New activity programmes were introduced and included an exercise programme, equine therapy, social farming, and kayaking.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Located on the grounds of St. Loman's Hospital in Mullingar, Co. Westmeath, the approved centre was a two-storey building which comprised of two separate wards, the Admissions Ward and St. Edna's Ward. Both wards were on the ground floor. The first floor of the approved centre contained offices and other non-clinical areas. The approved centre was registered to accommodate 44 residents. Eight community mental health teams, including four general adult teams and four specialist teams, had admission rights to the approved centre. The four general adult teams were assigned to the geographical areas covering North Mullingar, South Mullingar, Longford and Athlone. The four specialist teams provided a service for specified population cohorts and included the Psychiatry of Old Age team, the Rehabilitation and Recovery team, the Intellectual Disability team, and the Community Alcohol and Drugs Service.

St. Edna's Ward provided continuing care for male residents with enduring mental health issues. Sleeping accommodation consisted of single en suite bedrooms. St Edna's ward had capacity to accommodate 20 residents and, at the time of the inspection, there was an occupancy of 13 residents. The Admissions Ward provided care to both male and female residents presenting with acute mental health issues. The Admissions Ward had capacity to accommodate 24 residents, and at the time of inspection, there was an occupancy of 11 residents. Sleeping accommodation consisted of single en suite bedrooms and three two-bedded rooms.

Each ward also contained communal rooms such a recreational room, a sitting room, multipurpose room, and a dining room. There were also non-communal rooms designated for specific purposes; these included interview rooms, laundry rooms, a seclusion suite, a sensory room (on St. Edna's ward only), a kitchenette for resident use (on St Edna's ward only).

There were five outdoor areas in the approved centre, three of which were part of the Admission's Ward and two which were part of St. Edna's ward. Two of the outdoor spaces in the Admissions Ward were controlled access areas and there was one where residents had unrestricted access. Residents in St. Edna's ward had unrestricted access to its outdoor space.

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

Resident Profile	
Number of registered beds	***44***
Total number of residents	**24**
Number of detained patients	5
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	13
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was part of the Midlands Louth Meath Community Healthcare Organisation, which encompassed the governance of Louth/Meath, Laois/Offaly and Longford/Westmeath Mental Health Services. The approved centre was governed by the Longford/Westmeath Mental Health Services Catchment Management Team (CMT). The CMT met monthly and these meetings were attended by managers of core healthcare disciplines, the general manager, business manager, and the risk and patient safety advisor. Agenda items included themes relating to service planning/reform, key performance measures, capital and minor projects, recruitment, and finance. A Quality and Patient Safety committee also convened on a monthly basis. Direct reports on quality and patient safety issues concerning the approved centre were provided. Clinical governance meetings were conducted every month for the Admission's Ward and St. Edna's Ward. This forum reported into the CMT as appropriate. This meeting was attended by nursing management and various senior clinicians. Regulatory compliance, the local risk register, clinical and operational issues specific to the Admissions Ward and St. Edna's Ward were discussed at these meetings.

The approved centre had a local risk management policy which outlined risk and incident management processes. Incidents were reported and risk assessed through the National Incident Management system (NIMS). Significant incidents and trends were discussed at the approved centre Clinical Governance meeting. Identified risks were documented in the site-specific safety statement and local risk register. The safety statement was reviewed on an annual basis and the risk register was reviewed monthly at the approved centre Clinical Governance Group meeting. Risks were escalated to the wider service risk register as required; this register was reviewed at the CMT monthly meetings. Systems and processes were in place for the management of risks; however, processes were not always implemented comprehensively in the management of fire risk. In accordance with the site-specific safety statement, fire evacuation drills should have been conducted but records indicated that the last fire evacuation drill took place in January 2022. The responsibility for ensuring that fire evacuation drills were carried out was a function of the senior managers and line managers in the approved centre. At the time of inspection, there was no clear timelines for the completion of evacuation drills. On the Admissions Ward, one fire door entering the recreation room was faulty. This was identified by the service. At the time of inspection, new fire doors had been ordered and were due for installation in December 2023.

An organisational chart identified the leadership and management structures as well as the lines of authority and accountability within the approved centre. All heads of discipline (HODs) had defined strategic aims in relation to the approved centre. All heads of discipline met with staff regularly or utilised a line management structure for reporting and engaging with staff. All disciplines had a system in place for supervision or peer review of staff members. Most disciplines undertook a process of formal performance appraisal. Where this did not occur, elements of appraisal were integrated into the supervision process.

All staff had not completed the mandatory training in the required areas of Fire Safety, Basic Life Support and the Therapeutic Management of Violence and Aggression. In comparison to last year's inspection of mandatory training, however, there was an improvement in training completion rates. Training was monitored at the Clinical Governance meetings. There were multiple other training opportunities provided for staff in the approved centre. Training themes or topics included individual care planning, intramuscular injection techniques, diabetes, electroconvulsive therapy (ECT). One nurse completed a 12-week peri-mental

health course in the Dundalk Institute of Technology (DKIT) and two nursing staff members were enrolled in the 'Management of the deteriorating patient' course in DKIT.

The mental health teams consisted of nursing, medical, occupational therapy, psychology and social work disciplines. There were vacant nursing posts, and despite the use of overtime and agency staff, there were occasional deficits in the day or night staffing requirements for the approved centre. At the time of inspection, opportunities for recruitment to vacant posts, secondary to the conditions imposed by the HSE national embargo on recruitment, were limited to graduate nurses only. Two full time occupational therapy staff were based in the approved centre. Psychology and social work staff were based in the community and provided an inreach service to the approved centre. Senior managers reported that the in reach model was not an optimal model of care and had advocated for additional staff posts specifically for the approved centre at senior management forums.

There were issues concerning access to general health services. At the time of inspection, there was a vacant dietetics post within the Mental Health Service. This post had been vacant since mid-2022 and attempts to recruit to the post were unsuccessful. At the time of inspection, the HSE embargo on recruitment meant that attempts to recruit to the post were suspended. The approved centre had virtual access to a private dietetics service based in Dublin. However, residents with a dietetics need were only referred to the service based on risk assessment. Residents assessed as having an urgent dietetics need were referred to the private service, while residents, whose needs were deemed as non-urgent, were not referred and therefore did not receive a dietetics assessment. There was a vacant pharmacy post for the mental health service. Attempts to recruit to the post were also unsuccessful. Residents had access to a Speech and Language Therapy (SLT) service via referral to community primary care teams. However, due to long waiting lists in the community, the average waiting time was two-three months in duration. Risks associated with access/wait times to dietetics, pharmacy and SLT services and plans to mitigate these risks were documented in the local risk register.

Service user engagement was facilitated in different respects. A representative from the Peer Advocacy in Mental Health (formerly the Irish Advocacy Network) attended the approved centre weekly to meet with residents. The "Your Service Your Say" comments, complaints and compliments documents were accessible to service users and visitors. Formal complaints were dealt with by a complaints officer and their contact details were prominently displayed. Monthly community meetings were facilitated by staff of the approved centre. This was a forum where residents made requests and suggestions. Some of the disciplines obtained specific feedback from residents on the therapeutic activities offered. There was no Area Lead for Mental Health Engagement for Longford/Westmeath Mental Health Services at the time of the inspection. The Area Lead for Mental Health Engagement role supported access to key mental health and advocacy services and represented service users at CMT meetings.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 15: Individual Care Plans	✓		✓		✓		✓		✗	High
Regulation 16: Therapeutic Services and Programmes	✓		✓		✓		✓		✗	High
Regulation 18: Transfer of Residents	✓		✓		✓		✓		✗	Moderate
Regulation 19: General Health	✗	Moderate	✓		✓		✓		✗	High
Regulation 21: Privacy	✓		✗	Low	✗	Moderate	✓		✗	High
Regulation 22: Premises	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate	✗	Moderate
Regulation 23: Ordering, Storing, Prescribing and Administration of Medicines	✓		✓		✓		✗	High	✗	High
Regulation 26: Staffing	✗	High	✓		✓		✗	High	✗	High
Regulation 32: Risk Management Procedures	✗	High	✗	High	✗	Moderate	✗	Moderate	✗	High
Rules Governing the Use of Seclusion	✓		✓		✗	Moderate	✗	High	✗	Low
Rules Governing the Use of Mechanical Restraint		N/A		N/A		N/A		N/A	✗	Low
Code of Practice for the Use of Physical Restraint	✓		✓		✓		✓		✗	High
Code of Practice for the Use of Admission, Transfer and Discharge of residents from an approved centre	✓		✗	Low	✓		✗	Moderate	✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre had not admitted any children since the last inspection, this regulation 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 no voluntary resident had received ECT since the last inspection, this rule 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.

Seven residents spoke with the inspection team. Most of the commentary was very positive. In general residents were happy with the food and the choice available, they were also complimentary towards staff and felt they were very approachable. They enjoyed the activities and found groups useful. Residents reported that bedrooms were comfortable and the premises were clean.

No service user experience questionnaire was completed.

5.2 Advocacy

The approved centre had an advocacy service.

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

6.0 Feedback Meeting

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

- Assistant Director of Nursing
- Clinical Nurse Manager 2
- Clinical Nurse Manager 3
- Clinical Director
- Dietetics Manager
- Director of Nursing
- Occupational Therapy Manager
- Principal Psychologist
- Principal Social Worker
- Registered Proprietor

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, appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations and providing other healthcare services.

An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

For residents with special dietary requirements, nutritional and dietary needs were assessed where necessary and addressed in residents' individual care plans.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre had suitable and sufficient catering equipment. There were proper facilities for the refrigeration, storage, preparation, cooking, and serving of food.

Hygiene was maintained to a high standard 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 to the resident and considered their preferences, dignity, bodily integrity, religious and cultural practices.

Residents changed out of night clothes during daytime hours unless specified otherwise in the resident's individual care plan.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to residents' personal property and possessions. The policy was last reviewed in April 2023.

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 and was available to the resident.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities, including wardrobes, cupboards, safes and lockers, were provided for the safekeeping of the resident's monies and valuables, as necessary. Residents were supported to manage their own property, as appropriate.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and self-directed recreational activities during the weekend. Activities included books, boardgames, jigsaws, television, arts and crafts, gardening, music and puzzles. Group-based activities included a movie club, outings, baking, gardening and arts and crafts.

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 was practicable.

Residents had access to a priest and a multifaith chaplain in the approved centre. Residents were also able to attend mass in the community.

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 operational policy and procedures in relation to visits. The policy was last reviewed in July 2021.

Visiting times were appropriate and reasonable. Visiting times were displayed in the approved centre and visits outside of the visiting hours were facilitated if required. A visitors room was available where residents could meet visitors, 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 visitors room 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 operational policy and procedures relating to communication. The policy was last reviewed in March 2023.

Residents in both units had access to personal mobile phones, portable phones, Wi-Fi, two electronic tablets, a computer and a mobile phone provided by the approved centre, unless otherwise risk-assessed with due regard to the resident's well-being, safety, and health. The clinical director or senior staff member designated by the clinical director did not examine any incoming and outgoing resident communication as there was no reasonable cause to believe the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

- The management and application of searches of a resident, his or her belongings and the environment in which he or she was 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 resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out in the policy. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

The clinical files of three residents who were searched were inspected. Residents' consent was sought and documented, and risk was assessed prior to the search taking place. Residents were informed by the person implementing the searches of what was happening during each search and why. A minimum of two clinical staff were always in attendance when the searches were being conducted. The searches were implemented with due regard to residents' dignity and privacy. At least one of the staff members who conducted the searches was of the same gender as each individual resident being searched.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in July 2021.

As no deaths had occurred in the approved centre, 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 HIGH

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

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

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care and resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes. 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 identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment.

However, one ICP was not developed by the multi-disciplinary team. One ICP did not identify the resources required to provide the care and treatment identified. Two ICPs were not reviewed by the MDT in consultation with the resident. Two ICPs were not updated following review, as indicated by the resident's changing needs, condition, 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 a comprehensive assessment.**
b) **One individual care plan did not identify the resources required to provide the care and treatment identified.**
c) **Two individual care plans were not reviewed by the multi-disciplinary team in consultation with the resident.**
d) **Two individual care plans were not updated following review, as indicated by the resident's changing needs, condition, circumstances and goals.**

Regulation 16: Therapeutic Services and Programmes

NON-COMPLIANT

Risk Rating HIGH

(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 approved centre provided therapeutic services and programmes through a weekly therapeutic activities programme. Therapeutic interventions included an exercise group, social farming, a peer education groups, a music group, a gardening group facilitated by the local education training board, an art group and a cognitive remediation group.

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

However, the therapeutic services and programmes were not directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents, as the approved centre did not have a dietitian in post at the time of inspection and had not arranged for non-urgent cases to be referred to an approved, qualified health professional.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).

Regulation 18: Transfer of Residents

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the transfer of residents. The policy was last reviewed in August 2023.

A resident was transferred from the approved centre to another facility. While staff accompanied the resident, no transfer forms or transfer letter were communicated to the receiving facility.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all relevant information about a resident was provided to a receiving centre, hospital or other place when the resident was transferred there from the approved centre, 18(1).

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(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 written operational policy and procedures for responding to medical emergencies and in relation to general health. The policy was last reviewed in February 2023. The approved centre had an emergency resuscitation trolley and staff had access at all times to an automated external defibrillator.

Registered medical practitioners assessed residents' general health needs at admission and when indicated by the residents' specific needs. Residents received appropriate general health care interventions in line with their individual care plans however, all residents were not able to access a dietetics service when required. The approved centre had virtual access to a private dietetics service based in Dublin. However, residents with a dietetics need were only referred to the service based on risk assessment. Residents assessed as having an urgent dietetics need were referred to the private service, while residents, whose needs were deemed as non-urgent, were not referred and therefore did not received a dietetics assessment.

Six-monthly general health assessments were inspected in relation to 10 residents who were in the approved centre for a period greater than six months. These six-monthly health assessments documented a physical examination, body-mass index, weight, waist circumference, family and personal history, blood pressure, smoking status, nutritional status, diet, physical activity, medication review and dental health. Residents on antipsychotic medication received an annual assessment of their glucose regulation, blood lipids, electrocardiogram heart function and prolactin levels. Residents could access national screening programmes applicable to their age and gender, including a retina check for diabetics and bowel screening.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that adequate arrangements were in place, for all residents with an identified need, to access a dietetic service, 19(1)(a).

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 March 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 a translation service which took place in person and by phone.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

The general behaviour of staff and the manner in which staff spoke with residents was respectful. Staff appearance and dress were appropriate. Staff were discreet when discussing a resident's condition or treatment needs and sought the resident's permission before entering their room, as appropriate. 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. However, the visitors' rooms in both the Admissions Ward and in St. Enda's Ward did not have privacy screening on the doors. On the Admission's Ward, all bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to a resident. However, on St Edna's Ward, two toilets did not have locks on the inside of the doors.

Rooms were not overlooked by public areas. Noticeboards did not display any identifiable resident information. Residents were facilitated to make private phone calls.

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

a) **The registered proprietor did not ensure the residents' privacy and dignity was respected at all times, as two toilets did not have locks on the inside of the doors, 21.**
b) **The registered proprietor did not ensure the residents privacy and dignity was respected as the visitors' room on both units did not have privacy screening on the doors, 21.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating **MODERATE**

(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

The approved centre was appropriately lit, heated and ventilated. Residents had access to personal space and appropriately sized communal rooms. Sufficient spaces were provided for residents to move about, including outdoor spaces. Appropriate signage and sensory aids were provided to help residents' orientation needs. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges and hard or rough surfaces were minimised in the approved centre. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

External contractors completed works such as window cleaning, hedge cutting, electrical work, plumbing work and others. The approved centre was clean, hygienic and free from offensive odours. Rooms were centrally heated and current national infection control guidelines are followed.

The approved centre had a programme of maintenance and any maintenance issues were reported to the maintenance department by email or by phone however, outstanding maintenance and repair issues were observed on both wards. Marked flooring required replacement on both wards. On the Admissions Ward issues observed included dusty vents in the sluice room and a bathroom, the visitor room window's required cleaning, a faulty fire door entering the Recreational room, burn marks on the interior furnishings in one room, external walls required painting, external paving areas require cleaning. On St. Enda's Ward, the visitors room floor was marked and the walls needed painting. Externally, moss was growing on the garden-area paving, the garden wall needed power hosing and the window sills and paving in the internal courtyard needed cleaning.

There was a sufficient number of toilets and showers for residents in the approved centre. The approved centre had a designated sluice room and a designated cleaning room. All resident bedrooms are appropriately sized to address the resident needs. The approved centre provided suitable furnishings to support resident independence and comfort. The approved centre provided assisted devices and/or equipment to address resident needs.

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

a) **The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and wellbeing of the residents as not all ligatures were minimised to the lowest practicable level based on risk assessment, 22(3).**
b) **The registered proprietor did not ensure the premises was maintained in good structural and decorative condition as a fire door was not operational, 22(1)(a).**
c) **The registered proprietor did not ensure the premises was maintained in good structural and decorative condition as the walls of the external garden areas required painting; the paving and windowsills of external garden required power hosing, flooring of the approved centre required replacing, 22(1)(a).**

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

NON-COMPLIANT

Risk Rating HIGH

(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 operational policy and procedures in relation to the ordering, storing, prescribing, and administration of medicines to residents. The policy was last reviewed in March 2023, 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 administering resident medication, including routes of medication.

Each resident had a Medication Prescription and Administration Record (MPAR). All MPARs inspected evidenced a record of medication management practices, including a record of the following: medications administered, allergies or sensitivities to any medications including if the resident had no allergy, route of medication, dose of medication, date of discontinuation for each medication and frequency of medication. The Medical Council Registration Number and signature of the medical practitioner prescribing the medication were included in all cases.

All entries in the MPARs were legible. Medication was reviewed and rewritten at least six monthly or more frequently, where there was a significant change in the resident's care or condition, and this was documented in the clinical file. When a resident's medication was withheld a record was kept, and the justification was documented in the MPAR and in the clinical file.

In one MPAR reviewed, medications were required to be crushed. The medical practitioner gave a documented reason why crushing was required. However, in this MPAR, a period of at least nine days had elapsed where the need for crushed medication was not stated. There was no recent recorded evidence of a consultation with a pharmacist about the type of preparation to be used as there was no dedicated pharmacist on the mental health team.

Medication was stored in the appropriate environment as indicated on the label or packaging. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication which was recommended to be stored elsewhere. Scheduled 2 and 3

controlled drugs were locked in a separate locked cupboard from other medicinal products to ensure further security.

The approved centre was non-compliant with this regulation because the registered proprietor had not ensured that the approved centre had appropriate and suitable practices relating to the prescribing of crushed medicines to residents, 23(1).

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 March 2023.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and processes in relation to the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in July 2021 and included the purpose and function of using CCTV, in relation to the observation of a resident.

Clear signs in prominent positions indicated where CCTV cameras were located throughout the approved centre. The registered proprietor ensured that the existence and use of CCTV was disclosed to the residents and their representatives. Residents were monitored solely for the purposes of ensuring the health, safety and welfare of that resident.

The use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras used to observe residents were incapable of recording or storing a resident’s image on a tape, disc or hard drive. Images used to observe residents could only be seen by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a staffing policy and procedures in relation to the recruitment, selection and Garda vetting requirements of staff. The policy was last reviewed in March 2023. An appropriately qualified staff member was on duty at all times, and this was documented.

Eight community mental health teams, including four general adult teams and four specialist teams, had admission rights to the approved centre. The four general adult teams were assigned to the geographical areas covering North Mullingar, South Mullingar, Longford and Athlone. The four specialist teams provided a service for specified population cohorts and included the Psychiatry of Old Age team, the Rehabilitation and Recovery team, the Intellectual Disability team, and the Community Alcohol and Drugs Service. The mental health teams consisted of nursing, medical, occupational therapy, psychology and social work disciplines. However, the numbers of nursing staff were not always sufficient to meet resident needs. There were vacant nursing posts, and despite the use of overtime and agency staff, there were occasional deficits in the day or night staffing requirements for the approved centre.

The skill mix of staff was also insufficient to meet resident needs as there were issues concerning access to general health services. At the time of inspection, there was vacant dietetics post within the Mental Health Service. This post had been vacant since mid-2022 and attempts to recruit to the post were unsuccessful. The approved centre had virtual access to a private dietetics service based in Dublin. However, residents with a dietetics need were only referred to the service based on risk assessment. Residents assessed as having an urgent dietetics need were referred to the private service, while residents, whose needs were deemed as non-urgent, were not referred and therefore did not receive a dietetics assessment. There was a vacant pharmacy post for the mental health service. Attempts to recruit to the post were also unsuccessful.

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

Not all healthcare staff had received up-to-date mandatory training in fire safety, basic life support or management of violence and aggression. The following table shows the number and percentages of staff trained in the different aspects of mandatory training:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (38)	38	100%	34	89%	32	84%	38	100%
Medical (29)	25	86%	23	79%	25	86%	29	100%
Occupational Therapist (6)	6	100%	4	67%	4	67%	6	100%
Social Worker (7)	6	86%	6	86%	7	100%	6	86%
Psychologist (6)	6	100%	6	100%	6	100%	6	100%

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

a) **The registered proprietor did not ensure that the numbers of nursing staff were appropriate to the assessed needs of residents as staffing numbers were not always maintained at the required levels every day, 26(2).**
b) **The registered proprietor did not ensure that the skill mix of staff were appropriate to the assessed needs of residents as there was no dedicated pharmacist for the service, 26(2).**
c) **The registered proprietor did not ensure that the skill mix of staff were appropriate to the assessed needs of residents as all residents did not have access to a dietetics service, 26(2).**
d) **The registered proprietor did not ensure that all staff were trained to enable them to provide care and treatment in accordance with best contemporary practice as all staff were not trained in fire safety, basic life support and the therapeutic 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 operational policy and procedures in relation to the maintenance of records. The policy was last reviewed in March 2023. The policy covered the following provisions:

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

Residents' records both paper based and electronic were secure, up-to-date, in good order, and were stored together where possible. All resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were in good order, for example, no loose pages. Records were appropriately secured from loss or destruction, tampering and unauthorised access or use.

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All operating policies and procedures requiring a three-yearly review were reviewed appropriately.

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 provided assistance as necessary when the patient required assistance to attend or participate in the process.

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 operational policy and procedures on the complaints process. The policy was last reviewed in March 2023 and included the process for managing complaints, including the raising, handling and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

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

Residents, their representatives, family and next of kin were informed of all methods by which a complaint could be made. All complaints were investigated promptly and handled appropriately and sensitively. The nominated person maintained a record of all minor and formal complaints relating to the approved centre. Residents who had made a complaint were not adversely affected by reason of the complaint having been made. All complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint were fully and properly recorded. These records were in addition to and distinct from a resident’s individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a comprehensive written policy and procedures in relation to risk management and incident management processes. The policy was last reviewed in April 2022. The policy included all of the policy related regulation requirements, 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.

The person with responsibility for risk was identified and known by all staff, and responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation.

All clinical and corporate risks were properly identified, assessed, reported, treated, monitored and recorded in the risk register. Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre with the exception of fire risk which was not comprehensively managed. There were various systems and processes in place to manage fire risk in the approved centre however, in accordance with the local site-specific safety statement and the emergency plan, fire

evacuation drills were not completed regularly. The last recorded evacuation drill took place in January 2022. On the Admissions Ward, one fire door entering the recreation room was faulty. This was identified by the service. At the time of inspection, new fire doors had been ordered and were due for installation in December 2023.

Multi-disciplinary teams (MDTs) were involved in the development, implementation, and review of individual risk management processes. Individual risk assessments were completed prior to physical restraint episodes, seclusion, and at resident admission, transfer and discharge. Individual risk assessments were also completed in conjunction with medication requirements or medication administration, with the aim of identifying individual risk factors.

The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required. Incidents were risk-rated and recorded in a standardised format on the National Incident Management System (NIMS). All clinical incidents were reviewed by the MDT, and a record was maintained of clinical reviews and recommended actions. A six-monthly summary of incidents was provided to the Mental Health Commission. Information provided was anonymous at resident level. There was an emergency plan in place that specified responses by the approved centre staff in relation to possible emergencies. The emergency plan incorporated evacuation procedures.

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

a) **The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre. Risk of fire was not comprehensively mitigated as fire evacuation drills were not completed on a regular basis, 32(1).**
b) **The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre. The health and safety risk associated with a faulty fire door was not adequately treated, 32(1).**

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 and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered 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 conditions relating to the certificate of registration attached to it, which was displayed prominently. Where changes had arisen in relation to the information detailed in the certificate of registration, this was communicated to the Mental Health Commission.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59

(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –

(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or

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

(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the use of electroconvulsive therapy (ECT) for involuntary patients. The policy was last reviewed in March 2023. The policy addressed all policy-related criteria of this rule, including provisions in relation to the following:

- ECT protocols developed in line with best international practice.
- How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

Training and Education: All staff involved in delivering ECT were trained in line with best international practice. All staff involved in ECT had appropriate training and education in basic life support techniques.

Evidence of Implementation: The approved centre had a dedicated ECT suite in the Midlands Regional hospital, Mullingar for the delivery of ECT. Due to the location of the ECT suite the inspection team did not inspect it. A named consultant psychiatrist had overall responsibility for ECT management. There was a named consultant anaesthetist with overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one involuntary patient who was receiving ECT was examined. The consultant psychiatrist assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file. The patient was deemed unable to consent to receiving ECT. ECT was administered according to section 59(1)(b) of MHA 2001, as amended. A Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent was completed by two consultant psychiatrists for each ECT programme. A form 16 was placed in the patient's clinical file and a copy of it was sent to the MHC within five days.

A programme of ECT was prescribed by the responsible consultant psychiatrist and recorded in the clinical file. The prescription detailed the reason for using ECT, the consideration of alternative therapies that proved ineffective before prescribing ECT, the discussion with the patient and next of kin, and a current mental state examination. Cognitive assessments were completed and recorded before and after each ECT session. The process was in line with best international practice by the consultant psychiatrists.

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

The approved centre was compliant with this rule.

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating LOW

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 April 2023. The policy addressed the following:

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

The approved centre had a written policy on the reduction of seclusion that was last reviewed in August 2023. The policy addressed the following:

- How the approved centre aimed to reduce or, where possible eliminate, the use of seclusion.
- Leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice.
- How the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion.

The policy and procedures for training all staff involved in seclusion addressed all aspects of staff training as stipulated by the new rules for seclusion. All staff who participated, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures.

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

Monitoring: A multi-disciplinary review and oversight committee was established to analyse every episode of seclusion in detail. The committee met quarterly but did not produce a report following each meeting. As a result no report was available to staff who participate in seclusion to promote their on-going learning and awareness.

Evidence of Implementation: The seclusion facilities were furnished, maintained and cleaned to ensure the resident's inherent right to personal dignity and to respect their privacy. The seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. The room had an anti-barricade door and allowed for staff to clearly observe the resident within. There were no ligature points or electrical fixtures. The room had externally controlled heating and air conditioning which enabled those observing the resident to monitor the room temperature.

The resident in seclusion had sight of a clock displaying the time, day and date. The seclusion room had limited furnishings which met current safety requirements. The room was large enough to support the resident and any staff required for physical interventions during transition to seclusion. The seclusion room was as far away as possible from communal sitting rooms and sleeping accommodation without being isolated.

The secluded resident had ready access to sanitary facilities and sanitary items, unless a clearly documented reason otherwise was recorded in the seclusion care plan. Seclusion facilities were not used as bedrooms and bedrooms were not used as seclusion facilities.

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

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

The CP undertook a medical examination of the residents and signed the seclusion register within 24 hours of the commencement of each episode. The resident was informed of the reasons for, likely duration of, and circumstances which would lead to the discontinuation of seclusion. The resident's representative

was not informed about the seclusion except where it was the resident's wish. This was recorded in the clinical file.

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

The residents placed in seclusion were directly observed by an RN for the first hour of seclusion. After the first hour, an RN continuously observed the residents and remained within sight and sound of the seclusion room throughout the episode. A written record of the resident was made by the RN every 15 minutes.

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

All the required procedures for the renewal of seclusion orders were adhered to.

Renewal of Seclusion Orders: The RMP renewed the seclusion order in two instances under the supervision of a CP following a medical examination, for a further period less than four hours and for a maximum of five renewals.

Where the seclusion order was renewed beyond the initial 24 hours of continuous seclusion, the CP or the duty CP undertook a medical examination and this was recorded in the clinical file.

Ending of Seclusion: A RMP or the most senior RN in the Ward ended seclusion following discussion with the person in seclusion and relevant nursing staff or a RMP.

The residents were informed of the ending of each episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date the seclusion was ended.

An in-person debrief followed each episode, except where the resident decided not to participate in a debrief, if it was their wish. This debrief occurred within two working days of the episode, and gave the residents the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved with their care and treatment, including alternative de-escalation strategies to avoid future use of restrictive interventions. The residents were invited to have a representative or nominated person present at the debrief with them; if this person did not attend, 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: Seclusion was not used inappropriately, such as to manage staff shortages, punish a resident or protect property. Seclusion was not used in combination with mechanical restraint or as a substitute for less restrictive practices.

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. The MDT review documented actions and follow-up plans to eliminate or reduce interventions for the resident.

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 because the multi-disciplinary review and oversight committee did not produce a report following each meeting. Therefore no report was made available to staff who participated in seclusion to promote on-going learning and awareness, 10.8(vi).

Section 69: The Use of Mechanical Restraint

NON-COMPLIANT

Risk Rating LOW

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. It was last reviewed in April 2023.

The approved centre had a written policy on the reduction of enduring mechanical restraint that was last reviewed in August 2023.

Evidence of Implementation: Two episodes of mechanical restraint were reviewed on inspection. Mechanical restraint was used to address an identified clinical need or risk, and only when less restrictive alternatives were not deemed suitable.

A risk assessment of the safety and suitability for the resident was undertaken. The risk assessment was reviewed and updated regularly in line with the resident's individual care plan, and a copy was available for review.

The multi-disciplinary team developed a plan of care for each resident restrained by mechanical means and included information on attempts to reduce or eliminate the use of restraint.

Mechanical restraint was ordered by a registered medical practitioner under the supervision of a consultant psychiatrist. The clinical file specified that there was an enduring risk of harm to the resident or to others, that less restrictive alternatives had not been successful, the type of mechanical restraint, the situation and duration of the restraint and order and the review date.

A multi-disciplinary review and oversight committee met quarterly to review the appropriateness of the approved centre's use of mechanical restraint. The review outlined arrangements to reduce or eliminate the use of mechanical restraint, determined compliance with rules on the use of mechanical restraint, identified responsibility and documented areas for improvement. The review also assured the registered

proprietor's nominee that the use of mechanical restraint aligned with the Mental Health Commission's rules.

The oversight committee did not produce a report following each meeting.

The registered proprietor notified the Mental Health Commission about the use of mechanical restraint for enduring risk to the residents or others in line with the specified format and timeframes.

The approved centre was non-compliant with this rule because the oversight committee did not produce a report following each meeting, 10.6(vi).

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 two 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 both patients; one of the patients was able to consent, and the other was unable to consent.

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

- The name of the medications prescribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.

- Details of a discussion with the patients, including the nature and purpose of the medications, the effects of medications such as the risk and benefits and any views expressed by the patient.
- Any supports provided to the patient in relation to the discussion and their decision-making.

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

- The names of the medications proscribed.
- A confirmation of the assessment of the patient’s ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient, including the nature and purpose of the medications and their effects, 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 HIGH

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 April 2023, and addressed the following:

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

Policies and procedures regarding staff training included the following:

- Who will receive training based on the identified needs of residents who are restrained and staff.
- The areas to be covered in the training programme, including alternatives to physical restraint, trauma-informed care, cultural competence, human rights, positive behaviour support and the monitoring of the safety of the resident during and after the physical restraint.
- The identification of appropriately qualified persons to give the training
- The mandatory nature of training for those involved in physical restraint.

The approved centre had a policy for the reduction of physical restraint which was last reviewed in August 2023. The policy addressed the following:

- How the approved centre aims to reduce or eliminate the use of physical restraint.
- Leadership, the use of data to inform the practice, specific reduction tools in use, workforce development and the use of post-incident reviews.
- How the approved centre will provide positive behaviour supports as a means of reducing or eliminating the use of physical restraint.

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

Monitoring: A multi-disciplinary review and oversight committee in the approved centre met at least quarterly to determine compliance with the code of practice on physical restraint and the approved centre's own policies and procedures for each episode of physical restraint reviewed.

The committee identified areas of improvement, actions and persons responsible and provided assurance that each use of physical restraint was in accordance with the Mental Health Commission's code of practice.

The committee did not produce a report following each meeting.

Evidence of Implementation: Three episodes of physical restraint were examined on inspection. Physical restraint was initiated by a registered medical practitioner (RMP) or registered nurse (RN), in accordance with the approved centre's policy on physical restraint. The orders for physical restraint confirmed there were no other less restrictive methods available to manage the person's presentation. The consultant psychiatrist 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 order for physical restraint lasted a maximum of 10 minutes.

The relevant section of the clinical practice form was completed by the person who initiated and ordered the use of PR as soon as was practicable, and was signed by a clinical psychiatrist within 24 hours.

In one instance, the resident was not properly informed of the reasons for or the circumstances which lead to the discontinuation of physical restraint. A record explaining why this had not occurred was not entered into the resident's clinical file.

The residents wished not to inform their representatives of the episodes of physical restraint. No such communication occurred and a record of such, as well as a record explaining why the representative was not informed, was placed in the resident's clinical file. The Mental Health Commission was appropriately notified of each episode of physical restraint.

Staff involved in the use of physical restraint took into account relevant entries in the resident's individual care plan (ICP), pertaining to their specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episode of physical restraint and all staff involved had undertaken appropriate training.

The physical restraint in each instance was ended by the person who had lead it. The time, date, and reason for ending the physical restraint was recorded in the clinical file on the date that each episode ended.

An appropriate in-person debrief with the resident did not follow each episode of physical restraint. After one episode the debrief did not occur within two working days of the episode of physical restraint. After one episode it was not documented in the resident's clinical file whether the resident had been given the option of having their representative or nominated support person attend the debrief. In one episode,

appropriate emotional support was not offered to the resident or to other persons who may have witnessed the episode of physical restraint.

The resident's ICP was updated to reflect the outcome of the debrief, and in particular, their preferences in relation to restrictive interventions going forward.

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. A copy of the clinical practice form was kept in the clinical file and was available to the Mental Health Commission on request.

Clinical Governance: The episodes of PR were reviewed by members of the multi-disciplinary team within five working days from the date of the restraint. However, not all reviews satisfactorily dealt with each episode of physical restraint.

One review failed to identify alternative de-escalation strategies to be used in future. One review did not assess the factors in the physical environment that may have contributed to the use of restraint. One review did not record the actions and follow-up plans that the multi-disciplinary team decided upon to eliminate or reduce restrictive interventions for the resident.

A named senior manager was responsible 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) **In one episode of physical restraint the person was not informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint, 3.8.**
b) **In one episode of physical restraint an in-person debrief with the person who was restrained did not occur within two working days, 5.3(ii).**
c) **In one episode of physical restraint it was not recorded in the clinical file if the person was given the option of having their representative or their nominated support person attend the debrief with them, 5.3(vi).**
d) **In one episode of physical restraint appropriate emotional support was not provided to the person following the episode of physical restraint, 5.7.**
e) **In one episode of physical restraint alternative de-escalation strategies to be used in future were not identified, 7.3(iii).**
f) **In one episode of restraint an assessment of the factors in the physical environment that may have contributed to the use of restraint was not documented, 7.3(vi).**
g) **In one episode of physical restraint the multi-disciplinary team did not record actions decided upon and follow-up plans to eliminate or reduce restrictive interventions for the person, 7.4.**

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in July 2021, did not address the following policy-related criteria for this code of practice:

- Procedure for involuntary admission.

However, this was addressed in a separate policy dated from June 2023.

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

Discharge: The discharge policy, which was last reviewed in July 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 policy/policies.

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

Evidence of Implementation:

Admission: The clinical file of one resident who had been admitted to the approved centre was examined. A key worker system was in place. The resident had been admitted on the basis of a mental illness or disorder and an admission assessment was completed. The assessment included the presenting problem, past psychiatric history, family and medical history, current mental health state, risk assessment and all other relevant information.

The assessment did not include information on current or historic medications nor was there documentary evidence of a full physical examination undertaken in the admission period.

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, 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 and family or representative, where appropriate.

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

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

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

a) **The approved centre did not comply with Regulation 18: Transfer of Residents.**
b) **The admission assessment did not include current and historic medication information, 15(3).**
c) **The admissions assessment did not include documentary evidence of a full physical examination, 15(3).**

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10004917		**One individual care plan was not developed by the multi-disciplinary team following a comprehensive assessment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Governance team established a committee to review the current issues with ICPs. This is a multi-disciplinary review committee with a specific terms of reference and time frame to conclude its review	ICP audits weekly by CNM2s on each ward. implementation of the recommendations of the ICP committee into practice and ongoing audit	Yes 27/05/2024	27/05/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3
Preventative Action	ICP training was arranged and attended on 22/3/24 to educate staff on the issues occurring in care planning. ICP committee to make recommendations which are then established into policy.	Record of attendance shows 35 staff took part in the training. Audit pre committee recommendation and further ongoing audit after recommendations	ICP Training Completed 22/03/2024. Audit pre committee recommendation and further ongoing audit after recommendations 29.05.2024	29/05/2024	Assistant Director of Nursing Clinical Nurse Manager 3
Reason ID : 10004918		**One individual care plan did not identify the resources required to provide the care and treatment identified.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Governance team established a committee to review the current issues with ICPs. This is a multi-disciplinary Review committee with a specific terms of reference and	ICP audits weekly by CNM2s on each ward. implementation of the recommendations of the ICP committee into practice and ongoing audit	Yes. 27/05/2024	27/05/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
	time frame to conclude its review				
Preventative Action	ICP training was arranged and attended on 22/3/24 to educate staff on the issues occurring in care planning	Record of attendance shows 35 staff took part in the training.	Completed 22/03/2024	22/03/2024	Assistant Director of Nursing Clinical Nurse Manager 3
Reason ID : 10004919		**Two individual care plans were not reviewed by the multi-disciplinary team in consultation with the resident.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Governance team established a committee to review the current issues with ICPs. This is a multi-disciplinary Review committee with a specific terms of reference and time frame to conclude its review	ICP audits weekly by CNM2s on each ward. implementation of the recommendations of the ICP committee into practice and ongoing audit	yes 27/05/2024	27/05/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3
Preventative Action	ICP training was arranged and attended on 22/3/24 to educate staff on the issues occurring in care planning. ICP committee to make recommendations which are then established into policy.	Record of attendance shows 35 staff took part in the training. Audit pre committee recommendation and further ongoing audit after recommendations	Training Completed 22/03/2024. Audit pre committee recommendation and further ongoing audit after recommendations 29/05/2024	29/05/2024	Assistant Director of Nursing Clinical Nurse Manager 3
Reason ID : 10004920		**Two individual care plans were not updated following review, as indicated by the resident's changing needs, condition, circumstances and goals.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Governance team established a committee to review the current issues with ICPs. This is a multi-disciplinary Review committee with a specific terms of reference and	ICP audits weekly by CNM2s on each ward. implementation of the recommendations of the ICP committee into practice and ongoing audit	yes 27/05/2024	27/05/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3

	time frame to conclude its review				
Preventative Action	ICP training was arranged and attended on 22/3/24 to educate staff on the issues occurring in care planning. ICP committee to make recommendations which are then established into policy.	Record of attendance shows 35 staff took part in the training. Audit pre committee recommendation and further ongoing audit after recommendations	yes Training Completed 22/03/2024. Audit pre committee recommendation and further ongoing audit after recommendations 29.05.2024	29/05/2024	Assistant Director of Nursing Clinical Nurse Manager 3

Regulation 16: Therapeutic Services and Programmes					
Reason ID : 10004903		The registered proprietor did not ensure that programmes and services provided were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident, 16(2).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Vacant dietitian post has been upgraded to Clinical Specialist grade to assist in recruitment. Vacant post listed as critical post for filling in the context of the HSE recruitment pause. Funding secured for agency filling of posts. Relevant agencies have been contacted with a view to recruiting a suitably qualified dietitian. Private dietetic service in place for priority/ urgent referrals. This will be expanded to include some capacity for non-urgent cases pending recruitment. Alternative referral pathways to be explored	Options to fill vacant dietetic posts to be discussed as an agenda item on the Catchment Management Team. Meeting of Community Dietitian Manager with Clinical Director and Area DON scheduled to discuss approved centre dietetic needs and optimising private dietetic service provision.	Yes	31/05/2024	Community Dietitian Manager
Preventative Action	Dietitian Manager to ensure all recruitment documentation submitted and in place. Retrospective exit interviews conducted by Dietitian Manager in 2023 with the previous MHS dietitians to aid future recruitment & retention. A summary report	Dietitian Manager to compile and share summary report of exit interviews with MHS management. Meeting to take place between Dietitian Manager, Clinical Director and Area DON to discuss approved centre dietetic needs and optimising private dietetic service provision.	Yes	13/12/2024	Community Dietitian Manager

	to be compiled and shared with MHS management. Dietitian Manager to explore dietetic service needs of midlands MHS with stakeholders Mental health dietitian role remit to be reviewed to aid staff retention				

Regulation 18: Transfer of Residents					
Reason ID : 10004907		**The registered proprietor did not ensure that all relevant information about a resident was provided to a receiving centre, hospital or other place when the resident was transferred there from the approved centre, 18(1)**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A policy review will take place to include protocols for transfer of residents to other care centres and Hospitals	The policy will be reviewed and amended to include protocols for transfer. Transfers of residents will be audited monthly.	Yes. End of May 2024	31/05/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3 Policy review group
Preventative Action	There will be a policy in place which provides direction to all staff on the transfer of residents. The transfer of each resident from the approved centre is audited.	An audit will be completed monthly on the compliance with the Hospital policy.	Yes. End of June 2024	30/06/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3

Regulation 19 General Health					
Reason ID : 10004921		**The registered proprietor did not ensure that adequate arrangements were in place, for all residents with an identified need, to access a dietetic service, 19(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Vacant dietitian post has been upgraded to Clinical Specialist grade to assist in recruitment. Vacant post listed as critical post for filling in the context of the HSE recruitment pause. Funding secured for agency filling of posts. Relevant agencies have been contacted with a view to recruiting a suitably qualified dietitian. Private dietetic service in place for priority/ urgent referrals. This will be expanded to include some capacity for non-urgent cases pending recruitment. Alternative referral pathways to be explored	Options to fill vacant dietetic posts to be discussed as an agenda item on the Catchment Management Team. Meeting of Community Dietitian Manager with Clinical Director and Area DON scheduled to discuss approved centre dietetic needs and optimising private dietetic service provision.	Yes	31/05/2024	Community Dietitian Manager
Preventative Action	Dietitian Manager to ensure all recruitment documentation submitted and in place. Retrospective exit interviews conducted by Dietitian Manager in 2023 with the previous MHS dietitians to aid future recruitment & retention. A summary report to be compiled and shared	Dietitian Manager to compile and share summary report of exit interviews with MHS management. Meeting to take place between Dietitian Manager, Clinical Director and Area DON to discuss approved centre dietetic needs and optimising private dietetic service provision.	Yes	27/12/2024	Community Dietitian Manager

	with MHS management. Dietitian Manager to explore dietetic service needs of midlands MHS with stakeholders Mental health dietitian role remit to be reviewed to aid staff retention				

Regulation 21: Privacy

Reason ID : 10004908		The registered proprietor did not ensure the residents' privacy and dignity was respected at all times, as two toilets did not have locks on the inside of the doors, 21.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	. Locks were replaced in both toilet doors on the 23rd of November 2023	Completed on 23/11/23	Complete	23/11/2023	Maintenance Manager Assistant Director of Nursing
Preventative Action	Re auditing of all areas after anti ligature works are complete; to ensure that works have not led to issues of privacy.	Audit as part of monthly walk about	Yes.	23/11/2023	Hospital Administrator
Reason ID : 10004909		**The registered proprietor did not ensure the residents privacy and dignity was respected as the visitors' room on both units did not have privacy screening on the doors, 21.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Manifestations were fitted to the windows in one Visitors room, and further manifestations approved, ordered and will be fitted by Friday 5th April	Added to Maintenance log To be reviewed at next monthly walkabout	Yes	05/05/2024	Hospital Administrator
Preventative Action	Privacy audit to be completed monthly alongside the monthly walk about and issues to be raised and reviewed on the maintenance log.	All issues discovered in the privacy audit to be added to the Maintenance log and reviewed monthly.	Yes.	05/05/2024	Hospital Administrator, Assistant Director of Nursing and Maintenance Manager

Regulation 22: Premises					
Reason ID : 10004904		**The registered proprietor did not ensure that the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and wellbeing of the residents as not all ligatures were minimised to the lowest practicable level based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The replacement of 30 fire doors shall be all be ligature free. The hand towel/ toilet roll/soap dispenser project over the next fortnight shall remove 120 ligatures from system	To be completed on a phased basis	Achievable. 30 fire doors scheduled for completion, September 2024. Hand towel/toilet roll/soap dispenser completion time scheduled April 2024.	01/09/2024	Noel Giblin, Mark Jeffrey.
Preventative Action	Ligature Audit has been completed again over recent weeks with additional ligature work to be commenced over the next 12 months	To be completed on a phased basis	Achievable	04/04/2025	Noel Giblin, Mark Jeffrey.
Reason ID : 10004905		**The registered proprietor did not ensure the premises was maintained in good structural and decorative condition as a fire door was not operational, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire door replacement plan underway	To be completed on a phased basis	Achievable	30/09/2024	Noel Giblin, Mark Jeffrey.
Preventative Action	The fire contract now includes the checking of all alarms every 6 months	This is currently introduced	Achievable. There is a current contract in place.	30/09/2024	Noel Giblin, Mark Jeffrey.
Reason ID : 10004906		**The registered proprietor did not ensure the premises was maintained in good structural and decorative condition as the walls of the external garden areas required painting; the paving and windowsills of external garden required power hosing, flooring of the approved centre required replacing, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	See attached report which lists items and current status.	See attached report which lists items and current status. All areas of the external garden area were power washed in January 2024. The painting of the walls and ground area was reviewed in Feb 2023. A business case was submitted and approved. Painting is provided by an external organisation and painting of the external areas is weather dependent, and will be completed when weather permits this. There was significant financial investment in the floor replacement project over 2023 and continues in to 2024. There is a replacement plan for 4 public areas ongoing, a business case was made on 13/10/23 and approved and went to tender 1/11/2024.	See attached report which lists items and current status. Work is funded and agreed, tender awarded.	31/05/2024	Maintenance Manager Assistant Director of Nursing
Preventative Action	Monthly walkabout attended by the ADON, CNM3, Maintenance Manager. See attached report which lists items and current status.	Issues are noted on the monthly walkabout of the units. This walkabout is directed by the Hospital administrator and attended by the ADON, CNM3 & Maintenance Manager, Premises Staff and Domestic Services. A list is produced and work is detailed and completed	Yes – occurs monthly. The specific work detailed was already planned for.	31/05/2024	Hospital Administrator Assistant Director of Nursing Maintenance Manager

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10004912		**The registered proprietor had not ensured that the approved centre had appropriate and suitable practices relating to the prescribing of crushed medicines to residents, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A new document has been developed where all crushed medication on the MPARS will need to be completed	This will be audited quarterly	Yes 3/6/2024	03/06/2024	Clinical Director
Preventative Action	A new document has been developed where all crushed medication on the MPARS will need to be completed	This will be audited quarterly	Yes 3/6/2024	03/06/2024	Clinical Director

Regulation 26: Staffing					
Reason ID : 10004913		**The registered proprietor did not ensure that the numbers of nursing staff were appropriate to the assessed needs of residents as staffing numbers were not always maintained at the required levels every day, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Agreed staffing complements to be filled utilising overtime or agency hours in the absence of normal staffing resources.	Monthly audits of the nursing rosters to be completed by the Allocations Officer to be forwarded to the Area Director of Nursing to ensure complement of staff are met.	Yes 07.04.2024	07/04/2024	Area Director of Nursing
Preventative Action	Escalation of staff shortages to the Chief Officer, Head of Service and Head of HR advocating for derogation in relation to the moratorium and recruitment to allow nursing staff be hired.	Review of staffing complement in three months following the progression of a recruitment campaign.	31.07.2024	31/07/2024	Area Director of Nursing
Reason ID : 10004914		**The registered proprietor did not ensure that the skill mix of staff were appropriate to the assessed needs of residents as there was no dedicated pharmacist for the service, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seek approval through escalation pathways to run recruitment campaign to ensure the appointment of pharmacist	Discuss the following at monthly catchment management team meetings • recruitment of pharmacist • Uptake of offers of posts • identification of suitable qualified pharmacist	Yes	03/08/2024	Clinical Director
Preventative Action	Recruitment campaign to ensure the appointment of pharmacist	Discuss the following at monthly catchment management team meetings • recruitment of pharmacist • Uptake of offers of posts • identification of suitable qualified pharmacist	Yes	03/08/2024	Clinical Director
Reason ID : 10004915		**The registered proprietor did not ensure that the skill mix of staff were appropriate to the assessed needs of residents as all residents did not have access to a dietetics service, 26(2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Vacant dietitian post has been upgraded to Clinical Specialist grade to assist in recruitment. Vacant post listed as critical post for filling in the context of the HSE recruitment pause. Funding secured for agency filling of posts. Relevant agencies have been contacted with a view to recruiting a suitably qualified dietitian. Private dietetic service in place for priority/ urgent referrals. This will be expanded to include some capacity for non-urgent cases pending recruitment. Alternative referral pathways to be explored	Options to fill vacant dietetic posts to be discussed as an agenda item on the Catchment Management Team. Meeting of Community Dietitian Manager with Clinical Director and Area DON scheduled to discuss approved centre dietetic needs and optimising private dietetic service provision.	Yes	31/05/2024	Community Dietitian Manager
Preventative Action	Dietitian Manager to ensure all recruitment documentation submitted and in place. Retrospective exit interviews conducted by Dietitian Manager in 2023 with the previous MHS dietitians to aid future recruitment & retention. A summary report to be compiled and shared with MHS management. Dietitian Manager to explore dietetic service needs of midlands MHS with stakeholders Mental health	Dietitian Manager to compile and share summary report of exit interviews with MHS management. Meeting to take place between Dietitian Manager, Clinical Director and Area DON to discuss approved centre dietetic needs and optimising private dietetic service provision.	Yes	27/12/2024	Community Dietitian Manager

	dietitian role remit to be reviewed to aid staff retention				
Reason ID : 10004916		**The registered proprietor did not ensure that all staff were trained to enable them to provide care and treatment in accordance with best contemporary practice as all staff were not trained in fire safety, basic life support and the therapeutic management of violence and aggression, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ongoing training is underway in relation to Fire, BLS and TMVA/MAPA. Updated training stats attached for your information. Training a standing item on agenda of Catchment Management Team. All Heads of Discipline to be responsible for the upkeep of training rates of staff.	Training records to be submitted quarterly to CMT for review. Training plan provided	Yes. Quarterly review	31/05/2024	Clinical Director, ADON, CNM3, Area DON, General Manager, all Heads of Discipline
Preventative Action	On line training to be monitored by each Head of Discipline, ADON, CNM3 and CD. Face to face training to be arranged regularly and coordinated through Hospital Administrator and General Managers office	Mandatory training records to be reviewed at ACG and Catchment Management team meetings. Training plan provided	Yes	09/09/2024	All Heads of Discipline, CD, ADON, General Manager, Hospital Administrator

Regulation 32: Risk Management Procedures					
Reason ID : 10004910		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre. Risk of fire was not comprehensively mitigated as fire evacuation drills were not completed on a regular basis, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Assistant Director of Nursing to conduct fire drills. A schedule of fire drills agreed. This process is as agreed with the Estates Fire Advisor.	Both areas (Admissions & St Edna's Ward) have had a fire drill in 2024, and 6 more fire drills are planned for 2024. The fire register was assessed by the Acting Fire Officer 3/4/2024 Weekly bell test planned and documented and audited. Fire and Evacuation Safety Committee established.	Yes 01.06.2024	01/06/2024	Assistant Director of Nursing
Preventative Action	Fire and Evacuation Safety cCmmittee established to ensure compliance in the area of fire safety and fire management.	This committee reviews issues relating to fire safety and develops action plans to improve the process.	Yes 01.06.2024	01/06/2024	Assistant Director of Nursing Hospital Administrator
Reason ID : 10004911		**The registered proprietor did not ensure that the risk management policy was implemented throughout the approved centre. The health and safety risk associated with a faulty fire door was not adequately treated, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A fire door assessment audit was completed by an external fire safety service provider. A fire door replacement plan for 2024 is agreed.	Audited every 6 months by an external provider for fire safety. Fire door replacement plan in place to renew some fire doors.	Yes Fire Door audit conducted 28. Feb 2024 Replacement plan to commence in May 2024 and conclude in 30.09.2024	30/09/2024	Maintenance Manager Estates Assistant Director of Nursing
Preventative Action	Weekly visual inspection of all doors. 6 monthly audit of all doors by an external service provider.	Weekly audit	yes 30.09.2024	30/09/2024	Maintenance Manager Hospital Administrator Assistant

					Director of Nursing

Rules Governing the Use of Seclusion					
Reason ID : 10004930		**The multi-disciplinary review and oversight committee did not produce a report following each meeting. Therefore no report was made available to staff who participated in seclusion to promote on-going learning and awareness, 10.8 (vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Learning Reports have now been completed and circulated to staff this includes a report for: • 2023 • Jan 2024 • Feb 2024	Yes Completed	Yes. completed.	28/03/2024	Clinical Director, Assistant Director of Nursing, Clinical Nurse Manager 3 and RP nominee
Preventative Action	A systematic ICT based programme is in place for meeting of the over sight committee, leading to the producing of a report. A schedule of meetings is agreed	Yes review of each meeting.	yes - monthly. Timebound is monthly.	28/03/2024	RP nominee

Rules Governing the Use of Mechanical Means of Bodily Restraint					
Reason ID : 10004929		**The oversight committee did not produce a report following each meeting, 10.6.vi.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Learning Reports have now been completed and circulated to staff this includes a report for: • 2023 • Jan 2024 • Feb 2024	Completed	Completed	28/03/2024	Clinical Director, Assistant Director of Nursing, Clinical Nurse Manager 3 and RP nominee
Preventative Action	A systematic ICT based programme is in place for meeting of the over sight committee, leading to the producing of a report. A schedule of meetings is agreed.	Yes review of each meeting.	Yes. Monthly - ongoing.	28/02/2024	RP nominee

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10004922		**In one episode of physical restraint the person was not informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint, 3.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code is adhered to.	Introduction and audit of the Physical Restraint Care Pathway	yes completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing, Clinical Nurse Manager 3
Preventative Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to.	Introduction and audit of the Physical Restraint Care Pathway	completed 1/3/2024	01/03/2024	Clinical Director , Assistant Director of Nursing, and Clinical Nurse Manager 3
Reason ID : 10004923		**In one episode of physical restraint an in-person debrief with the person who was restrained did not occur within two working days, 5.3 (ii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to.	Introduction and audit of the Physical Restraint Care Pathway	yes. completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing, Clinical Nurse Manager 3
Preventative Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to.	Introduction and audit of the Physical Restraint Care Pathway	Yes. completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing, Clinical Nurse Manager 3

Reason ID : 10004924		In one episode of physical restraint it was not recorded in the clinical file if the person was given the option of having their representative or their nominated support person attend the debrief with them, 5.3(vi).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to.	Introduction and audit of the Physical Restraint Care Pathway	Yes. Completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager 3
Preventative Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to.	Introduction and audit of the Physical Restraint Care Pathway	Yes. completed 1/3/2024	01/03/202	Clinical Director, Assistant Direc4tor of Nursing and Clinical Nurse Manager 3

Reason ID : 10004925		In one episode of physical restraint appropriate emotional support was not provided to the person following the episode of physical restraint, 5.7.			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to. This will support the clinician in documenting the emotional support provided allowing evidence of the intervention to be detailed. Further education on the Code of Practice on Physical Restraint and Trauma Informed Care will be provided to staff in 6 sessions across 2024. One staff	Introduction and audit of the Physical Restraint Care Pathway	Yes. completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager 3

	member will be supported in completing Modules in Behaviour Support including Positive Behaviour support and Emotional Support and this staff member will act as a Champion within the Approved Centre.				
Preventative Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to. This will support the clinician in documenting the emotional support provided allowing evidence of the intervention to be detailed. Further education on the Code of Practice on Physical Restraint and Trauma Informed Care will be provided to staff in 6 sessions across 2024. One staff member will be supported in completing Modules in Behaviour Support including Positive Behaviour support and Emotional Support and this staff member will act as a Champion within the Approved Centre.	Introduction and audit of the Physical Restraint Care Pathway	Yes. Completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager 3
Reason ID : 10004926		**In one episode of physical restraint alternative de-escalation strategies to be used in future were not identified, 7.3 (iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to. This will allow Clinicians a process and system of developing learning from each episode of Physical Restraint which will in turn provide alternative strategies for the individual should concerns reoccur. See Attached Care Pathway on Physical Restraint.	introduction and audit of the Physical Restraint Care Pathway The introduction of a restricted practice risk assessment and decision-making tool was introduced to ensure that information is collected and that alternatives are agreed, going forward.	Yes. Completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager
Preventative Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to. Training on Restrictive Practices to include the creation of proactive and reactive strategies. This will allow Clinicians a process and system of developing learning from each episode of Physical Restraint which will in turn provide alternative strategies for the individual should concerns reoccur. See Attached Care Pathway on Physical Restraint.	Introduction and audit of the Physical Restraint Care Pathway Training dates planned for April, May, Aug, Sept	Yes. Completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager 3
Reason ID : 10004927		**In one episode of restraint an assessment of the factors in the physical environment that may have contributed to the use of restraint was not documented, 7.3(vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to. This Care Pathway will allow the Clinicians to document the impact of the physical environment in a structured way providing evidence that the physical environment was considered when considering the use of Physical Restraint.	Introduction and audit of the Physical Restraint Care Pathway The introduction of a restricted practice risk assessment and decision making tool was introduced to ensure that information is collected and that alternatives are agreed going forward.	Yes completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager 3
Preventative Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to. Training on Restrictive practices to include the creation of proactive and reactive strategies. his Care Pathway will allow the Clinicians to document the impact of the physical environment in a structured way providing evidence that the physical environment was considered when considering the use of Physical Restraint.	Introduction and audit of the Physical Restraint Care Pathway Training dates planned for April, May, Aug, Sept	Yes. completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager 3
Reason ID : 10004928		**In one episode of physical restraint the multi-disciplinary team did not record actions decided upon and follow-up plans to eliminate or reduce restrictive interventions for the person, 7.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The introduction of a Physical Restraint Care Pathway to	Introduction and audit of the Physical Restraint Care Pathway The introduction	Yes. Completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director

	ensure each element, as set out in the code, is adhered to. The Risk Assessment and Decision making tool attached provides the clinician with a dedicated place to record future management where restrictive intervention may be considered and allows the Service User and clinician space to detail a pre decided plan. We plan to audit this process in the coming months and develop further reactive and proactive plans for each Service User.	of a restricted practice risk assessment and decision-making tool was introduced to ensure that information is collected and that alternatives are agreed going forward.			of Nursing and Clinical Nurse Manager 3
Preventative Action	The introduction of a Physical Restraint Care Pathway to ensure each element, as set out in the code, is adhered to. Training on Restrictive practices to include the creation of proactive and reactive strategies. The Risk Assessment and Decision making tool attached provides the clinician with a dedicated place to record future management where restrictive intervention may be considered and allows the Service User and clinician space to detail a pre decided	Introduction and audit of the Physical Restraint Care Pathway Training dates planned for April, May, Aug, Sept	Yes. completed 1/3/2024	01/03/2024	Clinical Director, Assistant Director of Nursing and Clinical Nurse Manager 3

	plan. We plan to audit this process in the coming months and develop further reactive and proactive plans for each Service User.				

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10004900		**The approved centre did not comply with Regulation 18: Transfer of Residents.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A policy review will take place to include protocols for transfer of residents to other care centres and Hospitals	The policy will be reviewed and amended to include protocols. Transfers of residents will be audited monthly	Yes End May 2024	31/05/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3 Policy review group
Preventative Action	There is a policy in place which provides direction to all staff on the transfer policy and protocol. The Transfer of each resident from the approved centre is audited.	An audit will be completed monthly on the compliance with the Hospital policy.	Yes, end of June 2024	30/06/2024	Clinical Director Assistant Director of Nursing Clinical Nurse Manager 3
Reason ID : 10004901		**The admission assessment did not include current and historic medication information, 15(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Director will send a memo to all NCHDs and consultants informing them of the importance of recording current and historic medication. The importance of recording current and historic medication will be included in the schedule for teaching and induction.	Clinical audit of medical files will be carried out quarterly to ensure current and historic medication is recorded	Yes 3/5/2024	03/05/2024	Clinical Director
Preventative Action	The Clinical Director will send a memo to all NCHDs and consultants informing them of the importance of recording current and historic medication. The importance of	Clinical audit of medical files will be carried out quarterly to ensure current and historic medication is recorded	Yes 3/5/2024	03/05/2024	Clinical Director

	recording current and historic medication will be included in the schedule for teaching and induction.				
Reason ID : 10004902		**The admissions assessment did not include documentary evidence of a full physical examination, 15(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Director will send a memo to all NCHDs and consultants informing them of the requirement to record evidence of a full physical examination The importance of evidence of a full physical examination will be included in the schedule for teaching and induction	A clinical audit of medical files will be carried out quarterly to ensure documentary evidence of a full physical examination is recorded	Yes	03/05/2024	Clinical Director
Preventative Action	The Clinical Director will send a memo to all NCHDs and consultants informing them of the requirement to record documentary evidence of a full physical examination . The importance of recording documentary evidence of a full physical examination will be included in the schedule for teaching and induction	A clinical audit of medical files will be carried out quarterly to ensure documentary evidence of a full physical examination is recorded	Yes	03/05/2024	Clinical Director

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.

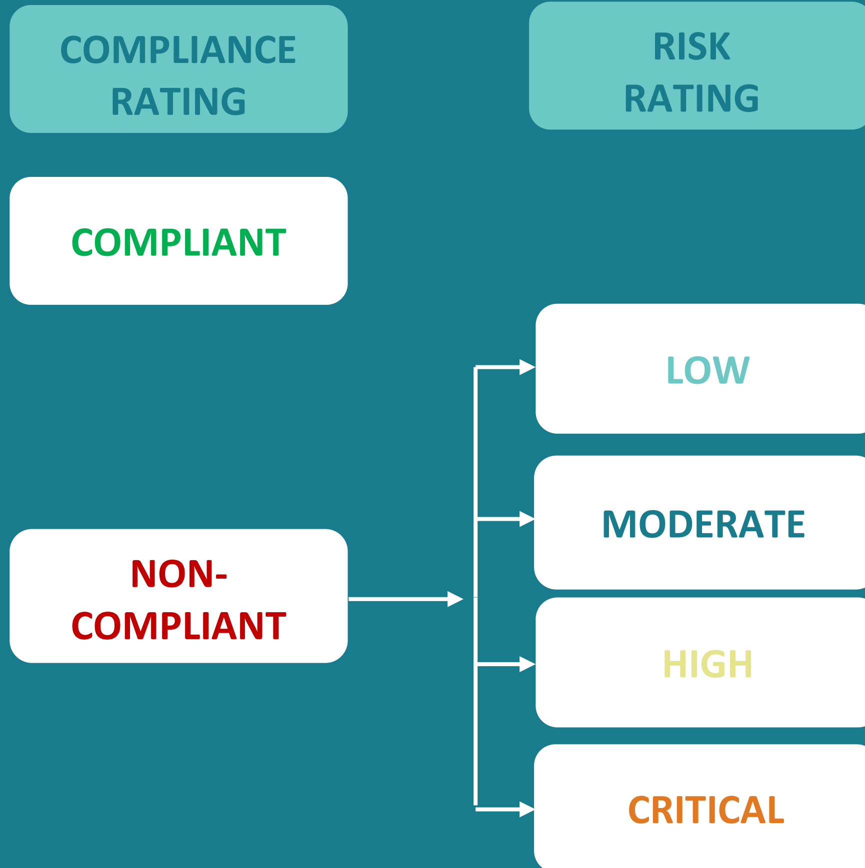
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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