Department of Psychiatry, St Luke's Hospital

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coimisiún meabhair - shláinte
mental health commission

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, ST LUKE'S HOSPITAL

Freshford Road, Kilkenny, R95FY71

Date of Publication: 24th May 2024

ID Number: AC0151

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Rehabilitation

Conditions Attached:
None

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Anne Donaghey, Head of Services, CHO5 Mental Health Services

Inspection Team:
Sarah Jones, Lead Inspector
Barbara Murphy
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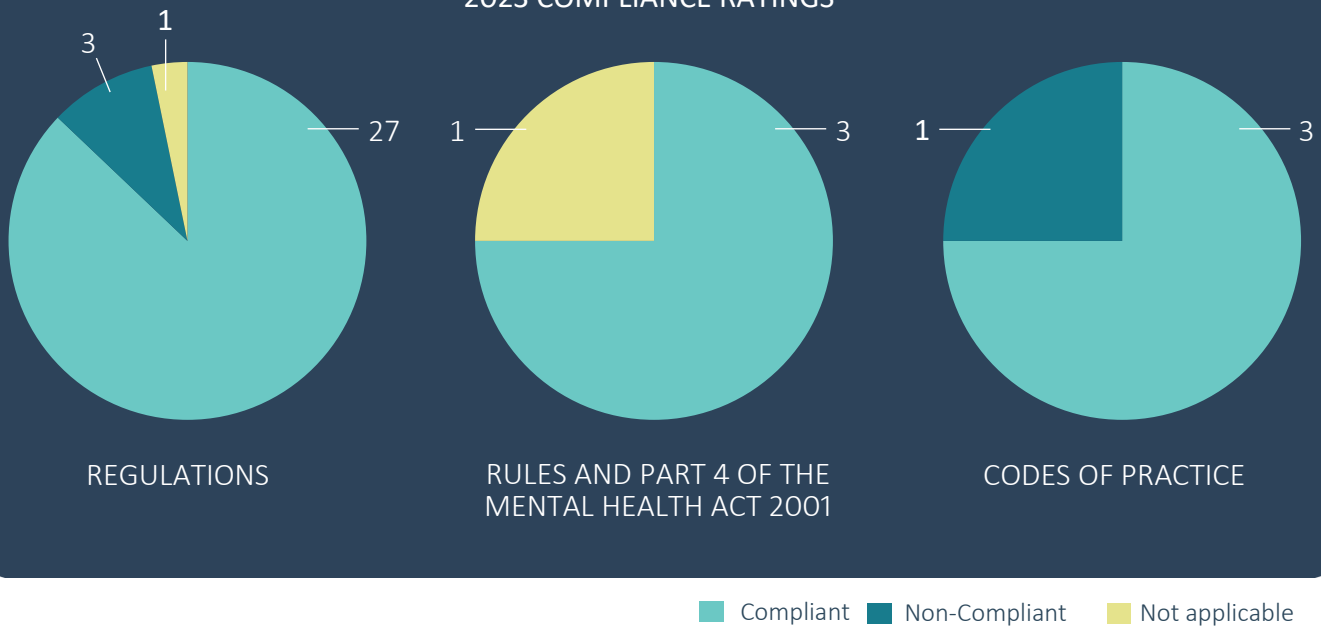
Inspection Date:
22 – 25 August 2023

Previous Inspection date:
25 – 28 October 2022

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

Inspection Type:
Announced Annual Inspection

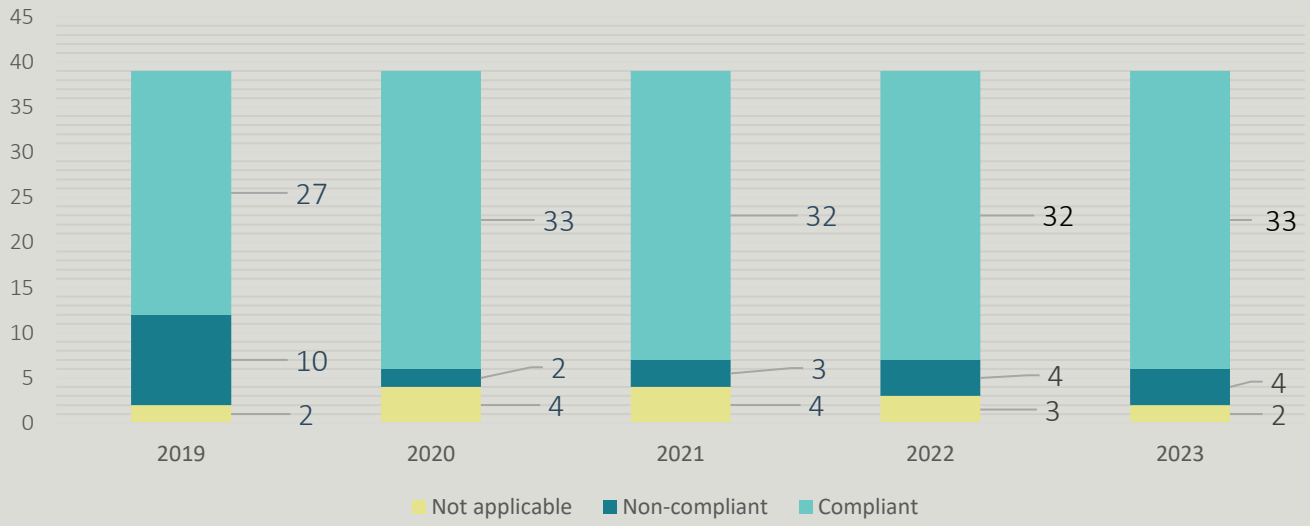
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

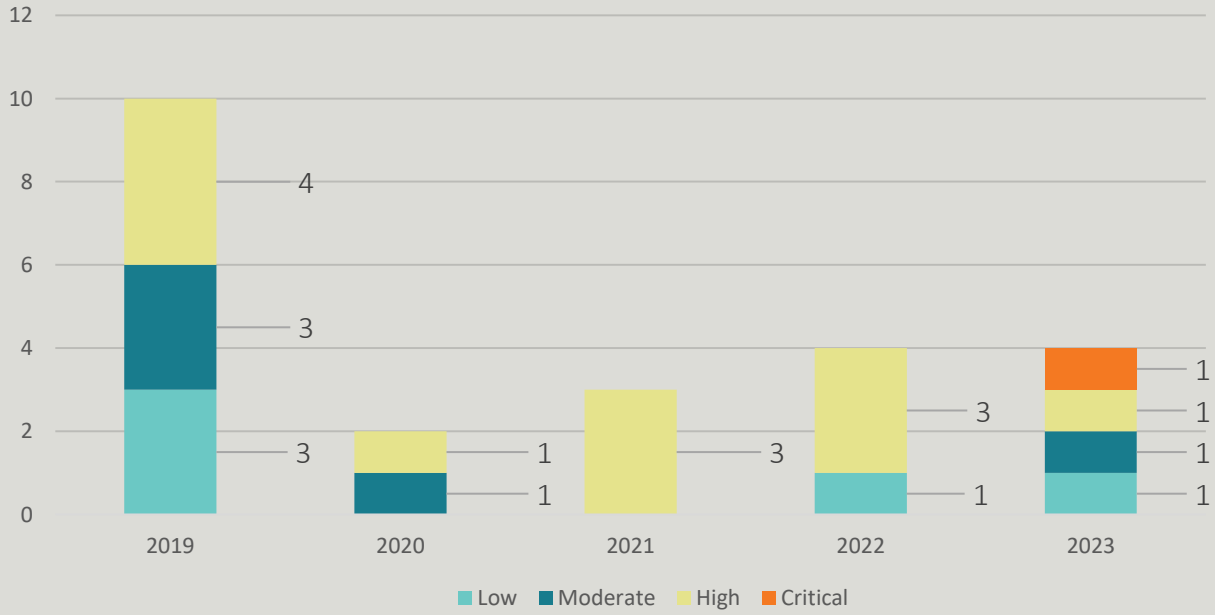
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



Contents

1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services

Professor James V Lucey

In brief

The Department of Psychiatry, St Luke's Hospital, was located on the grounds of St. Luke's General Hospital. It provided acute adult mental health care, psychiatry of later life and mental health rehabilitation services. Sleeping accommodation was a mixture of single bedrooms and dormitory-style accommodation, with a mix of four and six beds in each dormitory. The approved centre was registered for 44 beds and at the time of the inspection accommodated 39 residents. Admissions to the unit were referred from any of 14 consultant-led multi-disciplinary teams in the area.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	73%	94%	91%	89%	89%

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

Enforcement Action	Date applied	Reasons	Outcome
Immediate enforcement action	*08/09/2023*	*Further to the critical risks identified with Regulation 32: Risk Management Procedures the MHC decided to issue an immediate action notice.*	*The approved centre submitted a plan to rectify the issues identified on the annual inspection. Due to the serious nature of concerns, the MHC decided to hold a Regulatory*

			Compliance Meeting with the approved centre's representatives.
Regulatory compliance meeting	*12/12/2023*	*The Regulatory Compliance Meeting (RCM) was held to further discuss the serious risk management issues identified on the annual inspection.*	*Further to the RCM, the MHC continues to liaise with the approved centre.*

Safety of people in the approved centre

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

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

However:

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

Appropriate care and treatment of residents

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

- ***Appropriateness of environment*****:** The layout and the decoration of the approved centre was of good standard and met the needs of the residents.
- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.

- ***Physical assessment**:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines. Residents had access to a local General Practitioner (GP) and local hospital for assessment and any treatment required.
- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. There was an identified staff member to deliver the interventions. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT) consisting of a consultant psychiatrist, registered psychiatric nurse, an occupational therapist, a social worker and clinical and counselling psychologists. 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 plans.
- ***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:

- ***Admission of Children:*** Age-appropriate facilities were not provided.

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:*** A mixture of single bedroom accommodation and dormitory-style accommodation with a mix of four and six beds in each dormitory.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** Bedroom doors had privacy screens and all bathrooms, showers and toilets had locks on the inside of the door. 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.
- ***Use of restrictive practices:*** Mechanical restraint, physical restraint and seclusion was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained or secluded, including information on attempts to reduce or eliminate the use of restraint or seclusion for that person. The approved centre had a reduction of restrictive practices strategy.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity.

Relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Privacy and dignity:*** Two external security cameras had a partial view of the garden and garden entrance to the high dependency unit that were actively recording. This impacted the residents' privacy in that area.

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 multi-faith ministers were available to the residents.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Residents had access to both weekday and weekend activities, including books, television, DVDs, walking, and an onsite gym.
- ***Support groups:*** The approved centre provided residents with a weekly community meeting as well as therapeutic groups including art, anger management, creative writing, yoga, discharge planning among others.
- ***Residents' feedback:*** The residents were very complimentary about the environment and the care they received. They said that they received information on their treating teams and their individual care plans, were aware of their key workers and were able to give feedback about their care to staff. They said they had private spaces, their dignity was respected and that plenty of activities were provided during the day. Feedback was particularly complimentary toward the staff and service provided.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was under the management of South-East Community Healthcare (SECH) Mental Health Service and was closely aligned with St. Luke's Hospital.
- ***Leadership:*** There was an executive management team for the Carlow, Kilkenny and South Tipperary Mental Health Service which met monthly. A Quality and Patient Safety Committee (QPSC) also met monthly. Formal and informal structures and processes were in place for measuring and encouraging staff performance and personal development.
- ***Clinical governance:*** Many areas of clinical governance such as individual care planning processes were good. General health care provided met the needs of the residents and there was evidence in the files of multi-disciplinary team working and strong documentation. Audits were carried out.
- ***Restrictive practices reduction:*** The approved centre had implemented a restrictive practice reduction policy and strategy, and the registered proprietor had appointed a named senior manager who was responsible for the approved centre's reduction of restrictive practices. The approved centre was compliant with the rule on the use of seclusion, the rule on the use of mechanical restraint and the code of practice on physical restraint.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement.
- ***Policies:*** All of the approved centre's policies were up-to-date.
- ***Staff training:*** All staff had received mandatory training. Clinical supervision was provided for medical staff and the health and social care professional groups.
- ***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. Residents reported that they could contact staff at any time.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 91% over the last four years and maintained a compliance rate of 89% from the previous year. The approved centre also employed a compliance officer and continues to engage positively with the regulatory process and the Mental Health Commission.
- ***Advocacy service:*** The service has an advocacy service who visits weekly

However:

- ***Risk:*** While the person with responsibility for risk was known to all staff and risk management was supported by the QPSC, not all ligature risks had been identified and minimised, and not all risk procedures such as risk management plans actively reduced identified risks to the lowest practicable level.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A tissue viability nurse was appointed to the service.

2. New garden furniture was purchased for Sycamore Unit.

3. New outdoor fitness equipment was purchased for Oak garden.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The Department of Psychiatry, St Luke's Hospital, was located on the grounds of St. Luke's General Hospital in Kilkenny city. The approved centre served the catchment area of Carlow, Kilkenny, and South Tipperary. 14 consultant-led multi-disciplinary teams admitted residents to the approved centre.

The approved centre comprised two units, Sycamore and Oak, which had 25 and 19 beds respectively. There were three six-bed rooms, four four-bed rooms, and ten single rooms. Within Oak ward, there was a high observation area that accommodated the seclusion room and two single bedrooms. Both units provided care to both male and female residents. There were well maintained gardens that were accessible to both units. There was one large dining room shared by both units. The approved centre contained a reception area, Electro Convulsive Therapy suite, TV areas, art room, occupational therapy room, quiet room, occupational therapy kitchen, assessment room, gym room, and offices.

The approved centre was found to be clean and bright and resident areas appeared inviting and comfortable.

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

Resident Profile	
Number of registered beds	***44***
Total number of residents	**39**
Number of detained patients	7
Number of wards of court	2
Number of children	0
Number of residents in the approved centre for more than 6 months	3
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre was under the management of South-East Community Healthcare (SECH) Mental Health Service. The SECH Mental Health Service was divided into two distinct geographical areas, one covering Waterford/Wexford and the other Carlow/Kilkenny/south Tipperary. The approved centre was governed by the executive management team for the Carlow, Kilkenny and South Tipperary Mental Health Service. An executive management team (EMT) meeting and a Quality and Safety Executive Committee (QSEC) convened monthly. A local Quality and Patient safety committee (QPSC) for the approved centre also met monthly and reported to the QSEC. Membership within the various governance committees included the different heads of disciplines as a multi-disciplinary approach.

There were 14 multi-disciplinary teams for the Kilkenny, Carlow and South Tipperary area that admitting to the approved centre. An organisational chart identified the leadership and management structures and the lines of responsibility and accountability within the approved centre. At the time of inspection, the numbers and skill mix of staff were sufficient to meet the resident's needs. Health and Social care professionals, including occupational therapy, psychology, social work, and physiotherapy, were readily accessible to all residents with limited access to dietetics and speech and language therapy through private procurement. Vacant positions among disciplines were effectively managed through the use of overtime work, agency staff, or locum contracts.

All heads of disciplines completed and returned a Mental Health Commission Governance Questionnaire. These disciplines included nursing, medical, occupational therapy, social work, and psychology. Heads of discipline were in regular contact with staff members of the approved centre. Regular peer supervision sessions were facilitated for each discipline. Some disciplines did not have a formal performance appraisal system in place, however, in some instances, disciplines incorporated elements of performance review within the supervision process. Annual staff training plans were completed to identify required training. A rolling programme of mandatory training was in place and compliance with training completion was monitored at the QSEC meeting. Operational risks highlighted within these questionnaires included lack of designated mental health occupational therapy management; currently OT management is positioned within primary care, staff recruitment across disciplines, bed capacity, and training.

The approved centre's registered proprietor held overall responsibility for the risk management process. The Quality and Patient Safety Committee (QPSC) monitored and maintained the approved centre's risk register. Incidents and trends were also reviewed at the QPSC meetings. Risk issues were escalated to the wider South -East Community Healthcare risk register where deemed appropriate. Not all risks however, were adequately assessed, treated and monitored. The approved centre completed a ligature audit, but not all ligature risks were identified on it. High risk ligature points were identified, and, as a result, capital funding was approved which addressed some of these high-risk ligature points. The remaining ligature points, while incorporated into ligature reduction plans, still required minimisation. Not all risk procedures such as risk management plans actively reduced identified risks to the lowest practicable level. Two clinical files did not document adequate risk mitigation plans for all identified risks.

The service employed a Compliance Officer, who together with the approved centre management, oversaw a programme aimed at enhancing quality and regulatory compliance. A scheduled programme of audit, involving all disciplines, was implemented in the approved centre. Audit results were presented at the local Quality and Patient Safety Committee (QPSC). The QPSC convened on a monthly basis and meeting minutes indicated active review and planning with regard to several areas underpinning service improvement and quality; these included a review of regulatory and compliance issues, feedback from the service user engagement lead, review of incidents, health and safety issues, and staff training needs. In turn, the QPSC reported to the Quality and Safety Executive meeting forum and issues were escalated to this forum as appropriate.

The Area Lead for Mental Health Engagement was a member of the Carlow, Kilkenny & South Tipperary Mental Health Services Executive Management Team, as well as the Quality and Safety Executive Committee, and the approved centre's QPSC. Residents had the opportunity to provide feedback to the service through

forums such as the resident community meetings. Residents could also lodge suggestions, compliments, and complaints with the service. Service user evaluation of inpatient therapeutic groups and interventions were also sought regularly.

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 21: Privacy	✗	High	✗	Moderate	✓		✗	High	✗	Low
Regulation 22: Premises	✗	Low	✓		✗	High	✗	High	✗	High
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	Critical
COP Relating to Admission of Children under the Mental Health Act 2001	✗	High	✓		✓		✓		✗	Moderate

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient 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.

Eight questionnaires and three residents engaged with the inspection team. One questionnaire was incomplete, but the questions reported have been added to the collated response on service user experience.

Residents expressed satisfaction with the care and treatment provided in the approved centre. Seven of eight respondents reported staff explained what was happening on admission, in a way they understood. Seven of eight individuals expressed staff always gave information about their diagnosis, care, and treatment in a way they understood. All respondents stated they knew what their individual care plan was, and two individuals indicated they were "always" involved in setting their goals. Four individuals reported they were "sometimes" involved, and one person stated they did not want to be involved. All respondents expressed they knew their multi-disciplinary team and keyworker.

Five individuals reported they could "always" discuss worries or concerns with a member of staff. One person expressed they were able to do this sometimes and two individuals did not give feedback. Six respondents reported there were enough activities for residents, whilst two individuals did not feel there were enough during the day. Seven of eight individuals reported they were happy with how staff spoke with them, and all respondents reported their privacy and dignity were respected and they had space for privacy.

All feedback from residents reported they could communicate freely with family, friends, or advocates and seven of eight indicated in their response, they felt safe whilst in the approved centre. Six individuals expressed they were able to give feedback to staff and to make complaints, when they were not satisfied

with any part of their stay in the approved centre. Two individuals reported they did not know how to make a complaint.

When asked to rate the service on a scale of 1 –10, 1 being poor and 10 being excellent, regarding their overall experience of care and treatment, respondents scored the approved centre, 10, 10, 6, 10, 10, 8, 7 and 10 respectively.

Additional comments made by respondents on their experience included;

“All the staff do a great job”
“Not enough time for patients to go for coffee. Maybe nurses could be available to take at times”
“Staff are excellent, and my MDT are very understanding”
“The staff respect me, so I respect them”
“Keep up the good work”
“Staff members are not paid enough”

5.2 Advocacy

The approved centre did have an advocacy service which visits weekly.

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:

- Executive Clinical Director
- Clinical Director
- Head of Service
- Acting Area Director of Nursing
- Consultant Psychiatrist x 2
- Support Services Manager
- Area Lead for Mental Health Engagement
- Mental Health Act Administrator/Complaints Officer
- Clinical Risk Manager
- Assistant Director of Nursing
- Assistant Director of Nursing – Compliance Officer
- Clinical Nurse Manager III

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was complaint with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

For residents with special dietary requirements, nutritional and dietary needs were assessed, where necessary, and addressed in residents' individual care plans. The Malnutrition Universal Screening Tool (MUST) was used in the approved centre, and residents were referred to a dietitian where required.

The approved centre was complaint with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. Food was cooked in the main kitchen and transported to the approved centre. There were proper facilities for the refrigeration, storage, preparation, and serving of food. Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was complaint with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity, and religious and cultural practices. Residents changed out of nightclothes during daytime hours unless specified otherwise in their individual care plans.

The approved centre was complaint with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in April 2021. A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies, valuables, personal property, and possessions, as necessary.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident. Residents were supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP or in accordance with the approved centre's policy. There were no restrictions on any resident's use of their property at the time of inspection.

The approved centre was complaint with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Residents had access to a variety of recreational activities, including books, television, DVDs, walking, and an onsite gym.

The approved centre was complaint with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable. mass was available to residents of Christian faith and multi-faith ministers were available to residents of other religions if required.

The approved centre was complaint with this regulation.

Regulation 11: Visits

COMPLIANT

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

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

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

The approved centre was complaint with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to communication. The policy was last reviewed in February 2021.

Residents in the approved centre were free to communicate at all times, having due regard to their wellbeing, safety and health. Residents used their own mobile phones and had access to two computers with internet access, and residents received their postal mail.

It was the approved centre's policy that the clinical director (or senior staff member designated by the clinical director) only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others. There were no restrictions on any resident's communication at the time of inspection.

The approved centre was complaint 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 June 2021, and included all requirements related to:

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

The clinical files of two residents were examined on inspection in relation to the search process. Risk was assessed prior to the search of a resident, their property, or the environment, as appropriate to the type of search being undertaken. Resident consent was sought prior to all searches, and the request for consent and received consent were documented for every search of a resident and every property search. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out by the policy.

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

The approved centre was complaint with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on care of the dying. The policy was last reviewed in October 2020.

No end-of-life care was provided in the approved centre since the last inspection. All deaths of residents were notified to the Mental Health Commission as soon as was practicable and, in any event, no later than within 48 hours of the death.

The approved centre was complaint with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

ICPs identified goals for the resident. The care and treatment required to meet the goals was also identified, including the frequency and responsibility required for implementing the care and treatment. The ICPs were subject to weekly review by the MDT in consultation with the resident. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, circumstances and goals.

The approved centre was complaint with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. Therapy groups included art, anger management, creative writing, yoga, drop-in fitness, music therapy, walking, baking, relaxation, discharge planning, and managing emotions. There was a weekly community meeting, and the recovery college attended the approved centre to run courses (including community links).

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

The approved centre was complaint with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to transfers. The policy was last reviewed in August 2022. The clinical file of one resident who had been transferred from the approved centre was inspected. Full and complete written information about the resident was sent to a named individual in the receiving hospital when the resident was transferred. The transfer documentation included a letter of referral listing current medications, and the resident transfer form.

The approved centre was complaint with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was complaint with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

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

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

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

The approved centre was complaint with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

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

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

The dignity and privacy of residents was not appropriately respected at all times: two cameras used as a security measure for the outside parameters, and not for monitoring residents, were noted to be actively recording, these cameras showed a partial space within the garden and entrance of the high dependency unit (HDU) garden which residents within the HDU could access. The recording function of the cameras was disabled during the course of the inspection.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times. Two camera's used for security measures had an active record function. Whilst these cameras were not used for a monitoring purpose, they overlooked aspects of the high dependency unit garden which residents had access too.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space, and appropriately sized communal rooms were provided. There was suitable and sufficient heating in day areas and bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.

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

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

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

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

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the condition of the physical structure and overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, as ligature points were not minimised to the lowest practicable level, based on risk assessment, 22 (3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

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

All entries in the MPARs were legible, and included the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. In the event of medication being withheld, the justification was noted in the MPAR and documented in the clinical file.

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

The approved centre was complaint with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy and procedures in place. The policy was last reviewed in February 2022.

The approved centre was complaint with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was complaint with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in February 2023, and included the recruitment, selection, and Garda vetting requirements for staff in the approved centre.

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

The approved centre had 14 multi disciplinary teams. This included psychiatry, nursing, occupational therapy, social work and psychology staff. All allied health professionals provided an in-reach service. The approved centre also had a clinical pharmacy service that attends the approved centre on a weekly basis.

All healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, and the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory areas.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (40)	39	98%	40	100%	40	100%	40	100%

Consultant Psychiatrist (14)	14	100%	14	100%	14	100%	14	100%
Medical (12)	12	100%	12	100%	12	100%	12	100%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (15)	15	100%	15	100%	15	100%	15	100%
Psychologist (8)	8	100%	8	100%	8	100%	8	100%

The approved centre was complaint with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the creation of, access to, retention of and destruction of records. The policy was last reviewed in June 2021, and included the following:

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

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

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

The approved centre was complaint with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was complaint with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was complaint with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was complaint with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

The approved centre was complaint with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff. Not all risk management procedures actively reduce identified risks to the lowest practicable level of risk. In two clinical files examined, adequate risk mitigation plans were not in place.

Not all clinical risks were identified, assessed, treated, reported, and monitored in relation to ligatures. The audit of fixed ligatures did not identify all potential ligature anchor points; consequently, the ligature risk identified by the inspection team had not been assessed, treated or monitored. Therefore, structural risks, including ligature points, were not all removed or effectively mitigated. Identified clinical and structural risks by the approved centre were documented in the risk register as appropriate.

Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Corporate risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate.

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

Incidents were recorded and risk-rated in a standardised format however, on inspection, the recording of one incident using the national incident management system had not been completed. This was rectified by the team before the end of the inspection. All clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management, reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission, with the information provided anonymised at the resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies and the emergency plan incorporated evacuation procedures.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the approved centre's comprehensive written risk management policy was implemented throughout the approved centre, as not all structural risks (including ligature anchor points) were identified, risk procedures did not reduce risk to the lowest practicable level in all cases, and in one instance the reporting of an incident was not located at the time of inspection, 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 was provided to the inspection team. It confirmed that the approved centre was covered by the State Claims Agency for public liability, employer's liability, clinical indemnity, and property.

The approved centre was complaint with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was complaint with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre had a policy on the reduction of seclusion (the Seclusion and Physical Restraint Reduction Policy). It was last reviewed in June 2021, included all the policy-requirements for the rules governing the use of seclusion.

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

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

Evidence of Implementation: The seclusion facilities were furnished, maintained and cleaned in such a way as to ensure the resident's inherent right to personal dignity and to ensure that the resident's privacy was respected. The construction of the seclusion room was designed to withstand high levels of violence with the potential to damage the physical environment. There was an anti-barricade door. There were no ligature points or electrical fixtures. The room allowed for staff to clearly observe the resident in the

seclusion room. The seclusion room had externally controlled heating and air conditioning which enabled those observing the resident to monitor the room temperature.

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

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

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

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

The CP undertook a medical examination of the residents and signed the seclusion register within 24 hours of the commencement of each episode. The residents were informed of the reasons for, the likely duration of, and the circumstances which would lead to the discontinuation of seclusion, and a record of the reasons was documented in the residents' clinical files.

As soon as practicable, and at the residents' wishes in accordance with their individual care plans (ICPs), the residents' representatives were informed of the seclusion and a record of this communication was entered in the clinical files. Where this communication did not occur, a record explaining why it had not was entered in the clinical file.

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

Ending of Seclusion: The residents were informed of the ending of each episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date the seclusion was ended. An in-person debrief followed each episode of seclusion. This debrief was person-centred and gave the person the opportunity to discuss the seclusion with members of the MDT involved in their care and

treatment as part of a structured debrief process. It included a discussion regarding the resident's preferences in the event where a restrictive intervention was needed in the future. 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: The episodes of seclusion were reviewed by the members of the multi-disciplinary team (MDT) involved in the resident's care and treatment and this was documented in the clinical file no later than five working days after the seclusion. The MDT reviews were documented, and recorded actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the residents.

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

The approved centre was complaint with this rule.

Section 69: The Use of Mechanical Restraint

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had a written policy on the use of mechanical restraint. It was last reviewed in December 2022.

Evidence of Implementation: One episode of mechanical restraint for enduring risk of harm to the self or others was examined on inspection. Mechanical restraint was used to address an identified clinical need or risk. It was only used when less restrictive alternatives were not deemed suitable. A risk assessment of the safety and suitability of mechanical restraint for the resident was undertaken which specified the monitoring arrangements and frequency to be implemented during its use. A copy of the risk assessment and a record of the monitoring of the resident was available. The risk assessment was regularly reviewed and updated in line with the resident's individual care plan (ICP).

The multi-disciplinary team (MDT) developed a plan of care for the resident which included information on attempts to reduce or eliminate the use of restraint going forward. Mechanical restraint was ordered by a registered medical practitioner (RMP) under the supervision of the consultant psychiatrist (CP) responsible for the care and treatment of the resident.
The clinical file contained a contemporaneous record that specified:

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

The approved centre had established a multi-disciplinary review and oversight committee which met on a quarterly basis to:

- Determine if there was compliance with the rules on the use of mechanical restraint, for each episode reviewed.
- Determine if there was compliance with the approved centre's own policies and procedures relating to mechanical restraint.
- Identify and document any areas for improvement.
- Identify the actions, the persons responsible, and the timeframes for completion of any actions.
- Provide assurance to the Registered Proprietor Nominee that each use of mechanical restraint was in accordance with the Mental Health Commission's Rules.
- Produce a report following each meeting of the review and oversight committee.

The review and oversight committee had undertaken a review of all residents at the approved centre who were the subject of Part 4 of the rules on mechanical restraint to determine the appropriateness of the use of this restrictive practice. The review outlined the arrangements that were place at the approved centre to reduce or, where possible, eliminate the use of mechanical restraint as it related to Part 4 of the rules.

The registered proprietor notified the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others in the correct format and within the specified timeframes.

The approved centre was complaint with this rule.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

- The names of the medications proscribed.
- A confirmation of the assessment of the patient's ability to understand the nature, purpose, and likely effects of the medications.
- Details of the discussion with the patient, which included the nature and purpose of the medications and their effects, including risks and benefits.

- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre had a written policy on the reduction of physical restraint (Seclusion and Physical Restraint Reduction Policy). The policy was last reviewed in December 2022, and included all the policy requirements for this code of practice.

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

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

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

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

The orders for physical restraint lasted for a maximum of 10 minutes. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the CP within 24 hours.

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

Where it was the resident's wish in accordance with their individual care plan (ICP), their representative was informed of the restraint as soon as was practicable. Where the resident's representative was not informed, was there a record explaining why this did not occur in the clinical file. The Mental Health Commission was notified of the start and end time and date of each episode of physical restraint in the correct format and within three days of each episode.

Staff involved in the episodes of physical restraint had taken into account any relevant entries in the resident's ICP pertaining to that resident's specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy. The residents were continuously assessed throughout the uses of restraint to ensure their safety.

The physical restraint in each instance was ended by the person who had initiated the restraint. The time, date, and reason for ending the physical restraint was recorded in the clinical file on the date that each episode ended. The residents were given the opportunity, where appropriate, to discuss the physical restraint with members of the multi-disciplinary team involved in their care and treatment as part of a structured debrief process. This occurred within two working days of each episode of physical restraint, unless it was the preference of the resident who was restrained to have the debrief outside of this timeframe.

Appropriate emotional support was provided to the person following each episode of physical restraint. Support was also offered to any persons who may have witnessed the episodes of restraint.

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

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

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

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

The approved centre was complaint with this code of practice.

Admission of Children

NON-COMPLIANT

Risk Rating **MODERATE**

Please refer to the Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 and the Mental Health Commission Code of Practice Relating to Admission of Children under the Mental Act 2001 Addendum, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in January 2023. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures in place in relation to family liaison, parental consent, and confidentiality.
- Procedures for identifying the person responsible for notifying the Mental Health Commission of the child admission.

Training and Education: Staff had received training in relation to the care of children.

Evidence of Implementation: The inspection team reviewed the clinical files of two children who had been admitted to the approved centre since the last inspection. The approved centre was an adult facility, therefore age-appropriate facilities and a programme of activities appropriate to age and ability were not provided. However, the approved centre did provide one-to-one activities such as music, art, and fitness.

Provisions were in place to ensure the safety of the children, to respond to their needs as young people in an adult setting, and to ensure the right of the children to have their views heard.

Staff who had contact with the children had undergone Garda vetting. Copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Appropriate accommodation was designated, including age and gender- segregated sleeping and bathroom areas. Staff observation acknowledged gender sensitivity. Observation arrangements, including assignment of designated staff member, was provided as considered clinically appropriate.

The children had their rights explained and information about the ward and facilities provided in a form and language that they could understand. The clinical files recorded the children's understanding of the explanation given. Advice from the Child and Adolescent Mental Health Service was available, where necessary, to the approved centre. Appropriate visiting arrangements for families, including children, were available. The Mental Health Commission was notified of all children admitted to approved centre within 72 hours using the appropriate notification form. Consent for treatment was obtained from one or both parents.

The approved centre was non-compliant with this code of practice because two children were admitted to an adult facility, age-appropriate facilities were not provided, 2.5(b).

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy was last reviewed in May 2023. It contained protocols that were developed in line with best international practice, including

- Item 1. How and where the initial and subsequent doses of Dantrolene are stored.
- Management of cardiac arrest.
- Management of anaphylaxis.
- Management of malignant hyperthermia.

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

Evidence of Implementation: ECT was conducted in the theatres of St. Luke's Hospital. A named consultant psychiatrist (CP) 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 voluntary resident who had received ECT was examined. The CP assessed the resident's capacity to consent to receiving treatment, and this was documented in the resident's clinical file. The resident was deemed able to consent to receiving ECT. Capacity to consent ensured that the resident could understand the nature of ECT (including risks, benefits, and alternatives), understand why ECT was proposed, and the broad consequences of not receiving ECT, and make a free choice to receive or refuse ECT. Consent was obtained in writing for each ECT treatment session, including anaesthesia. All consent was obtained by the CP, or registered medical practitioner (RMP) under supervision of the CP, prior to each ECT treatment session and recorded in the clinical file.

A programme of ECT was prescribed by the responsible CP 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 resident and next of kin, and a current mental state examination. Cognitive assessments, in line with best international practice, were completed and recorded before and after each ECT session.

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. 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 placed in the clinical file. All post-ECT assessments, including clinical status and patient progress, were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT were recorded.

The approved centre was complaint with this code of practice.

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

Transfer: The transfer policy, which was last reviewed in August 2022, included all of the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in June 2021, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

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

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

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

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

The approved centre was complaint with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 21: Privacy					
Reason ID : 10005206		The registered proprietor did not ensure that the resident's privacy and dignity was appropriately respected at all times. Two camera's used for security measures had an active record function. Whilst these cameras were not used for a monitoring purpose, they overlooked aspects of the high dependency unit garden which residents had access too.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The camera's have been de-commissioned.	Walk through review	Achievable + realistic	02/04/2024	Technical Services
Preventative Action	The camera's have been de-commissioned.	Walk through review.	Achievable + realistic	02/04/2024	Technical Services

Regulation 22: Premises					
Reason ID : 10005205		**The registered proprietor did not ensure that the condition of the physical structure and overall approved centre environment was developed and maintained with due regard to the safety and well-being of residents, as ligature points were not minimised to the lowest practicable level, based on risk assessment, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A fully costed, funded and time bound programme of ligature reduction works is in place which will minimise to the lowest level all remaining ligature points. Works will be completed by Q4. 2024.	Audit of ligature points	Achievable and realistic	31/12/2024	Project Management Group. Technical Services.
Preventative Action	A fully costed, funded and time bound programme of ligature reduction works is in place which will minimise to the lowest level all remaining ligature points. Works will be completed by Q4. 2024	Audit of ligature points	Achievable and realistic	31/12/2024	Project Management Group Technical Service.

Regulation 32: Risk Management Procedures					
Reason ID : 10005207		**The registered proprietor did not ensure that the approved centre's comprehensive written risk management policy was implemented throughout the approved centre, as not all structural risks (including ligature anchor points) were identified, risk procedures did not reduce risk to the lowest practicable level in all cases, and in one instance the reporting of an incident was not located at the time of inspection, 32 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The unit's Risk Management Policy is fully implemented throughout the approved centre. The unit's fixed ligature audit is updated to capture all ligature anchor points.. A fully costed, funded and time bound programme of ligature reduction works is in place with works to be completed by Q4. 2024. A copy of all clinical incident forms are stored on the unit.	Audit	Achievable + realistic	31/12/2024	Ward Management. Technical Services Head of Service
Preventative Action	The unit's Risk Management Policy is fully implemented in the approved centre. The unit's fixed ligature audit	Audit	Achievable + realistic	31/12/2024	Ward Management Technical Services Head of Service

	is updated to capture all ligature anchor points. A fully costed, funded and time bound programme of ligature reduction works is in place with works to be completed by Q4. 2024. A copy of all clinical incident forms are stored on the unit.				

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10005204		Two children were admitted to an adult facility, age-appropriate facilities were not provided, 2.5(b).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	The service will continue to endeavour to source age appropriate facilities for each child who requires inpatient treatment.	Case review	Barriers to implementation include timely access to CAMHs inpatient beds. This remains a national issue.	02/04/2024	Treating consultant National Office for CAMHs
Preventative Action	The service will endeavour to source age appropriate inpatient facilities for each child who require inpatient traetment	Case review	Barriers to implementation include timely access to CAMHs inpatient beds.	02/04/2024	Treating consultant National Office for CAMHs

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.

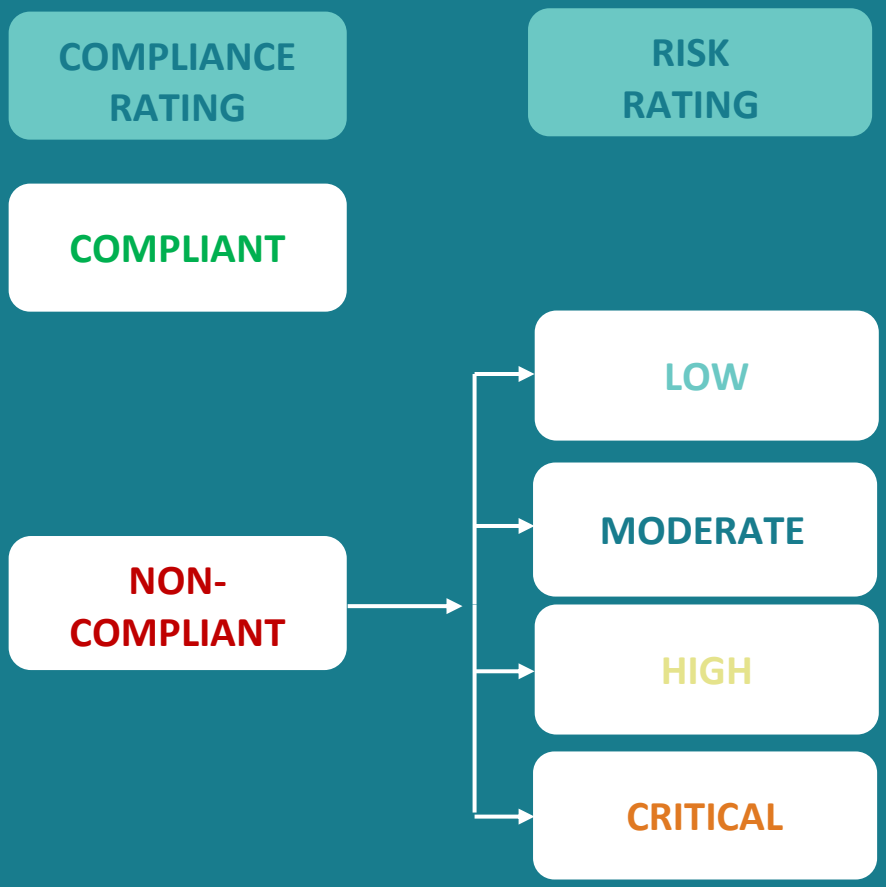
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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