Sliabh Mis Mental Health Admission Unit, University Hospital Kerry

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Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

SLIABH MIS MENTAL HEALTH ADMISSION UNIT, UNIVERSITY HOSPITAL KERRY

Sliabh Mis Mental Health Admission Ward
University Hospital Kerry, Rathass, Tralee, Co Kerry

Date of Publication: 24th May 2024

ID Number: AC0161

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Conditions Attached:
None

Most Recent Registration Date:
4 April 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms Angela O'Neill, Acting Registered Proprietor, Mental Health Services

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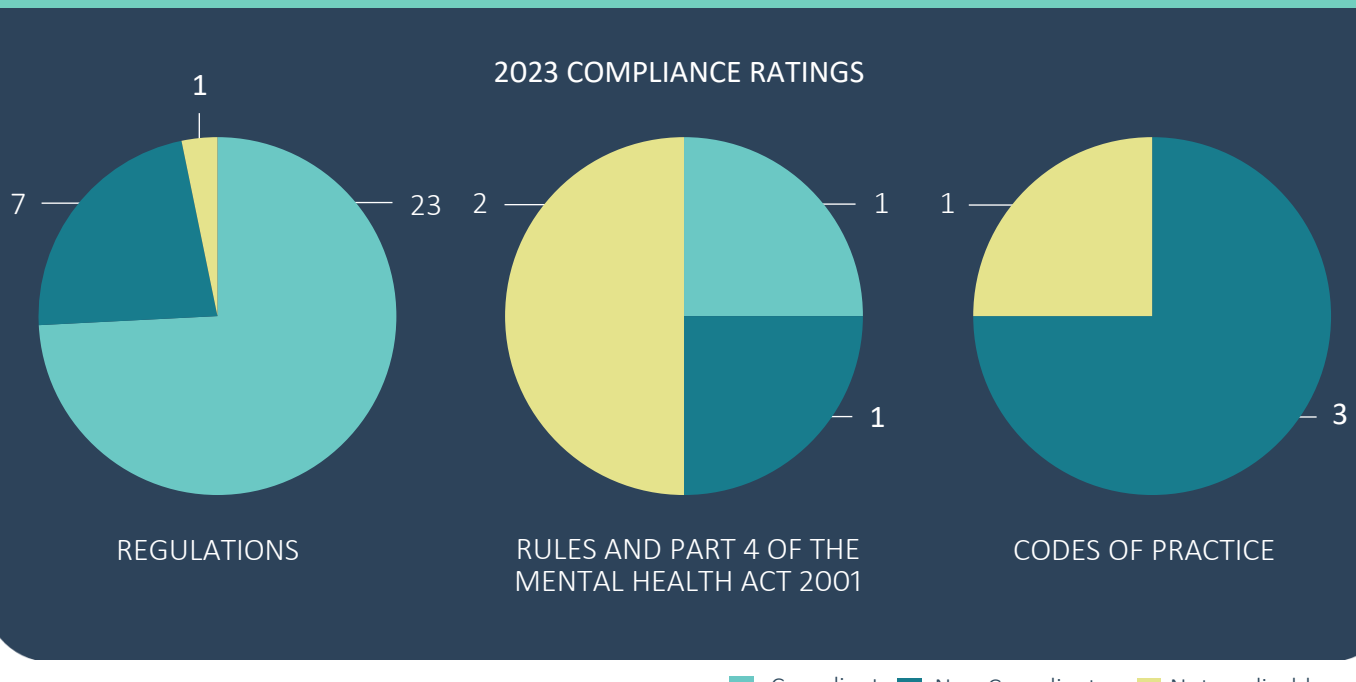
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
21 – 24 November 2023

Previous Inspection date:
18 – 21 October 2022

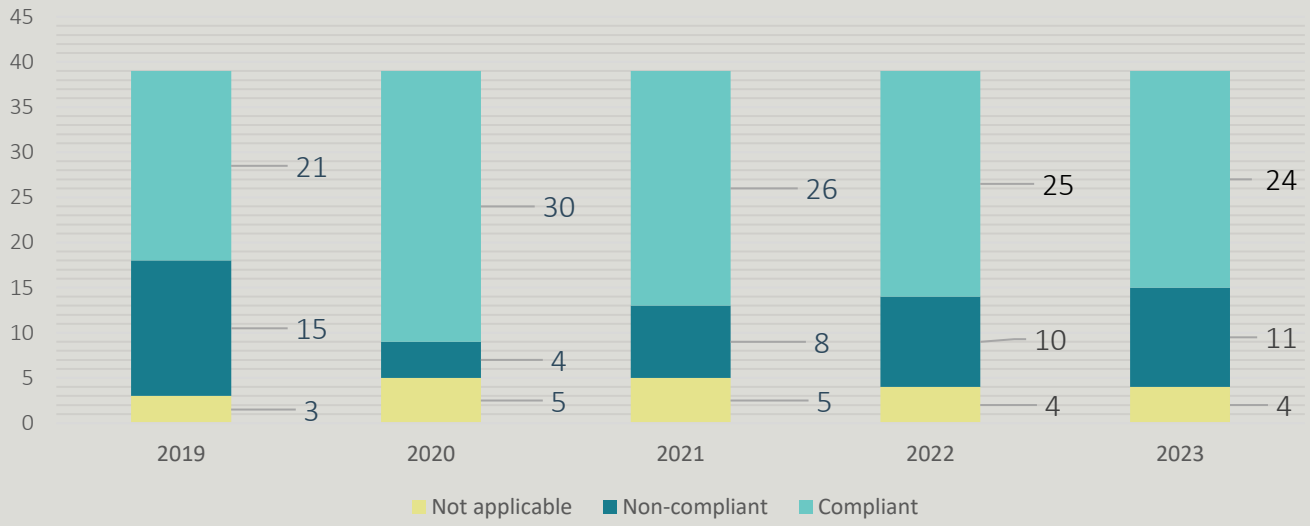
Inspection Type:
Announced Annual Inspection



RATINGS SUMMARY 2019 – 2023

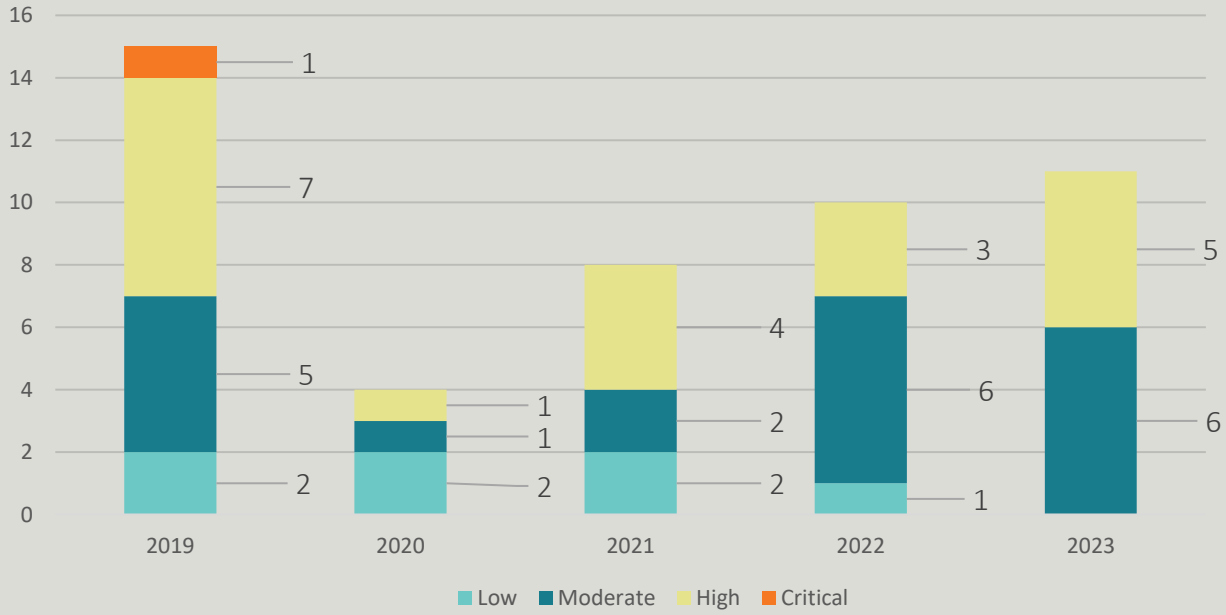
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

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

Sliabh Mis was an acute admission unit for adult mental health located on the ground floor of University Hospital Kerry in Tralee. The approved centre consisted of three distinct wards and was registered to accommodate 34 residents in total. Reask was 15-bed acute admissions ward. Valentia was a 15-bed step down sub-acute ward. Brandon was a four-bed high observation ward.

There were eight community teams which included four general adult teams and four specialist teams who had admitting rights to the approved centre from across the county of Kerry. The four general adult teams were assigned to the geographical areas of South Kerry, North Kerry/Castleisland, Tralee/Dingle, and Killarney. The four specialist teams provided a service for specified population cohorts and included the Psychiatry of Later Life team, the Rehabilitation and Recovery team, the Liaison Psychiatry team (liaised with University Hospital Kerry) and the Mental Health Intellectual Disability team. The admitting community teams attended the approved centre for multi-disciplinary team meetings, and during discharge planning if required.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	58%	88%	76%	71%	69%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***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.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***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.
- ***Medication safety:*** While the ordering, prescription and administration of medication was carried out in a safe manner, the approved centre had no operational policies relating to the storage of non-stock items prescribed to residents on a named basis.
- ***Mandatory training:*** Not all staff were trained in fire safety, basic life support, management of violence and aggression or the Mental Health Act.
- ***Access to essential information*****:** Clinical files were not in good order, making it difficult to find essential information on residents. The majority of files in use were temporary files that had not been amalgamated into the clinical file. Two clinical files had loose pages. The consultant psychiatrist lead's name was wrong on the majority of clinical files.

Appropriate care and treatment of residents

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

- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. Residents who were in the approved centre for more than six months had a physical examination. 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 has access to a multi-disciplinary team (MDT) consisting of psychiatry, nursing, occupational therapy, psychology, and social work staff. There were regular multi-disciplinary team meetings to discuss residents' care plans.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line residents' individual care plan. Residents had access to specialist services such as physiotherapy and speech and language therapy via referral pathways.

However:

- ***Appropriateness of environment:*** The structural and decorative condition of Sliabh Mis was not of acceptable standard. Some bedroom curtains were not fit for purpose, were detached from curtain rail and stained. There were rusted radiators in en suite bathrooms.
- ***Physical assessment:*** The six-monthly medical examinations did not monitor all the resident's clinical needs. One file examined did not record the resident's waist circumference, smoking and nutritional status or dental health.
- ***Admission, Transfer and Discharge:*** Not all staff had signed the policy on admission, transfer and discharge to indicate that they had read and understood it.
- ***Admission of Children:*** Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions.

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:*** Much of the sleeping accommodation was in dormitory-style en suite bedrooms of up to four beds; there were also en suite single bedrooms.
- ***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:*** All bathrooms, showers, and toilets had locks on the inside of the door, and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Privacy and dignity:*** Residents could not operate the opaque observation panels in the bedroom doors.
- ***Use of restrictive practices:*** The approved centre was not compliant with the rules governing the use of seclusion or with the code of practice on physical restraint. Risk assessment, monitoring, medical

examination, the provision of information, debriefing and reporting on the use of the restrictive practices were all areas found to be non-compliant during the inspection.

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 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. A chapel was available to residents in the approved centre, and a list of contact numbers for different religious leaders and providers in the area was kept.
- ***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***: A range of activities were available to residents, including books, newspapers, television, radio, CDs and DVDs, board games, knitting, gardening, exercise equipment, walking and arts groups.
- ***Residents' feedback:*** The residents were complimentary about the environment and the care they received. Most residents who completed the inspection questionnaire 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. Feedback was very complimentary toward the nursing, kitchen and cleaning staff. One resident compared the kitchen staff to a five-star hotel.

However:

- ***Environment***: Communal areas were not adequately sized. The dining room used by Valentia and Reask wards was unable to fit residents at full capacity.

Governance, Leadership and Accountability

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

- ***Structure in Place***: Sliabh Mis was part of Cork/Kerry Community Healthcare, formerly known as Community Healthcare Organisation (CHO) 4. The approved centre was governed by Cork/Kerry Mental Health Services.

- ***Leadership***: The Cork/Kerry Mental Health Services Governance Team meeting convened monthly and was chaired by the head of service. The Kerry Mental Health Services Management Team, which also met monthly, reported to the Cork/Kerry Governance Team. A Cork/Kerry Quality and Patient Safety (QPS) meeting, and a Kerry QPS meeting which reported to the Cork/Kerry QPS meeting, each occurred quarterly. A Unit Management Team (UMT) meeting was held every six weeks.
- ***Clinical governance:*** Clinical governance structures and lines of accountability and responsibility were clearly identified in the approved centre. There were aspects of good clinical governance: residents were assessed on admission and each resident had an individual care plan. Recreational services and therapeutic services and programmes provided met the needs of the residents. The multi-disciplinary teams operated well within the approved centre and the therapeutic services programme met the needs of residents.
- ***Restrictive practices reduction:*** The approved centre had written policies on the reduction of restrictive practices. A named senior manager was responsible for the approved centre's reduction in restrictive practices.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement.
- ***Complaints:*** There was a complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement. Residents were involved with the care planning process and knew staff by name. They reported that they could contact staff at any time.
- ***Advocacy services:*** A peer advocacy service was in place in the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last four years of 76%. The compliance rate has been trending downward over those four years, but from the previous year's inspection to this year's inspection there was a decrease of only 2%. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Staff training:*** Not all staff had received mandatory training.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. However, the Mental Health Commission had not been notified of all incidents that had occurred in the approved centre. The six-monthly summary report had not been submitted to the Mental Health Commission. The risk management policy was not implemented in relation to the clinical risk of transferring and amalgamating clinical files between the approved centre and other services.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. The nursing disciplines introduced a safety plan and a wellness plan toolkit as part of the admission package for residents. These worksheets were self-assessment tools which supported residents to identify their preferred activities, their abilities, triggers and supports required.

2. In conjunction with the National Council for the Blind and Working for People with Sight Loss, tactile visual supports were introduced: rubber dots were placed on light switches, tables, doors and other furnishings to aid residents who were visually impaired.

3. A mindfulness art project was completed collaboratively by student nurses and residents.

4. An information station was introduced for residents which contained information leaflets and booklets on medication, wellbeing, medication, grief, sleep hygiene and other topics.

5. The clinical nurse specialist of psychiatry of later life and the clinical nurse manager of the approved centre developed a life-story workbook which aimed to provide recovery-focused reminiscences and life-review interventions for residents affected by dementia.

6. A family support information pack for relatives was introduced. The pack included a Family, Carer and Supporter guide, a Sliabh Mis information booklet, an Occupational Therapy programme booklet, a Mental Health and Family Caring booklet and information leaflets on individual care plans and recovery. The aim of the information pack was to provide relatives with information and reassurance about their relative's care.

7. Two members of the Sliabh Mis nursing team completed a Train the Trainer course in basic life support.

8. Safety Pause was introduced, which aimed to enhance staff communication, prioritise resident safety and experience and embed quality improvement in daily practice. Safety awareness helped all teams to be more proactive about the challenges they faced providing safe, high-quality care for residents. Safety pauses were held throughout the day amongst the multi-disciplinary team members for up to five minutes. These meetings supported focus on necessary safety knowledge.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Sliabh Mis was located on the ground floor of University Hospital Kerry in Tralee. The approved centre was bright, very clean and well maintained. The approved centre consisted of three distinct wards, with accommodation for thirty-four residents in total. Reask was fifteen-bed acute admissions ward. Valentia was a fifteen-bed step down sub-acute ward. Brandon was a four-bed high observation ward.

The accommodation on both Reask and Valentia wards consisted of three four-bed en suite bedrooms and three single en suite bedrooms. Brandon ward had four single en suite bedrooms. The bedrooms were decorated with residents' personal effects and furnished to the resident's needs. Reask and Valentia wards had access to a shared corridor, which contained a dining room, two sitting rooms, a quiet room, and a family room. Residents also had access to an exercise room, which contained an exercise bike and a cross-trainer. Brandon ward had a separate open plan dining area and sitting room. Brandon ward also included a relaxation room, a seclusion suite, and a smoking area.

The therapy corridor of the approved centre consisted of a group room, activity room, and an occupational therapy kitchen. The approved centre had two well maintained enclosed courtyards- one for the Reask and Valentia ward residents and one for the residents in Brandon ward.

Sliabh Mis was registered with the Mental Health Commission for acute adult mental health care. At the time of inspection, there were eight community teams which included four general adult teams and four specialist teams who had admitting rights to the approved centre from across the county of Kerry. The four general adult teams were assigned to the geographical areas of South Kerry, North Kerry/Castleisland, Tralee/Dingle and Killarney. The four specialist teams provided a service for specified population cohorts and included a Psychiatry of Later Life team, a Rehabilitation and Recovery team, a Liaison Psychiatry team (liaised with University Hospital Kerry), and a Mental Health Intellectual Disability team.

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

Resident Profile	
Number of registered beds	***34***
Total number of residents	**30**
Number of detained patients	4
Number of wards of court	0
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

Sliabh Mis was part of Cork/Kerry Community Healthcare. The approved centre was governed at regional level by Cork/Kerry Mental Health Services. The executive governance forum was the Cork/Kerry Mental Health Services Governance Team meeting which convened monthly and was chaired by the head of service. It was attended by the executive clinical director, area director of nursing, general managers, and senior management representatives from health and social care professions. Key agenda items included quality and patient safety, strategic planning, human resources, service planning, policies and procedures, and regulatory compliance. The Kerry Mental Health Services Management Team meeting was held monthly and reported to the Cork/Kerry Governance Team. The meeting minutes evidenced discussions on topics such as risk management, complaints, finance, service and operational planning, staff training, GDPR, human resources, and regulatory compliance.

There was a Cork/Kerry Quality and Patient Safety (QPS) meeting which occurred quarterly. The Kerry QPS group also convened quarterly and reported to the Cork/Kerry QPS meeting. Key agenda items for these forums included patient safety, clinical effectiveness, complaints management, clinical audits, risk register, incidents review, clinical and patient safety related risks, quality improvement, safeguarding and staff training. A Unit Management Team (UMT) meeting was held every six weeks. The UMT was a multi-disciplinary team forum to discuss local operational issues such as risk management, patient safety issues, regulatory compliance, health and safety, and compliments/complaints. The approved centre had function specific sub-groups reporting to the UMT including Regulatory Compliance committee; the Policy, Procedure, Protocols and Guidelines Group; the Discharge committee; the Health and Safety committee; the Drugs and Therapeutic committee, and the Restrictive Practices Reduction committee. At the time of inspection, the head of services was acting as interim registered proprietor, because the general manager post was vacant. A person had been appointed to the general manager role and was due to commence in the role soon after the inspection.

All clinical staff had received training on clinical risk management procedures appropriate to their role and function. Key personnel were responsible for risk management in the approved centre. The person with overall responsibility for risk was identified and known by staff. Responsibilities regarding risk were allocated at management level and throughout the approved centre with support from the QPS Advisor. The approved centre maintained a risk register and members of the local management team reviewed, monitored, and updated the risk register monthly. Risks identified in Sliabh Mis included the maintenance of records. The risk of poorly maintained files was rated as high due to a lack of a dedicated ward clerk. There were risk management procedures and control measures in place, but clinical risks were not adequately treated and managed. At the time of inspection, there were no processes in place and no person responsible for the transfer of clinical files from community bases to the approved centre when a person was admitted. Also, there was no person responsible for the amalgamation of the temporary clinical files set up on admission and the actual clinical files when they were received from community bases. Significant clinical and risk-related information was not available to the treating teams when two files (one temporary and one actual) existed for any one resident at the same time.

The approved centre had a standardised process for the management of risks and incidents. Incidents were recorded and risk rated on the National Incident Management System and were reviewed at local

management meetings. When required they were escalated and reviewed at the Cork/Kerry Management Team meetings. All incidents were gathered in quarterly incident analyses to identify any trends or patterns that occurred in the service. Analysis of incidents took place at the QPS meeting and feedback was given to staff of Sliabh Mis through the relevant line managers. A Serious Incident Management Team convened if a serious incident occurred in the approved centre.

An organisational chart clearly identified the lines of responsibility and accountability within the approved centre. Governance questionnaires were completed by each head of discipline and returned to the inspection team. Respondents provided a clear overview of the clinical governance structures within their respective disciplines, issues of risk or specific concerns, and outlined strategic goals for the service and systems to monitor goal progression. Recruitment and retention of staff was identified as a risk across all disciplines. Other risks identified included the lack of an Electroconvulsive Therapy (ECT) service in the Cork/Kerry region, discharge delays, the lack of a ward clerk, and the lack of senior posts across all health and social care professionals in the approved centre.

At the time of inspection, the approved centre had appropriately qualified staff on duty and in charge at all times. The numbers and skill mix of staffing were sufficient to meet residents' needs. The eight admitting mental health teams consisted of medical, occupational therapy, psychology, and social work disciplines. occupational therapy, social work, and nursing staff were based in the approved centre. Psychology and medical staff were based in the community and provided an in-reach service to residents in the approved centre. A psychology post for the approved centre had been developed and a candidate was undergoing final recruitment procedures at the time of the inspection. There was a vacant consultant psychiatrist post at the time of the inspection. A candidate for the post had also been recruited and was due to start in mid-January 2024. Once candidates had commenced their roles the service plan was that all in-patient residents would come under the care of the in-patient consultant psychiatry team for the duration of their hospital stay. Their care and treatment would revert to their community team on discharge. That would replace the in-reach by community-based teams model in operation at the time of the inspection. A Clinical Nurse Specialist in recreational and therapeutic activities had started working in the approved centre two weeks prior to the inspection.

Not all staff were up to date in mandatory training. The mandatory training progress record provided by the approved centre indicated that not all staff were trained in basic life support, fire safety, management of violence and aggression, and the Mental Health Act 2001. There was a plan and schedule in place to address the deficits in training.

Adequate and appropriate supervision structures were in place within each department through the line management system. Clinical supervision was available to all staff. The Health Service Executive (HSE) performance management policy and processes were implemented by all disciplines. A training needs analysis had been conducted for all clinical staff, incorporating HSE and Mental Health Commission (MHC) mandatory training and non-mandated training. The approved centre had an annual staff training schedule designed to provide the training identified by the training needs analysis.

Resident involvement and engagement in service delivery was facilitated by suggestion boxes in the approved centre along with a complaints process to support service improvement. The process of making

complaints and the complaints officer's contact details were displayed within the approved centre and were accessible to residents and their representatives in information booklets. Minor complaints that had been dealt with by the first point of contact were documented. All formal complaints were reviewed and dealt with by the nominated complaints officer and were documented with clear actions and outcomes detailed in the complaints log. Residents were involved in the development and review of their individual care plans. Resident community meetings were held once every three weeks in the approved centre, and this provided an opportunity for residents to raise concerns or make suggestions. A review of the meeting minutes indicated that activity planning and requests from residents were discussed. An advocate from the Peer Advocacy in Mental Health Service visited the approved centre once each week. The advocates contact details were displayed in the approved centre. A peer support worker visited the approved centre once each week and co-facilitated a recovery group for the residents.

On 28 September 2022, the Mental Health Commission published revised Rules Governing the use of Seclusion and a revised Code of Practice relating to the use of Physical Restraint in approved centres. The date of commencement for the rules and the code of practice was 1st of January 2023. The approved centre had used physical restraint and seclusion during 2023 and had integrated the revised code of practice and rules. The policy on physical restraint and the policy on the use of seclusion had been updated and were implemented. The oversight committee in place met bimonthly; it reviewed the restrictive practice data and completed audits and meeting minutes. However, it did not complete a report following each meeting. The Clinical Nurse Manager 3 was the named senior manager with responsibility for the approved centre's reduction in restrictive practices.

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 19: General Health	✓		✓		✓		✗	Moderate	✗	Moderate
Regulation 21: Privacy	✗	Critical	✓		✗	Low	✓		✗	High
Regulation 22: Premises	✗	High	✓		✗	High	✗	Moderate	✗	Moderate
Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines	✗	High	✓		✓		✗	Low	✗	Moderate
Regulation 26: Staffing	✗	High	✗	Moderate	✗	High	✗	Moderate	✗	High
Regulation 27: Maintenance of Records	✗	Moderate	✓		✓		✓		✗	High
Regulation 32: Risk Management Procedures	✗	High	✓		✗	Moderate	✓		✗	High
Rules on the Use of Seclusion	✗	Moderate	✓		✓		✗	High	✗	High
Code of Practice on the Use of Physical Restraint	✗	High	✓		✗	Low	✗	High	✗	Moderate
Code of Practice on the Admission of Children	✗	High	✗	High	✗	High	✗	Moderate	✗	Moderate
Code of Practice on Admission, Transfer and Discharge	✗	Moderate	✗	Low	✓		✓		✗	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 the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Residents were given the opportunity to speak with the inspection team and to complete feedback questionnaires. Seven completed resident questionnaires were returned to the inspection team.

Six residents indicated that they knew who their multi-disciplinary team members were; one indicated that they did not know. Seven residents indicated that they were 'always' involved in setting their goals for the individual care plans and that they understood their care plan. Four residents indicated that staff 'always' gave them information about their diagnosis, care, and treatment in a way they understood; two answered 'sometimes' and one was unanswered.

Seven completed questionnaires indicated that residents were happy with how staff talked to them.
Five residents knew who their keyworker was, one resident did not know, and one left the question unanswered. All residents indicated that they 'always' felt safe in the approved centre. Seven residents indicated they could 'always' discuss worries and concerns.

Six residents indicated that a staff member explained what was happening in a way they understood; one answered 'no'. Seven residents indicated that they could communicate freely with family, friends or an advocate. Five residents indicated there were enough activities during the day; two answered that there were not.

On a scale of one to ten, with one being poor and ten being excellent, four residents rated the approved centre '10', two rated '9' and one rated '8' for their care and treatment in the approved centre.

In the ‘any comments’ section, one resident answered, “I am very happy and so are my family with my care”. Other residents commented, “It is a good mental health unit”, “I’m happy here”, “all is good” and “the Brandon smoking area needs a canopy to protect us from the rain”.

5.2 Advocacy

The approved centre had an advocacy service.

The inspectors received a report from the Peer Advocacy in Mental Health Representative. Residents reported the nursing staff were great, willing to listen and help. Residents reported the kitchen staff treated everyone like it was a five-star hotel and the cleaning staff were very nice and great at their job. Residents reported the garden was a wonderful facility, it was well-kept and there were covered areas to sit. Residents reported the smoking area was great. Residents reported that the Clinical Nurse Manager 3 had done a great job since taking up the position.

Residents identified some areas in need of improvement. They wanted more activities on weekends, especially bank holiday weekends. Residents reported they would like to see more holistic therapeutic approaches such as talk therapies and one-to-one counselling.

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:

- Head of Services
- Executive Clinical Director
- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Nurse Manager II
- Senior Clinical Psychologist
- Principal Social Worker
- Occupational Therapist Manager
- Area Administrator

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers appropriate to the resident group profile and individual residents' needs. Two appropriate resident identifiers were used when administering medication, undertaking medical investigations, and providing other healthcare services.

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate to the resident and took into account their preferences, dignity, bodily integrity, religious and cultural practices.

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

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Residents' 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 and valuables, 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, except where this posed a danger to themselves, or others as indicated in their ICP.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile on weekdays and during the weekend. Activities included books, newspapers, television, radio, CDs and DVDs, board games, knitting, mindfulness colouring, gardening, an ice-hockey table, Netflix, indoor and outdoor exercise equipment, walking and arts groups.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable.

A chapel was available to residents on the grounds of the approved centre. The approved centre kept a list of contact numbers for different religious leaders and providers in the area.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits. The policy was last reviewed in August 2023.

Visiting times were appropriate and reasonable. Visiting times were displayed in the approved centre and visits were pre-booked by contacting the respective wards. Visits outside of the visiting hours were facilitated if required. A private visitors room was available to residents, 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 family room was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication. The policy was last reviewed in August 2023.

Residents had access to personal mobile phones, electronic tablets, Wi-Fi, and ward phones, unless otherwise risk-assessed with due regard to the resident's well-being, safety and health.

The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The clinical files of three residents who were searched were inspected. Residents' consent was sought and documented prior to the search taking place. Risk had been assessed prior to the search of the residents. The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out in the policy. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

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

Every search of a resident and of property was recorded, and this written record was available for inspection. Where illicit substances were found, they were handled in accordance with policy requirements.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying. The policy was last reviewed in July 2023.

The sudden death of a resident was managed in accordance with the resident's religious and cultural practices, with dignity and propriety, and in a way that accommodated the resident representatives, family, next of kin and friends.

The death of the resident was notified to the Mental Health Commission as soon as was practicable and no later than within 48 hours of the death.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

COMPLIANT

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

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

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents and included allocated space for goals, treatment, care, and resources required, as well as allocated space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes. The ICPs were developed by a multi-disciplinary team (MDT) following a comprehensive assessment 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 identified appropriate goals for the resident and the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing the care and treatment. The ICPs identified the resources required to provide the care and treatment identified and were reviewed by the MDT in consultation with the resident, weekly in the acute setting.

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate, met the assessed needs of the residents as documented in their individual care plans and were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

The weekly therapy programme was agreed with residents each Monday morning at a “Plan Ahead” meeting between therapy staff and residents. Therapeutic programmes included art therapy, a wellness recovery action planning group, an anxiety and stress management group, an exercise group, relaxation, a music group, and a recovery peer support group. One-to-one therapy sessions were provided to residents on an identified needs basis, or where the group setting was not appropriate.

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. Specialist services such as physiotherapy and speech and language therapy were available through referral.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had an operational policy and procedures in relation to transfers. The policy was last reviewed in August 2023.

The clinical file of one resident who had been transferred from the approved centre was inspected. Complete and full written information accompanied the resident upon transfer. The transfer documentation included a letter of referral listing current medications and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating MODERATE

(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 and procedures, which included emergency procedures. The policy was last reviewed in August 2023.

The approved centre had an emergency trolley and staff had access at all times to an Automated External Defibrillator. The approved centre had access to the emergency response team in University Hospital Kerry.

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 and personal history, blood pressure, medication review, and weight. However, waist circumference, smoking status, nutritional status and dental health were not recorded on the six-monthly health assessment of one resident. For residents on anti-psychotic medication, there was an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram heart function.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required. Residents could access national screening programmes that were available according to age and gender, including breast check, cervical screening, retina check for diabetics and bowel screening.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that all residents general health needs were assessed. One of three files examined did not have the resident's waist circumference, smoking and nutritional status, and dental health recorded, 19.1(b).

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

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

On admission, residents were provided with an admission pack which contained 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 had a separate information booklet for parents and carers.

The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, residents' rights, details of advocacy agencies 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 translator services as required.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

The general demeanour of the staff in the approved centre was supportive of the dignity and privacy of the residents. Staff were observed to be friendly, approachable, and respectful in communication with residents. Residents were called by their preferred names, staff appearance and dress were 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. The opaque observation panels in the bedroom doors could only be operated from the outside by use of a key that staff held; as a result, residents could not operate them internally to ensure their privacy and dignity if required.

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

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure resident's privacy and dignity was appropriately respected as residents could not operate the opaque observation panels in the bedroom doors to ensure privacy and dignity when required.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

Residents in the approved centre had access to appropriate personal space. Communal areas were appropriately sized, with the exception of the small dining room which was used by the residents of Valentia and Reask ward. There were thirty residents when both wards were at full capacity. Residents could access the sitting room on either side of the dining room to eat at mealtimes. Tables and chairs had been set up for this purpose.

There was suitable and sufficient heating in day areas and bedrooms, rooms were centrally heated both by underfloor heating and with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43°C. 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.

There were sufficient indoor and outdoor spaces provided for residents to move freely. Residents in Valentia and Reask wards had access to a large well-maintained garden. Residents in Brandon ward had access to a separate, secure outdoor space. Hazards were minimised in the approved centre. Ligature points were not minimised to the lowest practicable level, based on risk assessment.

The approved centre was not in a good state of repair internally or externally. On Reask ward there were rusted radiators in some of the en suite bathrooms. The curtains in some bedrooms throughout the

approved centre were not fit for purpose (did not keep out light), were detached from curtain rail and stained.

The approved centre was clean, hygienic, and free from offensive odours. There was a programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Relevant national infection control guidelines were followed.

The approved centre provided sufficient toilets and showers for residents, with at least one assisted toilet available within the unit. There was a designated cleaning room and sluice room, and the centre provided assistive devices and equipment to address resident needs. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

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

a) **The registered proprietor did not ensure the premises was maintained in good structural and decorative condition, because the curtains in some bedrooms throughout the approved centre were not fit for purpose (did not keep out light), were detached from curtain rail, and stained. There were rusted radiators in en suite bathrooms, 22(1)(a).**
b) **The registered proprietor did not ensure the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and wellbeing of residents as not all ligatures were minimised to the lowest practicable level based on risk assessment, 22(3).**
c) **The registered proprietor did not ensure the overall approved centre environment was developed with due regards to the specific needs of the residents. The dining room used by Valentia and Reask wards was unable to fit all residents at full capacity, 22(3).**

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

NON-COMPLIANT

Risk Rating MODERATE

(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 on the ordering, prescribing, storing and administration of medicines. The policy was last reviewed in September 2023. The policy included:

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

However, the policy had not included the process for storing medication of residents prescribed a non-stock item on a named basis. Pharmacy required the name of the resident prescribed some preparations e.g. inhalers. In turn the nurses on the ward wrote the name of the resident on the box before storing. This was to ensure that the item cannot be administered to another resident in error. This process and the preparations included was not documented.

A medication prescription and administration record (MPAR) was maintained for each resident, five of which were examined on inspection. The MPARs contained a record of any allergies or sensitivities to any medications including if the resident had no allergies, the administration route for the medication, a record of all medications administered to the resident, and a clear record of the date of discontinuation for each medication. The MPARs also contained the medical council registration number (MCRN) of every medical practitioner prescribing medication to the resident and the signature of the medical practitioner for each entry.

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

Medication was stored in the appropriate environment as indicated on the label or packaging or as advised by the pharmacist and, where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, apart from medication that was recommended to be stored elsewhere.

The registered proprietor did not ensure that the approved centre had written operational policies relating to the storing of medicines to residents prescribed a non-stock item on a named basis, 23(1).

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had written operational policies and procedures relating to the health and safety of residents, staff, and visitors. The health and safety policy was last reviewed in August 2023.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and 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 July 2023.

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

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

INSPECTION FINDINGS

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

The approved centre had eight multi-disciplinary teams. This included psychiatry, nursing, occupational therapy, psychology, and social work staff. The approved centre also had a clinical pharmacy service. Residents had access to specialist services such as physiotherapy and speech and language therapy via referral pathways.

Not all healthcare staff had received up-to-date mandatory training in basic life support, fire safety, or the management of violence and aggression. Not all healthcare staff had received mandatory training in the Mental Health Act 2001.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The following table gives a breakdown of the numbers and percentages of staff trained in each of the mandatory subjects:

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (42)	26	62%	31	74%	42	100%	42	100%

Consultant Psychiatrist (11)	5	45%	7	64%	9	82%	10	91%
Medical (16)	7	44%	3	19%	4	25%	6	38%
Occupational Therapist (1)	1	100%	1	100%	1	100%	1	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%
Psychologist (1)	1	100%	1	100%	1	100%	1	100%

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure all staff were trained to enable them to provide care and treatment in accordance with best contemporary practice as all staff were not trained in Fire Safety, Basic Life Support, Management of Violence and Aggression and the Mental Health Act 2001, 26(4).

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to the creation of, access to, retention of and destruction of records. The policy was last reviewed in July 2023. The policy covered the following provisions:

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

Resident records were secure, up to date and physically stored together in a secure office; however, they were not in good order. When a resident was admitted to the approved centre from community services, a temporary clinical file was created, and the community clinical file requested. The centre's policy was to amalgamate both files, but the majority of files used in the approved centre were temporary files dating back to the admission of the residents. Files had not been received from the community or had not been amalgamated due to the lack of a ward clerk. As a result, resident records had not been maintained so as to ensure completeness, accuracy and ease of retrieval.

The approved centre had no defined process in place nor person responsible for bringing clinical files from or to the community on resident's admission or discharge. There was no process or person responsible for amalgamating temporary files with clinical files. Some temporary files in use were large in size. Two of the clinical files contained loose pages.

The identification stickers on the majority of resident clinical files contained incorrect information regarding the name of treating consultant psychiatrist. The person responsible for updating the names of consultants on the Patient Information Management System (PIMS) was not contactable.

Resident records were developed and maintained in a logical sequence. Records were appropriately secured throughout the approved centre from loss or destruction and tampering and unauthorised access or use. All resident records were reflective of the residents' current status and the care and treatment being provided.

Documentation of inspections relating to food safety, health and safety and fire inspections were maintained in the approved centre.

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

a) **The registered proprietor did not ensure records were maintained in a manner so as to ensure accuracy because the name of the consultant psychiatrist clinical lead was wrong on the majority of clinical files, 27(1).**
b) **The registered proprietor did not ensure that records were maintained in good order, as two clinical files had loose pages, 27(1).**
c) **The registered proprietor did not ensure records were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval because the majority of the files in use were temporary files, 27(1).**

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 the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

All policies and procedures requiring a three yearly review had been reviewed and updated as required.

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. Staff attended Mental Health Tribunals and provided assistance as necessary when the patient required assistance to attend or participate in the process.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a comprehensive written operational policy and procedures in relation to risk management. The policy was last reviewed in October 2023. The risk management policy and associated safety statement addressed all policy requirements, including:

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

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.

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Clinical risks were not properly assessed, treated, and monitored, as there was no process in place or no person responsible for the transfer of clinical files between inpatient and community services. No person was identified as responsible for amalgamating clinical files and the temporary files received in the

approved centre. Without all the relevant clinical information accessible to clinicians in the approved centre, there was a risk of sub-optimal care and treatment being provided.

Corporate risks were identified, assessed, treated, reported, monitored, and documented in the risk register as appropriate. Health and safety risks were identified, assessed, treated, reported, monitored, and documented within the risk register as appropriate. Structural risks, including ligature points, were removed, or effectively mitigated.

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

Incidents were recorded and risk rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting. A record was maintained of this review and recommended actions. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre had not submitted a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. The incident summary report for the period of January–June 2023 had not been submitted. An emergency plan 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 for the following reasons:

a) **The registered proprietor did not ensure the risk management policy was implemented throughout the approved centre in relation to clinical risk, as there was no process in place or person responsible for the transfer of clinical files between the inpatient and community services, 32(1).**
b) **The registered proprietor did not ensure the risk management policy was implemented throughout the approved centre as there was no process in place or person responsible for the amalgamation of the temporary and clinical files once received by the approved centre, 32(1).**
c) **The registered proprietor did not ensure the approved centre notified the Mental Health Commission of incidents occurring in the approved centre. From January to July 2023, the six-monthly summary report had not been submitted to the Mental Health Commission, 32(3).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

The approved centre's insurance certificate and indemnity scheme statement was available to the inspection team. It confirmed that the approved centre was covered for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration which was displayed prominently on the wall at the centre hub area of the approved centre. No changes had arisen in relation to the information detailed in the certificate of registration.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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 December 2022. The policy addressed the following:

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

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

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

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

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

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

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

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

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

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

A medical examination of the resident by a RMP was carried out no later than two hours after the commencement of the 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. The RMP recorded this consultation in the clinical files and indicated on the seclusion register the consultant psychiatrist's (CP) order regarding the continued use of seclusion. Where the CP ordered the continued use of seclusion, they advised the duration of each order. This information was recorded by the RMP on the seclusion register. Seclusion orders were not made for any period of time longer than four hours from the commencement of each seclusion episode. The orders of the CP confirmed that there were no other less restrictive ways available to manage the residents' presentation. The CP undertook a medical examination of the person and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The resident was informed of the reasons for, the likely duration of, and circumstances which lead to the discontinuation of seclusion and a record was recorded in the resident's clinical file.

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

Monitoring and review: 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 resident under continuous observation and remained within sight and sound of the seclusion room throughout the episode. A written record of the resident made by the registered nurse every 15 minutes was always completed. In one episode of seclusion, the written record of one resident did not include a record of the resident's level of stress, the resident's behaviour, the resident's level of awareness or the resident's physical health. Following risk assessment, a nursing review of the resident took place every two hours, and a medical examination was carried out by a RMP every four hours and the decision to end or continue seclusion was recorded. Upon commencement of seclusion, a seclusion care plan was developed in all three episodes.

Renewal of Seclusion Orders: The seclusion order was renewed by an order made by an RMP under the supervision of the Consultant Psychiatrist or the duty Consultant Psychiatrist following a medical examination.

Ending of seclusion: In two episodes of seclusion, a RMP or the most senior RN ended seclusion following discussion with the person in seclusion and relevant nursing staff or a RMP. In one episode a discussion with the person in seclusion did not occur.

In one episode of seclusion the resident was not informed of the ending of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date the seclusion was ended.

An in-person debrief followed each episode, except where the resident wished not to participate in a debrief. This debrief occurred within two working days of the episode and gave the residents the opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved with their care and treatment, including alternative de-escalation strategies to avoid future use of restrictive interventions. The residents were invited to have a representative or nominated person present at the debrief with them; if this person did not attend, reasons why were recorded in the clinical file. The residents ICP was updated following the debrief. In one episode, the resident's representative was not informed of the ending of the seclusion.

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.

Seclusion of a child: There was a requirement to conduct a risk assessment upon admission, to determine if seclusion could safely be used on a child. There was no evidence this assessment was completed. The reasons for, likely duration of and the circumstances which lead to the discontinuation of seclusion was explained in a way that a child could understand, and a record was maintained. The child's parent or guardian was informed of the seclusion and the circumstances which led to seclusion. However, they were not informed when the seclusion ended. Child protection policies and procedures were in line with relevant legislation and regulations were in place in the approved centre.

Clinical Governance: Seclusion was not used inappropriately, such as to manage staff shortages, punish a resident or protect property. Seclusion was not used in combination with mechanical restraint or as a substitute for less restrictive practices. One episode of seclusion was not reviewed by members of the MDT involved in the person's care and treatment within five working days after the episode of seclusion.

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

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

a) **In one episode of seclusion, the resident's level of distress, behaviour, level of awareness or physical health were not recorded by a registered nurse at least every 15 minutes, 5.3(i–iv).**
b) **In one episode of seclusion, it was not recorded that the resident was informed of the ending of the episode of seclusion, 7.3.**
c) **In one episode of seclusion, the resident's representative was not informed of the ending of the episode of seclusion as soon as was practicable, 7.10.**
d) **In one episode of seclusion, no documented risk assessment was carried out by a registered medical practitioner or registered nurse on admission to determine if seclusion could be safely used or not, 13.1.**
e) **The multi-disciplinary review and oversight committee did not produce a report following each meeting. Therefore, no report was made available to staff who participated in seclusion to promote on-going learning and awareness, 10.8(vi).**

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 one 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 for the patient who 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 who was unable to consent. It documented the following:

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

- Details of the discussion with the patient, including the nature and purpose of the medications and their effects, risks and benefits.
- Any supports provided to the patient in relation to the discussion and their decision-making.
- Approval by a consultant psychiatrist and an authorisation by a second consultant psychiatrist.

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating **MODERATE**

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated December 2022. It addressed the following:

- The provision of information to the person, which included information about the person's rights, presented in accessible language and format.
- Information regarding who can initiate and who may carry out physical restraint.
- Information regarding the safety, safeguarding and risk management arrangements that should be followed during any episode of physical restraint.

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

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

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

Training and Education: There was a written record to indicate that staff involved in the use of physical restraint had read and understood the policy. The record was available to the inspector. A record of attendance at training on the use of physical restraint was maintained.

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

Evidence of Implementation: Three episodes of physical restraint were reviewed on inspection.

Orders of Physical Restraint: Physical restraint was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy on physical restraint. The physical restraint order confirmed that there were no other less restrictive ways available to manage the person's presentation. The consultant psychiatrist (CP) or the duty consultant psychiatrist was notified as soon as was practicable and this was recorded in the clinical files. In one episode of physical restraint, the RMP did not complete a medical examination of the resident sooner than two hours after the episode of physical restraint. The orders for physical restraint lasted a maximum of 10 minutes.

The clinical practice form was signed by the CP within 24 hours. In one episode, the resident was not informed of reasons for, likely duration of and circumstances leading to discontinuation of physical restraint. In the other two episodes, the residents were informed except where the information was prejudicial to the residents' mental health, well-being, or emotional condition.

As soon as was practicable and in accordance with the resident's wish with their individual care plan (ICP), the resident's representative was informed of the physical restraint.

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

Dignity and Safety: Staff involved in the use of physical restraint took into account relevant entries in the resident's ICP pertaining to their specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times during the episode of physical restraint and all staff involved had undertaken appropriate training. In all three episodes of physical restraint the person's head and neck were supported where necessary and their airway and breathing were not compromised. Observations were conducted, including vital clinical indicators such as the monitoring of pulse, respiration and complexion, with special attention to pallor or discolouration. These observations were documented.

Ending of Physical Restraint: The person who led the physical restraint ended it. The time, date and reason for ending the physical restraint were recorded in the clinical file on the date that the physical restraint ended.

An in-person debrief with the resident who was restrained followed every episode of physical restraint. The debrief was person-centred, occurred within two working days and gave each resident the opportunity to discuss the physical restraint with members of the multi-disciplinary team (MDT) involved in the resident's care and treatment as part of a structured debrief process.

The debrief included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. The debrief included a discussion regarding the resident's preferences in the event where a restrictive intervention is needed in the future, such as preferences in relation to which restrictive intervention they would not like to be used. The debrief gave each resident the option of having their representative or their nominated support person attend the

debrief with them. The resident's ICP was updated to reflect the outcome of the debrief and, in particular, the resident's preferences in relation to restrictive interventions going forward. There was a record of all attendees who were present at the debrief and this was recorded in the clinical files.

Appropriate emotional support was provided to the resident following the episode of physical restraint. Each episode of physical restraint was recorded in the clinical file and clearly recorded on the Clinical Practice Form (CPF) in accordance with Provision 3.7. A copy of the CPF was kept in the clinical file and was available to the Mental Health Commission on request.

Clinical Governance: All episodes of physical restraint was reviewed by members of the MDT within five working days from the date of the restraint. The review included the identification of the trigger events which contributed to the restraint episode, any missed opportunities for earlier intervention, the identification of alternative de-escalation strategies to be used in the future, the duration of the restraint episode, consideration of the outcomes of the person-centred debrief and an assessment of the factors in the physical environment that may have contributed to the use of restraint. The MDT recorded actions decided upon and follow-up plans to eliminate or reduce restrictive interventions for the person.

A named senior manager was responsible for the approved centre's reduction of physical restraint.

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

a) **In one episode of physical restraint, a medical examination of the person by a registered medical practitioner did not take place no later than two hours after the start of the episode, 3.4.**
b) **In one episode of physical restraint the person was not informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint, 3.8.**
c) **The multi-disciplinary review and oversight committee did not produce a report following each meeting, 10.8(vi).**

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 September 2022. It addressed the following:

- A policy requiring each child to be individually risk-assessed.
- Policies and procedures 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 one clinical file in relation to the children admitted to the approved centre since the last inspection. The approved centre was an adult facility, and age-appropriate facilities and a programme of activities appropriate to age and ability were not provided.

Provisions were in place to ensure the safety of the children, that their views would be heard and to respond to the children's needs. Advice from the Child and Adolescent Mental Health Service was available, when necessary, to the approved centre in relation to child protection issues. Staff had received training in relation to the care of children, with staff in contact with the child having 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 and included segregation according to age and gender, sleeping arrangements and bathroom areas. The children received one-to-one care from a nurse, one-to-one therapeutic activities and each child was accommodated in a single bedroom.

Staff were gender sensitive. The children had their rights explained and information about the approved centre and facilities provided in a form and language that they could understand. The clinical files recorded each child's understanding of the explanation given. Appropriate visiting arrangements for families, including children, were available.

The Mental Health Commission was notified of all children admitted within 72 hours with the appropriate notification form.

The approved centre was non-compliant with this code of practice because age-appropriate facilities and a programme of activities appropriate to age and ability were not provided, 2.5(b).

Admission, Transfer and Discharge

NON-COMPLIANT
Risk Rating MODERATE

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

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to admission, transfer and discharge, which was last reviewed in September 2023 and included all of the policy-related criteria for this code.

Training and Education: Documentary evidence indicated that not all 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 resident had been admitted on the basis of a mental illness or mental disorder. 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, a risk assessment, work situation, dietary requirements and education. A key worker system was in place, and a full physical examination was carried out. 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 risks and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, their key worker and relevant members of the resident's multi-disciplinary team.

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

The discharge summary included details of 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.

The approved centre was non-compliant with this code of practice because not all staff had signed the policy on admission, transfer and discharge to indicate they had read and understood it, 9.1.

Appendix 1: Corrective and Preventative Action Plan

Regulation 19 General Health					
Reason ID : 10005179		**The registered proprietor did not ensure that all residents general health needs were assessed. One of three files examined did not have the resident's waist circumference, smoking and nutritional status, and dental health recorded, 19.1(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	It is noted that waist circumference is no long a requirement under Reg 19. All 6 monthly physicals and physicals on admissions will now be audited on a bi-monthly basis and fed back to the Kerry Audit Committee	Bi-yearly audit results	Achievable	31/12/2024	CNM2, Audit Committee, Nursing and Medical Staff
Preventative Action	It is noted that waist circumference is no long a requirement under Reg 19. All 6 monthly physicals and physicals on admissions will now be audited on a bi-monthly basis and fed back to the Kerry Audit Committee	Bi-yearly audit results	Achievable	31/12/2024	CNM2, Audit Committee, Nursing and Medical Staff

Regulation 21: Privacy					
Reason ID : 10005166		The registered proprietor did not ensure resident's privacy and dignity was appropriately respected as residents could not operate the opaque observation panels in the bedroom doors to ensure privacy and dignity when required.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Quotes sought via maintenance regarding retrofitting anti-ligature handles to allow patient control of opaque panels	Operational privacy screen	Achievable	30/11/2024	Area Administrator
Preventative Action	Quotes sought via maintenance regarding retrofitting anti-ligature handles to allow patient control of opaque panels	Operational privacy screen	achievable	30/11/2024	Area Administrator

Regulation 22: Premises					
Reason ID : 10005152		**The registered proprietor did not ensure the premises was maintained in good structural and decorative condition, because the curtains in some bedrooms throughout the approved centre were not fit for purpose (did not keep out light), were detached from curtain rail, and stained. There were rusted radiators in en suite bathrooms, 22(1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Curtains cleaned and rehung with cleaning schedule adjusted. Quotes sought to replace radiator covers for the General Manager's approval Quotes sought to purchase new curtains for the General Manager's approval	Well maintained and functioning curtains Radiators in good condition	Achievable	31/05/2024	CNM3 and General Manager
Preventative Action	1. Cleaning schedule of curtains increased with housekeeping service with monthly monitoring and re hanging of curtains as necessary	Well maintained and functioning curtains	Achievable	31/05/2024	CNM3, Cleaning Supervisor
Reason ID : 10005153		**The registered proprietor did not ensure the condition of the physical structure and the overall approved centre environment was maintained with due regard to the safety and wellbeing of residents as not all ligatures were minimised to the lowest practicable level based on risk assessment, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature audit action plan is completed and risk mitigation	Updated ligature audit action plan	Achievable	31/12/2024	A/DON & CNM3

	reviewed on a monthly basis.				
Preventative Action	Monthly walkthrough of Unit by 2 rotating members of the Management Team and any ligatures identified are escalated to the Management Team for mitigation.	Lowest practical level of ligatures	Achievable	31/12/2024	All HOD
Reason ID : 10005154		**The registered proprietor did not ensure the overall approved centre environment was developed with due regards to the specific needs of the residents. The dining room used by Valentia and Reask wards was unable to fit all residents at full capacity, 22(3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A business case to extend the dinning room in Sliabh Mis is currently under review by the Head of Service for National Funding.	Refurbished dinning room to facilitate a full compliment of Patients	Achievable	30/04/2025	GM , Head of Service and HSE Estates
Preventative Action	A business case to extend the dinning room in Sliabh Mis is currently under review by the Head of Service for National Funding.	Refurbished dinning room to facilitate the full compliment of patients	Achievable	30/04/2025	GM, Head of Service and HSE Estates

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines					
Reason ID : 10005173		**The registered proprietor did not ensure that the approved centre had written operational policies relating to the storing of medicines to residents prescribed a non-stock item on a named basis, 23(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Patient labels to be added to single use items box once received on ward.	Audit results	Achievable	31/12/2024	CNM2 and CNM3
Preventative Action	A proposal for the provision of additional hours from UHK to be submitted to UKH for their consideration. This is currently being costed for funding purposes.	Audit results	Achievable	31/12/2024	General Manager, Executive Clinical Director, Clinical Director

Regulation 26: Staffing					
Reason ID : 10005176		**The registered proprietor did not ensure all staff were trained to enable them to provide care and treatment in accordance with best contemporary practice as all staff were not trained in Fire Safety, Basic Life Support, Management of Violence and Aggression and the Mental Health Act 2001, 26(4).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The RPN emailed all HOD requesting that the completion of mandatory training to meet MHC requirements be prioritised and that monthly review of training records be added to the LMT agenda as a standing item	100% Compliance with regulation	Achievable	31/12/2024	General Manager and all HOD
Preventative Action	A template to track the completion of all mandatory training (MHC) is in development and will issue to each HOD for completion and monthly monitoring by the RPN office	100% compliance with regulation	Achievable	31/12/2024	General Manager, all HOD

Regulation 27:Maintenance of Records					
Reason ID : 10005163		**The registered proprietor did not ensure records were maintained in a manner so as to ensure accuracy because the name of the consultant psychiatrist clinical lead was wrong on the majority of clinical files, 27(1). The registered proprietor did not ensure that records were maintained in good order, as two clinical files had loose pages, 27(1). The registered proprietor did not ensure records were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval because the majority of the files in use were temporary files, 27(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	PIMS system updated with consultants name added to system. Regular auditing of files. Documentation adjusted to prompt staff to send admission slip to community to retrieve files, this is then followed up with email from CNM3 or admin staff	100% compliance with the Regulation. On-going audits in line with the JSF schedule.	Achievable	31/12/2024	CNM3, Area Administrator and Audit Committee
Preventative Action	Funding secured for the provision of a private transportation service of files in a secure and timely manner.	100% compliance with regulation. On-going audits in line with the JSF schedule	Achievable	31/12/2024	Area Administrator and General Manager

Regulation 32: Risk Management Procedures					
Reason ID : 10005168		**The registered proprietor did not ensure the risk management policy was implemented throughout the approved centre in relation to clinical risk, as there was no process in place or person responsible for the transfer of clinical files between the inpatient and community services, 32(1). The registered proprietor did not ensure the risk management policy was implemented throughout the approved centre as there was no process in place or person responsible for the amalgamation of the temporary and clinical files once received by the approved centre, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Funding secured for the provision of a private courier service to transport the files in a secure and timely manner Temporary ward clerk in place pending the appointment of permanent ward clerk	100% compliance with JSF Audits	Achievable	31/12/2024	Area Administrator and GM
Preventative Action	Funding secured for the provision of a private courier service to transport the files in a secure and timely manner Temporary ward clerk in place pending the appointment of permanent ward clerk	100% compliance with JSF Audits	Achievable	31/12/2024	Area Administrator and GM

Reason ID : 10005170		The registered proprietor did not ensure the approved centre notified the Mental Health Commission of incidents occurring in the approved centre. From January to July 2023, the six-monthly summary report had not been submitted to the Mental Health Commission, 32(3).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Reports collated and uploaded post the annual inspection by the Mental Health Act Administrator	Reports uploaded within the specified timeframe going forward	Achievable	30/04/2024	Mental Health Act Administrator and CNM3
Preventative Action	CNM3 provides information to Mental Health Act Administrator for uploading on a monthly basis.	Reports uploaded to CIS on a monthly basis	Ac hievable	31/12/2024	CNM3 and Mental Health Act Administrator

Rules Governing the Use of Seclusion					
Reason ID : 10005183		**In one episode of seclusion, the resident's level of distress, behaviour, level of awareness or physical health were not recorded by a registered nurse at least every 15 minutes, 5.3(i–iv).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion pathway to be developed and implemented for use in the approved centre to ensure compliance with entire process.	Compliance with Code of Practice	Achievable	31/12/2024	Clinical Director, Assistant Director of Nursing, CNM3
Preventative Action	Seclusion review sheet is completed post each episode of seclusion	100% Compliance with Code of Practice	Achievable	31/12/2024	CNM3, A/DON
Reason ID : 10005184		**In one episode of seclusion, it was not recorded that the resident was informed of the ending of the episode of seclusion, 7.3.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion pathway to be developed and implemented for use in the approved centre to ensure compliance with entire process.	Compliance with Code of Practice	Achievable	31/12/2024	Clinical Director, A/DON, CNM3
Preventative Action	Seclusion review sheet is completed post each episode of seclusion	Compliance with Code of Practice	Achievable	31/12/2024	Clinical Director, A/DON, CNM3
Reason ID : 10005185		**In one episode of seclusion, the resident's representative was not informed of the ending of the episode of seclusion as soon as was practicable, 7.10.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Seclusion pathway to be developed and implemented for use in the approved centre to ensure compliance with entire process.	100% Compliance with Code of Practice	Achievable	31/12/2024	Clinical Director, Assistant Director of Nursing, CNM3
Preventative Action	Seclusion review sheet is completed post each episode of seclusion	100% compliance with Code of Practice	Achievable	31/12/2024	A/DON, CNM3
Reason ID : 10005186		**In one episode of seclusion, no documented risk assessment was carried out by a registered medical practitioner or registered nurse on admission to determine if seclusion could be safely used or not, 13.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Seclusion pathway to be developed and implemented for use in the approved centre to ensure compliance with entire process	Compliance with Code of Practice	Achievable	31/12/2024	Clinical Director, A/DON, CNM3
Preventative Action	Seclusion review sheet is completed post each episode of seclusion	Compliance with Code of Practice	Achievable	31/12/2024	A/DON, CNM3
Reason ID : 10005187		**The multi-disciplinary review and oversight committee did not produce a report following each meeting. Therefore, no report was made available to staff who participated in seclusion to promote on-going learning and awareness, 10.8(vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A process is now in place to complete these reports. CNM3 and MHA	Compliance with Code of Practice	Achievable	31/12/2024	A/DON, CNM3, MHA

	Administrator compile these reports for the Multi-disciplinary Review & Oversight Committee				
Preventative Action	Compliance with this COP will be audited on an annual basis and a plan put in place to address areas of non-compliance. A copy of this audit will be reviewed by the Kerry QPS Committee	Compliance with Code of Practice	Achievable	31/12/2024	MDT Review & Oversight Committee and Kerry QPS Committe

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10005180		**In one episode of physical restraint, a medical examination of the person by a registered medical practitioner did not take place no later than two hours after the start of the episode, 3.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Restraint pathway to be developed and implemented for use in the approved centre to ensure compliance with entire process.	Audit results	Achievable	31/12/2024	Clinical Director, CNM3 and Regulatory Compliance A/DON
Preventative Action	Restraint pathway to be developed and implemented for use in the approved centre to ensure compliance with entire process.	Audit results	Achievable	31/12/2024	Clinical Director, CNM3 and Regulatory Compliance A/DON
Reason ID : 10005181		**In one episode of physical restraint the person was not informed of the reasons for, and the circumstances which lead to the discontinuation of physical restraint, 3.8.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Restraint pathway to be developed and implemented for use in the approved centre to ensure compliance with entire process.	Audit results	Achievable	31/12/2024	Clinical Director, CNM3 and Regulatory Compliance A/DON
Preventative Action	Restraint pathway to be developed and implemented for use in the approved centre to ensure	Audit results	Achievable	31/12/2024	Clinical Director, CNM3 and Regulatory Compliance A/DON

	compliance with entire process.				
Reason ID : 10005182		**The multi-disciplinary review and oversight committee did not produce a report following each meeting, 10.8(vi).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A process is now in place to complete these reports. CNM3 and MHA Administrator compile these reports	Compliance with Code of Practice	Achievable	31/12/2024	CNM3, MHA Administrator,
Preventative Action	Compliance with this COP will be audited on an annual basis and a plan put in place to address areas of non-compliance.	Compliance with Code of Practice	Achievable	31/12/2024	CNM3, A/DON

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10005135		**Age-appropriate facilities and a programme of activities appropriate to age and ability were not provided for child admissions, 2.5(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Child Admissions only occur in line with National Clinical CAMHS Operational Guidelines 201 and following discussion with the ECD. If a child is admitted under Section 25 then the Child ICP will be utilised. The ward social worker will review the educational needs of the child and link with the appropriate Camhs team as necessary	Audit results - ongoing in line with the JSF audit schedule.	Achievable	31/12/2024	Executive Clinical Director and Clinical Director
Preventative Action	Admission of a child to the Sliabh Mis Adult Acute Mental Health Centre should only happen in extreme situations and when it does it is for the shortest time possible.	Audit results - ongoing in line with the JSF schedule	Achievable	31/12/2024	Executive Clinical Director and Clinical Director

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10005133		**Not all staff had signed the policy on admission, transfer and discharge to indicate they had read and understood it, 9.1.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Staff are requested to read and sign all policies of the approved centre by HOD. NCHD Induction informs new doctors of the importance of signing policies to confirm their understanding.	Audit results	Achievable	31/12/2024	Clinical Director and Head of Discipline
Preventative Action	Staff are requested to read and sign all policies of the approved centre by HOD	100% Compliance with the Code of Practice	Achievable	31/12/2024	Clinical Director and Heads of Discipline

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.

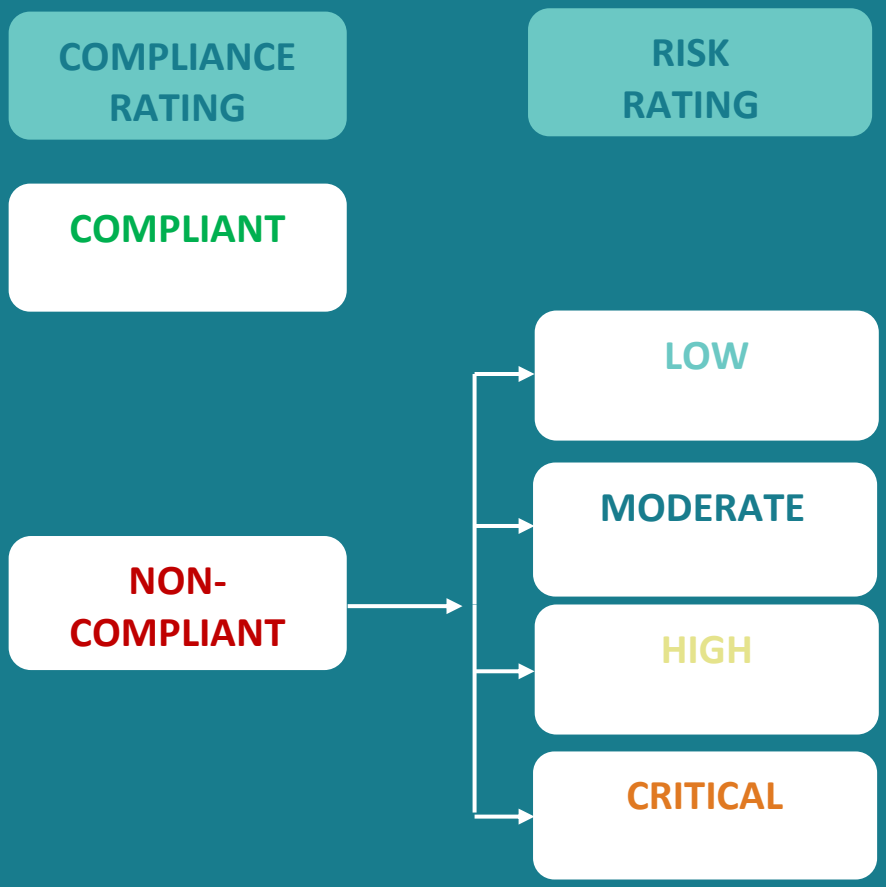
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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