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mental health commission

St Michael's Unit, Mercy University Hospital

Annual Inspection
Report 2023

Promoting Quality, Safety and
Human Rights in Mental Health

ST MICHAEL'S UNIT, MERCY UNIVERSITY HOSPITAL

St Michael's Unit, Mercy University Hospital, Grenville Place, Cork

Date of Publication: 24th May 2024

ID Number: AC00163

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute adult mental health care
Psychiatry of later life

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
Ms. Deborah Harrington, Acting General Manager, Mental Health Services

Inspection Team:
Susan O'Neill, Lead Inspector
Fergal Duffy
Marianne Griffith
Siobhan Dinan

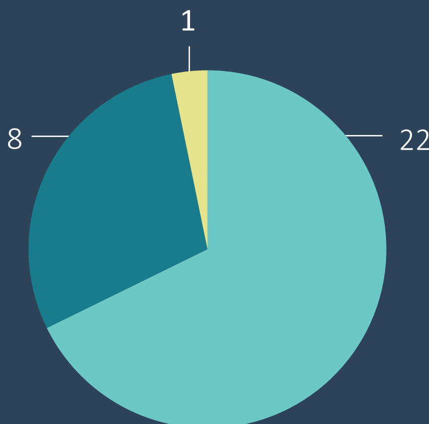
The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Date:
24 – 27 October 2023

Previous Inspection date:
11 – 14 October 2022

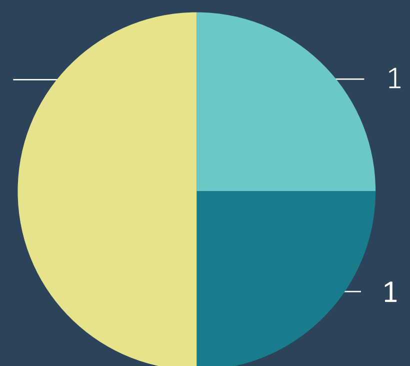
Inspection Type:
Announced Annual Inspection

2023 COMPLIANCE RATINGS



REGULATIONS

RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



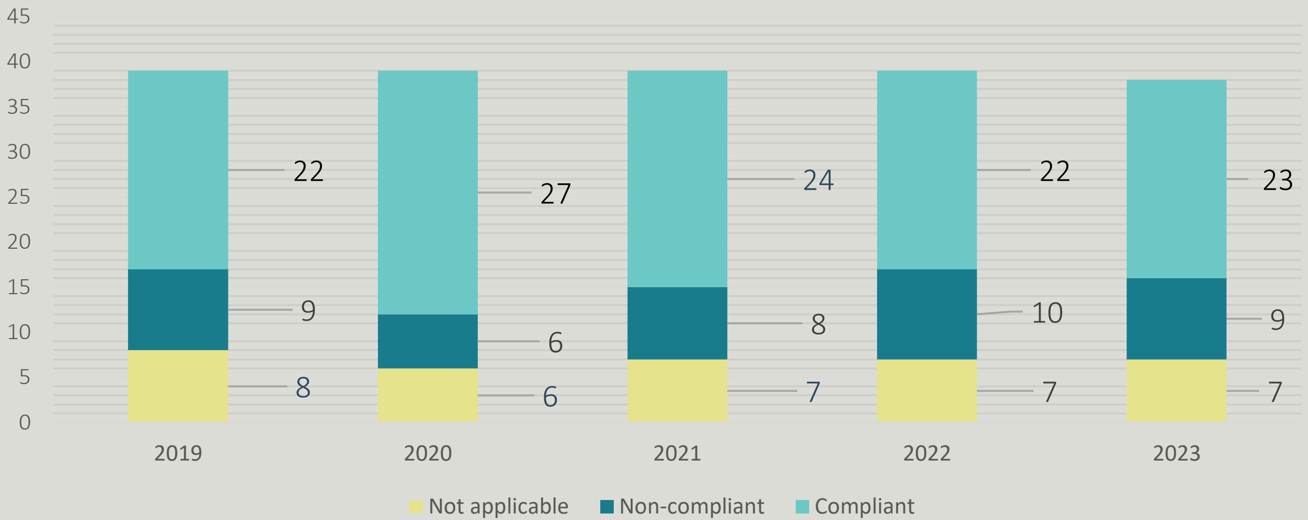
CODES OF PRACTICE

Compliant Non-Compliant Not applicable

RATINGS SUMMARY 2019 – 2023

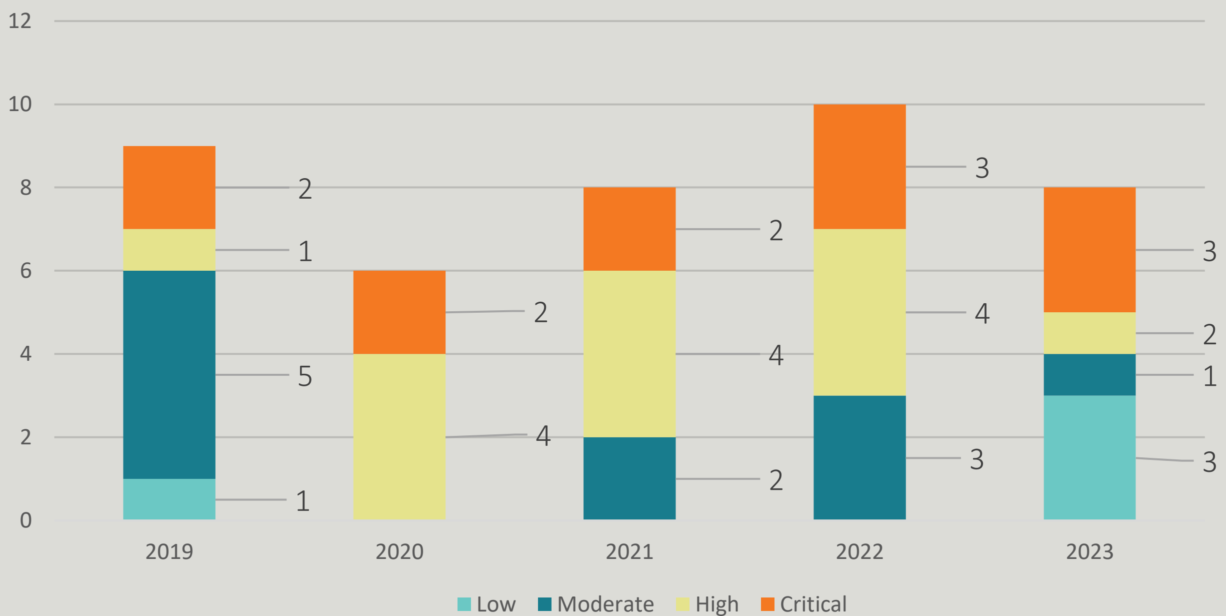
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Professor Jim V Lucey

In brief

St. Michael's Unit (SMU) was part of the Mercy University Hospital, next to the river Lee, in Cork city centre. The 50-bed approved centre was on the first floor of the Mercy University Hospital and it was split into two wards: an acute and a sub-acute ward. The acute ward contained twenty beds and the sub-acute ward had thirty beds. Six multi-disciplinary teams had admitting rights to the approved centre, and these included Adult Mental Health Teams and a Psychiatry of Later Life team.

The approved centre showed an increase in compliance since 2022 by 3%. Three of the non-compliances found during this inspection were rated as critical risk. These were: Regulation 21: Privacy, Regulation 22: Premises and Regulation 32: Risk Management Procedures.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	71%	82%	75%	69%	72%

Conditions to registration

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

Conditions	Findings
Condition 1: *The registered proprietor must implement the costed, funded and timebound plan to address identified ligature and fire safety risk in the approved centre, as identified in Appendix B of their correspondence to the Mental Health Commission (MHC) of 25 January 2023. These works must be completed by 31 January 2024. The registered proprietor shall submit updates in a form and frequency specified by the MHC.*	The approved centre was not in breach of Condition 1 at the time of inspection.

Condition 2: *The registered proprietor must renovate and reconfigure the approved centre to provide adequate communal and bedroom space, and address identified ligature and fire safety risks, in line with plans (revision F) submitted on 21 June 2021 and in line with commitments submitted by the registered proprietor on 25 January 2023. The registered proprietor shall submit updates in a form and frequency specified by the Mental Health Commission.*	The approved centre was not in breach of Condition 2 at the time of inspection.
Condition 3: *The registered proprietor must submit a costed, funded and timebound governance plan to comprehensively address continuous areas of non-compliance with the Mental Health Act 2001 (Approved Centres) Regulations 2006 (SI No 551 of 2006). The plan must detail how improvements will be overseen and sustained on a continuing basis. This plan must be submitted on a date specified by the Mental Health Commission (MHC). The registered proprietor shall submit updates in a form and frequency specified by the MHC.*	The approved centre was in breach of Condition 3 and the approved centre was non-compliant with Regulation 22: Premises at the time of inspection. Reason for breach: In accordance the submitted governance plan, an adequate maintenance programme was not developed and implemented within the approved centre
Condition 4: *The registered proprietor must develop and implement a safeguarding policy in the approved centre in line with their correspondence submitted to the Mental Health Commission (MHC) on 25 January 2023. The registered proprietor shall carry out regular audits of the implementation of this policy. The registered provider shall submit updates in a form and frequency specified by the MHC.*	The approved centre was in breach of Condition 4 and the approved centre at the time of inspection. Reason for breach: Training in the sexual safety policy had not commenced for staff members at the time of inspection.

Ongoing escalation and enforcement actions at time of inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate action notice 10000246	*19/10/2022*	*Following the annual regulatory inspection of 11 to 17 October 2022, the approved centre was found non-compliant with 11 regulations and three of*	*Approved centre took action and submitted plans, but these were not comprehensive.*

		these, Regulation 21: Privacy, Regulation 22: Premises and Regulation 32: Risk were risk rated as critical.	
Regulatory compliance meeting 10000256	*15/11/2022*	*As MHC not assured by response in relation to above IAN, a Regulatory Compliance Meeting was held.*	*MHC articulated concerns regarding suitability of St Michael's Unit. Approved centre provided additional detail on plans.*
Proposal to attach a condition	*27/01/2023*	*Due to concerns regarding the suitability of the approved centre and persistent non-compliance, four conditions of registration attached.*	*Conditions attached for 2023- 2026 registration period.*

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate action notice 10000305	*14/11/2023*	*At the 2023 annual inspection the approved centre was non-compliant with nine regulations and three of these were risk rated as critical. The three critical non-compliances were in relation to Regulation 21: Privacy, Regulation 22: Premises and Regulation 32: Risk. Additionally, the approved centre was found to be in contravention of two of its four conditions of registration.*	*Enforcement is ongoing.*
Regulatory compliance meeting 10000306	*21/11/2023*	*Due to the MHC's concerns regarding the above non-compliance, a Regulatory Compliance meeting was also scheduled.*	*Enforcement is ongoing.*

Safety of people in the approved centre

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

- ***Number of registered nurses in the approved centre***: There was an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Mandatory training:*** Not all staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Access to essential information***: The clinical files were in order and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***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:

- ***Food safety:*** Hygiene was not always maintained to support food safety requirements. In the acute-unit kitchenette, non-food items were stored in the freezers. In general, there were adequate storage facilities for food but in one of the kitchenettes, one of the cupboards which stored chemical solutions did not have a door.
- ***Cleanliness:*** The approved centre was not clean everywhere. Some rooms inside the approved centre were malodorous and some mould had formed on the ceilings of two shower rooms.
- ***Ligature anchor points:*** Ligature points were not minimised to the lowest level, based on individual risk assessment.
- ***Fire Safety:*** Fire doors on a bedroom and on an interview room were not closing correctly when released from the magnet. Fire drills were not completed regularly. The risk of fire was not adequately treated, as daily fire checks were not consistently undertaken, in accordance with the documented risk assessment.
- ***Poor ventilation:*** In shower rooms.
- ***Risk Management:*** The risk of non-compliance with Regulation 22: Premises, was not comprehensively treated, as a maintenance programme was not adequately implemented, in accordance with the documented risk assessment.
- ***Risk Management: Safety:*** The requirements for the protection of vulnerable adults were not implemented as training for all staff in the sexual safety policy had not been implemented.

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.

- ***Individual care plans:*** Each resident had an appropriate individual care plan (ICP) and there was evidence of significant engagement with residents in respect of their ICP. 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 medical, nursing, occupational therapy, psychology and social work disciplines. 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.
- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Physical assessment****:* In a sample of clinical files inspected, one resident on antipsychotic medication did not receive an electrocardiogram heart function assessment, as part of their six monthly general health assessment. In addition, the physical health assessment document, completed for one resident, did not contain a record of the resident's Body Mass Index rating.

Respect for residents' privacy, dignity and autonomy

The approved centre demonstrated that they respected people's privacy, dignity and autonomy in the following areas:

- ***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.
- ***Sleeping accommodation:*** St. Michael's Unit contained four single en suite bedrooms, three double bedrooms, two of which were en suite, one four bed dormitory style en suite bedroom and six-bed dormitory style en suite 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.
- ***Use of restrictive practices:*** The approved centre did not use Seclusion or Mechanical Restraint. The approved centre had a reduction of restrictive practices strategy. Physical restraint was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restrained by physical means, including information on attempts to reduce or eliminate the use of restraint for that person.

However:

- ***Use of restrictive practices: Physical Restraint:*** The approved centre was not compliant with the Code of Practice on Physical Restraint because the areas to be addressed within the training programme did not include training in cultural competence, human rights including the legal principles of restrictive interventions, positive behavioural support or the monitoring of the safety of the person during and after the physical restraint.
- ***Autonomy: Property:*** Not all residents, were adequately supported to manage their own property. In the property room, a laptop was not labelled with the owner's identity. The laptop did not belong to any resident admitted to the ward at the time of inspection, and staff were unable to identify the owner who had been discharged from the unit.
- ***Privacy and dignity and CCTV:*** The approved centre was not complaint with Regulation 21: Privacy for seven different reasons and was risk-rated critical. A selection of deficits included: the two-bedded dormitories were too small which meant beds were too close to each other, and the medication room where physical health checks were carried out was visible to passers-by through the window in the door. The approved centre was not complaint with Regulation 25: CCTV because residents were visible on CCTV by non-clinical staff, and CCTV locations in the approved centre were not clearly labelled, evident, and disclosed to residents and resident representatives.

Responsiveness to residents' needs

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

- ***Environment:*** 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.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Residents were provided with appropriate recreational activities at the weekend and during the week.
- ***Residents' feedback:*** The residents were very complimentary about the staff and the care they received. Ten residents spoke with the inspection team and fourteen residents completed service user feedback questionnaires *(please refer to 5.1 for detailed service user feedback).*

However:

- ***Environment:*** There was inadequate programme of routine maintenance in place. The approved centre was in a poor state of repair structurally and decoratively. For example, there was marked and stained flooring, graffiti was on one bedroom wall, and chipped paint in bedrooms. Residents had a lack of personal indoor and outdoor space. There was a lack of storage space and there were not enough chairs in the sitting room for the number of residents accommodated.

Governance, Leadership and Accountability

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

- ***Structure in place:*** St. Michael's Unit, Mercy University Hospital was part of the North Lee Mental Health Services. North Lee was a subsection of Cork Mental Health Services, which was part of the wider Cork/Kerry Community Healthcare Organisation.
- ***Leadership:*** St. Michael's Unit was governed by the North Lee Mental Health Services Senior Management Team. Numerous sub-committees and working groups reported into the North Lee Senior Management Team. The Governance and Steering Group meeting was a local business meeting that was held bimonthly in SMU and attended by various approved centre managers and heads of discipline. The SMU Governance and Steering group reported relevant issues to the Quality and Patient Safety (QPS).
- ***Restrictive practices reduction:*** The approved centre did not use Seclusion or Mechanical Restraint. The approved centre had a reduction of restrictive practices strategy. Three physical restraint episodes were examined. It was not compliant with the Code of Practice on Physical Restraint and risk rated low.
- ***Risk:*** St. Michael's Unit risk register was reviewed by the Incident Review Group which met monthly. Risks were escalated to Cork Area Management Team risk register when required.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. Since the last inspection quality initiatives had been implemented by the approved centre (*please refer to section 2.0 of this report for a list of quality initiatives).*
- ***Complaints:*** There was a robust complaints process in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings which took place on wards, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** A peer advocacy representative met with residents; the inspectors did not receive a report from the Peer Advocacy in Mental Health.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate of 75% over the last four years. It has four conditions on its registration.

However:

- ***Risks, Safety:*** There were significant deficits found on inspection in relation to residents' privacy and dignity, and in relation to risk management and the safety of residents including fire safety risks, and the presence of ligature points on inspection. Also, the requirements for the protection of vulnerable adults were not implemented as training for all staff in the sexual safety policy had not been implemented.
- ***Staff training:*** Not all staff had received mandatory training.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. New furnishings were purchased for the approved centre including specialised beds for the acute area, wing back chairs and new dining-room tables and chairs.

2. New focus groups were facilitated for residents to discuss matters relating to resident safety.

3. There was a dedicated creative wall space on the unit for the purpose of displaying art and photography undertaken by residents and staff.

4. The resident information booklet was reviewed and updated. The booklet was coproduced by the residents, healthcare professionals, the service librarian, and student nurses.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St Michael's Unit (SMU) was part of Mercy University Hospital, beside the river Lee in Cork city centre. On-site parking was very limited due to the city centre location. Access to the building was controlled and monitored by a security guard, who was positioned at the main entrance to SMU.

The 50-bed approved centre was on the first floor of the Mercy University Hospital and was comprised of an acute and a sub-acute unit. The acute unit contained 20 beds and the sub-acute unit had 30 beds. SMU provided in-patient mental health services to the following catchment areas within Cork city and county: City North East, City North West, Blarney, Macroom, Cobh, Glenville, Midleton and Youghal. Six multi-disciplinary teams had admitting rights to the approved centre, and these included five adult mental health teams and a psychiatry of later life team.

SMU contained four single en suite bedrooms; three two-bedded rooms, two of which were en suite; one four-bed dormitory style en suite bedroom and six six-bed dormitory style en suite bedrooms. Two of the two-bedded rooms within the sub-acute unit were not adequately sized resulting in beds positioned close to each other. The approved centre's communal areas included a dining room, an occupational therapy kitchen, an art room, an activities room, a gym, and a multi-purpose consultation room. The approved centre had a conservatory area which overlooked the river Lee; however, at the time of the inspection the conservatory was locked and could only be accessed by the residents under supervision of nursing staff. This limited the communal space available to residents. The residents' relaxation and recreational areas were confined, and residents had no access to an on-site outdoor space. As a result of this, the environment was restrictive in nature.

The sub-acute unit had a small sitting room which did not have seating capacity for 30 residents. The acute unit had a centrally located large communal sitting area with a television. Bedroom areas, showers, toilets, and the nurses station surrounded this area. This area acted as a thoroughfare from which other areas of the unit were accessed.

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

Resident Profile	
Number of registered beds	***50***
Total number of residents	**47**
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	4
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

St Michael's Unit (SMU), Mercy University Hospital was part of the North Lee Mental Health Services. North Lee was a subsection of Cork Mental Health Services, which was part of the wider Cork/Kerry Community Healthcare Organisation (CHO). SMU was governed by the North Lee Mental Health Services senior management team. There were various governance committee meeting forums spanning SMU and North Lee Mental Health Services. The Governance and Steering Group meeting was a local business meeting that was held bimonthly in SMU and attended by various approved centre managers and heads of discipline. Agenda items concerned regulatory compliance, audit results and staff training relating to the approved centre. In this forum, reports from various subcommittees for areas such as drugs and therapeutics, policy review and development, and individual care planning were also reviewed and discussed.

The SMU Governance and Steering group reported relevant issues to the Quality and Patient Safety (QPS) Committee for North Lee Mental Health Services. The QPS committee convened on a quarterly basis throughout the year and was attended by various heads of discipline and senior management. Agenda items included a review of complaints, incidents, training and patient safety issues from across the services. Reports were also provided by various subcommittees responsible for infection control, drugs and therapeutics, health and safety, policy and procedures and auditing. The QPS committee reported to the Heads of Service QPS committee which reviewed all quality and patient safety issues across the Cork/Kerry CHO. The QPS committee also reported to the North Lee management team meeting. This forum convened monthly and was attended by heads of discipline and senior management across North Lee Mental Health Services. The risk register for North Lee Mental Health services was reviewed at this forum in addition to relevant quality and patient safety issues.

The approved centre had a local risk management policy which outlined risk and incident management processes. Incidents were reported and risk assessed through the National Incident Management system (NIMS). Incidents and trends were discussed at the monthly Incident Review Group meeting and also discussed by the North Lee QPS committee. Identified risks were documented in the site-specific safety statement and local risk register. The safety statement was reviewed on an annual basis and the risk register was reviewed monthly at the Incident Review Group meeting. Risks could be escalated to the wider service risk register if required. Systems and processes were in place for the management of risks; however, processes were not always implemented comprehensively in the management of fire risk. A fire risk assessment was completed and included in the site-specific safety statement but not all documented control measures to manage risk were being consistently completed. The completion of fire drills was one of the documented control measures. Fire drills should have been conducted on a regular basis in accordance with the local risk management policy but records indicated that only one fire drill had taken place in the approved centre involving 17 staff members. The completion of daily fire checks was another documented control measure, however, daily fire checks only commenced 11 days preceding the inspection date with no records prior. The fire checks that had been completed did not identify that two fire doors on the unit did not shut properly and therefore required reporting.

For the previous five years, the approved centre was non-compliant with regulation governing the premises (Regulation 22: Premises). Conditions had been applied to the registration of the approved centre by the Mental Health Commission in response to previous inspection findings. The approved centre submitted a

governance plan outlining actions to address non-compliance with Regulation 22. Significant works had been undertaken to improve identified areas such as ligature-point reduction work, work on structural fire risks, painting and replacement of stained ceiling tiles. There were also regular inspections of the unit completed by nursing management. However, despite these efforts, the risk of ongoing non-compliance with Regulation 22 had not been adequately managed by the service. In accordance with the requirements of the governance plan and local risk assessment, the service had not adequately developed a maintenance programme for the premises as evidenced by the numerous maintenance issues observed on the unit.

Plans to renovate and reconfigure the approved centre had been submitted to the Mental Health Commission. Since initial approval of funding for the project, however, there was a significant elevation in costs. At the time of inspection, the service was seeking additional funding approval in order to proceed with the project.

An organisational chart identified the leadership and management structures as well as the lines of authority and accountability within the approved centre. All heads of discipline had defined strategic aims in relation to the approved centre. All heads of discipline met with staff regularly or utilised a line management structure for reporting and engaging with staff. All disciplines had a system in place for supervision or peer review of staff members. All disciplines undertook performance appraisal in differing modes. Staff numbers and skill mix were adequate in the approved centre. Each team included nursing, medical, social work, occupational therapy and psychology disciplines. There were some vacant posts across the disciplines, however, effective short-term arrangements were put in place to manage workload. Procedures for recruitment had commenced for each post.

Not all staff had completed mandatory training in the areas of fire safety, basic life support or the management of violence and aggression. In comparison to last year's inspection however, there was an improvement in training completion rates. Another condition applied to the registration of the approved centre required the service to develop and implement a safeguarding policy in the approved centre in accordance with plans submitted to the Mental Health Commission. The principal actions required to meet the condition were the development of a sexual safety policy and corresponding training for all staff. The policy was approved in June 2023, although at the time of inspection, training for staff had not commenced. An additional risk management action, documented on the submitted plans, included the completion of Adult Safeguarding training. This training was mandated for all staff but had been completed by only 62% of staff.

Four conditions had been applied to the registration of the approved centre by the Mental Health Commission in response to previous inspection findings and serious reportable events. The service developed action plans to comply with the different conditions but upon inspection, two of these conditions had been breached (See page six for conditions description and reasons for breach). There were various governance arrangements in place to monitor requirements of the conditions either indirectly or directly. The SMU Governance and Steering Group regularly reviewed repeated areas of non-compliance with specific regulations governing premises, privacy and risk management procedures. A continuous cycle of auditing was undertaken and results were reported to the SMU Governance and Steering Group and the North Lee Quality and Patient Safety Committee. A Regulatory Compliance subcommittee convened bimonthly and

was attended by senior management. This committee reviewed regulatory compliance issues and monitored conditions for services across Cork Mental Health Services.

Community meetings with residents were facilitated on wards and feedback was provided to the teams. Residents could also engage via the complaints process. There was a log for minor complaints and a clear complaints procedure for non-minor complaints was implemented. Representatives from the Peer Advocacy in Mental Health advocacy service also visited the approved centre and met with residents.

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 6: Food Safety	✓		✓		✓		✓		✗	Moderate
Regulation 8: Resident's Property and Possessions	✓		✓		✓		✗	Moderate	✗	Low
Regulation 19: General Health	✗	Moderate	✗	High	✗	High	✓		✗	Low
Regulation 21: Privacy	✗	Critical	✗	Critical	✗	Critical	✗	Critical	✗	Critical
Regulation 22: Premises	✗	Critical	✗	Critical	✗	Critical	✗	Critical	✗	Critical
Regulation 25: CCTV		N/A		N/A		N/A		N/A	✗	High
Regulation 26: Staffing	✗	High	✓		✗	Moderate	✗	Moderate	✗	High
Regulation 32: Risk Management Procedures	✗	Moderate	✗	High	✗	High	✗	Critical	✗	Critical
Code of Practice for the Use of Physical Restraint	✗	Moderate	✓		✓		✓		✗	Low

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre had not admitted any children since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy (ECT)	As the approved centre did not provide an ECT service, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection,

	Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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

Ten residents spoke with the inspection team and the following feedback was received:

- Most residents stated that the food was very good. One resident felt that the salad option was very repetitive.
- Residents reported that the therapy groups were excellent and very useful.
- There was widespread praise for the staff although some residents felt that members of the night staff were less approachable.
- The premises were noted to be clean.
- One resident reported that staff had too much paperwork and suggested greater use of electronic systems so that staff could have more time to talk.
- Two residents reported that mealtimes were very rushed which was overwhelming for people in the canteen. One resident stated that while mealtimes were scheduled as lasting 30 minutes in duration, in reality mealtimes lasted only 15 minutes.
- One resident was disappointed by the difficulty in finding accommodation which had caused a delay in discharge.
- One resident reported that they did not have access to information about their illness or treatment options.
- One person felt that there was not enough access to therapies and that the weekends were very long due to lack of activity.
- One resident reported that there were long waiting times to receive 'as required' medication.
- One resident wanted to have more space on the ward and thought there should be fewer people in the shared room.

Fourteen service user experience questionnaires were completed and returned to the inspection team:

- Seven residents reported that staff always provided information about their diagnosis, care and treatment in a way that was understandable. Four residents reported that this occurred only sometimes, and three residents reported that this never occurred.
- Nine residents understood their individual care plan and nine residents reported that they were always involved in setting goals. Five residents reported that they were involved in the goal-setting process sometimes.
- Thirteen residents knew who the members of their multi-disciplinary team were.
- Eight residents indicated that they were always able to discuss worries or concerns with a member of staff, while six residents indicated they could only do this sometimes.
- Eight residents reported that there were enough activities to engage in during the day.
- Thirteen residents reported that they were happy with how staff talked to them.
- Twelve residents reported that they had space for privacy.
- Fourteen residents reported that they could communicate freely with family, friends or advocates.
- Seven residents reported that they always felt safe in the approved centre, while seven residents indicated that they only felt safe sometimes.
- Ten residents reported that they felt able to give feedback to staff and to make complaints when not satisfied with any part of their stay in the approved centre, while two residents only felt able to give feedback sometimes and two residents felt that they were never able to give feedback.

Specific comments were also documented by residents in the surveys and included the following:

- There were many complimentary comments towards staff. One comment noted that staff were exceptionally committed, caring and hardworking. Another resident stated that the staff were very attentive and caring. Another resident reported that the consultant psychiatrist was extremely understanding.
- One resident stated that the premises were an old building, the showers broke repeatedly, and the premises were claustrophobic.
- The issue of access to the multi-disciplinary team members was noted by two residents. One resident wanted more access to the team more than once a week. One resident suggested that all paperwork might be completed on a computer, giving staff more time with residents.

5.2 Advocacy

The approved centre had an advocacy service.

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

6.0 Feedback Meeting

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

- Area Director of Nursing
- Assistant Director of Nursing
- Clinical Director
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Executive Clinical Director
- Principal Psychologist
- Principal Social Worker
- Registered Proprietor Nominee
- Senior Occupational Therapist

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

The approved centre used a minimum of two resident identifiers, appropriate to the resident group profile and individual residents' needs. Resident identifiers were used before administering medications, undertaking medical investigations and providing other health care services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals 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

NON-COMPLIANT

Risk Rating **MODERATE**

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

The approved centre provided suitable and sufficient catering equipment. There were two kitchenettes in the approved centre which contained proper facilities for the refrigeration, preparation and serving of food. In general, there were adequate storage facilities; however, in one of the kitchenettes, one of the cupboards which stored chemical solutions did not have a door.

Hygiene was not always maintained to support food safety requirements. In the acute-unit kitchenette, non-food items were stored in the freezers. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

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

a) The fact that chemicals were stored in a press within the kitchen that did not have a functioning door indicated that proper facilities were not provided for the storage of food, 6 (1)(b).

b) A high standard of hygiene was not maintained in relation to the storage of food as non-food items were stored in the freezer of the acute-unit kitchen, 6 (1)(c).

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with emergency personal clothing that was appropriate and took account of their preferences, dignity, bodily integrity and religious and cultural practices. At the time of the inspection, no residents wore nightclothes during the day.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

NON-COMPLIANT

Risk Rating **LOW**

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures which detailed the processes for managing residents' personal property and possessions. The policy was last reviewed in August 2021.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The property checklist was kept separately to the resident's individual care plan and was available to the resident. Residents' personal property and possessions were safeguarded when the approved centre assumed responsibility for them. There was a locked property room for the safekeeping of the residents' valuables, personal property, and possessions, as necessary. Not all residents, however, were adequately supported to manage their own property. In the property room, a laptop was not labelled with the owner's identity. The laptop did not belong to any resident admitted to the ward at the time of inspection, and staff were unable to identify the owner who had been discharged from the unit.

The approved centre maintained storage of a laptop, however there was no indication as to who owned it. The laptop did not belong to a current resident and had therefore not been returned to its owner prior to discharge. For this reason, the registered proprietor did not ensure that each resident retained control of their personal property as required, 8(5).

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 a wide range of recreational activities appropriate to the resident group on weekdays and weekends. Recreational activities included jigsaws, books, television, and boardgames. Residents also had supervised access to a small gym room which included a cross trainer and two exercise bikes.

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 practise religion were facilitated within the approved centre insofar as practicable.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to visits. The policy was last reviewed in October 2020.

Visiting times were appropriate and reasonable. Appropriate steps were taken to ensure the safety of residents and visitors during visits. Residents were facilitated to meet privately with visitors in an internal visiting room and in a family room. The visiting area was suitable for child visitors.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

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

Residents had access to mail, internet, telephone or any device for the sending or receiving messages or goods unless otherwise risk-assessed with due regard to the residents' well-being, safety and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication where there was reasonable cause to believe the communication may result in harm to the resident or to others.

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 2021, and included all requirements related to:

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

The resident search policy and procedure was communicated to all residents, and relevant staff could articulate the searching processes as set out in the policy. Searches were only conducted for the purpose of creating and maintaining a safe and therapeutic environment for residents and staff.

The clinical files of three residents who were searched were inspected. Residents' consent was sought and documented prior to the search taking place. Risk had been assessed prior to the search of the residents. 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. Policy requirements were implemented when illicit substances were found as a result of a search. General written consent was sought for routine environmental searches.

The approved centre was compliant with this regulation.

Regulation 14: Care of the Dying

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

One resident had died in the approved centre since the last inspection. This was a sudden death, and it 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 within 48 hours.

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 (ICP) were inspected. All ICPs were a composite set of documents. Specific space and sections were allocated for needs, goals, treatment, care and resources required. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes.

Each ICP was developed by the multi-disciplinary team (MDT) following comprehensive assessment. All ICPs were discussed and drawn up with the participation of the resident or their next of kin. All ICPs identified appropriate goals for the residents and the care, treatment and resources required for such goals. Each ICP was reviewed by the MDT in consultation with the resident on a weekly basis. The ICPs were updated following review, as indicated by the resident's changing needs, conditions, 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 and met the assessed needs of the residents, as detailed in their individual care plans (ICPs). The approved centre's therapeutic services and programmes were directed towards restoring and maintaining residents' optimal levels of physical and psychosocial functioning. All disciplines, including nursing, psychology, occupational therapy, social work, and medical gave input to the therapeutic programmes and services. Residents also had access to general health services such as physiotherapy, speech and language therapy, dietetics and chiropody as required.

Therapeutic services and programmes were provided to residents on an individual basis and a group basis. At the time of inspection, the group programme included various themes such as preparation for discharge, mindfulness, chair-based exercise, indoor gardening, anxiety management, cooking and baking, peer support, social interaction, distress tolerance, wellbeing, compassion focused therapy, routine management and communication skills. An art therapist also attended the approved centre twice a week.

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

The approved centre was 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 a written policy and procedures in relation to transfers. The policy was last reviewed in August 2021.

The clinical file of one resident who had been transferred from the approved centre to the emergency department was inspected. Full and complete written information regarding the resident was transferred when the resident moved from approved centre. The transfer documentation included a letter of referral, a list of current medications and the resident transfer form.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating LOW

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies. The policy was last reviewed in July 2023.

The approved centre had an emergency trolley and staff always had access to an Automated External Defibrillator. Residents received appropriate general health care interventions in line with individual care plans. Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

Four residents had been in the approved centre for six months at the time of inspection. Their clinical files were examined in relation to the provision of general health services during the inspection process. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs not less than every six months. The six-monthly health assessment documented a physical examination, family or personal history, blood pressure, smoking status, dental health, nutritional status, weight and waist circumference. Body mass index was documented in three of the four inspected assessments. Residents on anti-psychotic medication received an annual assessment of their glucose regulation, prolactin, and blood lipids. An electrocardiogram (ECG) heart function test was completed in three of the assessments. An ECG was not completed for one assessment.

Residents could access national screening programs that were available according to age and gender, including breast check, cervical screening, retina check, and bowel screening.

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

a) **The general health assessment for one resident on antipsychotic medication did not contain an ECG, 19(1)(b).**
b) **The physical health assessment for one resident did not contain a BMI rating, 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 August 2021.

On admission, residents were provided with required information, including the approved centre's information booklet detailing care and services. The information in the booklet was clearly and simply written and available in the required formats to support residents' needs. The approved centre's information booklet included details of mealtimes and arrangements for personal property, visiting times, relevant advocacy and voluntary agencies, residents' rights and the complaints procedure. Residents were also provided with details of their multi-disciplinary team.

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating CRITICAL

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

INSPECTION FINDINGS

Residents were called by their preferred name. Staff addressed and communicated with residents in a respectful manner. Staff were discreet when discussing the resident's condition or treatment needs. Staff sought the resident's permission before entering their room.

The majority of bathrooms, showers and toilets had locks on the inside of the door, unless there was an identified risk to the resident. However, one bathroom on the acute unit did not have a functioning lock on the door. In the majority of dormitory bedrooms, there were privacy curtains that could be pulled around the entire bed area. However, in one two-bedded room, the privacy curtain did not surround one side of both beds, thus compromising resident privacy. Not all bedroom doors with observation panels were fitted with blinds or other privacy screening mechanism. In two cases, residents were unable to close privacy screens on the door observation panels from inside the room. Treatment room observation panels were not all fitted with privacy screening either. Due to insufficient space, some general health checks such as weight, height and blood pressure were carried out in the medication room which was visible to passers-by through the door observation panel.

The two-bedded dormitory bedrooms did not provide sufficient space to facilitate resident privacy and dignity. Beds were positioned close to each other due to the small room size. The communal seating area in the acute unit was not designed for resident comfort. This was an open area located in the centre of the acute unit and contained multiple chairs and a television. Surrounding this area were doors to various rooms including bathrooms, bedrooms and a nurse's station. Therefore, this space also acted as a thoroughfare for residents and staff accessing different parts of the acute ward. This was not a relaxing space and did not meet residents' dignity and privacy needs.

Rooms were not overlooked by public areas. Residents were facilitated to make and take private phone calls. Noticeboards did not display resident names or other identifiable information. A CCTV system had been installed in the approved centre since the last inspection. The footage from each camera could be viewed by non-clinical staff. Security guards were able to view a monitor located in the small security room. Video footage from four exterior CCTV cameras were viewed on this monitor however, the video footage from 20 other cameras in clinical areas could also be viewed.

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

a) **One bathroom did not have a functioning lock at the time of the inspection.**
b) **Not all rooms had curtains on the windows within the doors. Privacy screening did not surround the beds entirely to provide privacy if another person was looking in these windows. In two cases residents were unable to close privacy screens on the windows in the doors from the inside.**
c) **The two-bedded dormitories did not provide sufficient space to facilitate resident privacy and dignity.**
d) **The sitting room in the acute unit was not designed in a manner that facilitated resident comfort.**
e) **There was insufficient space for delivering some general health checks such as weight, height and blood pressure in a way that took account of resident dignity at all times.**
f) **The medication room where physical health checks were carried out was visible to passers-by through the window in the door.**
g) **Residents were visible on CCTV by non-clinical staff.**

Regulation 22: Premises

NON-COMPLIANT

Risk Rating **CRITICAL**

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre was adequately lit and heated in all areas. There were enough toilets and showers for residents, and there was at least one assisted toilet. Appropriate signage was present throughout most of the approved centre to support resident orientation needs, but there was no sign on the door of the female toilets located on the sub-acute corridor.

The approved centre was not clean or free from offensive odours. A smell of urine and cigarette smoke was detected in some of the toilets. Mould was forming on the ceiling of two of the shower rooms on the acute unit. The ventilation system in some of the bathroom/toilet areas was not functioning properly. The approved centre had a dedicated cleaning room and a dedicated sluice room.

The physical structure of the approved centre was not developed and maintained with due regard for the number and mix of residents in the approved centre. Residents in the approved centre had limited access or outdoor space to relax and to move about in. Personal space was limited for residents occupying the two-bedded bedrooms. These bedrooms were too small to comfortably accommodate residents. There was less space between the bed areas and only one chair could fit into the room. Communal rooms were not large enough to accommodate all residents simultaneously.

The approved centre did not have suitable furnishings to support residents' independence and comfort. Resident beds were not of a design and quality to provide a comfortable resting space. Space was limited in the communal areas. Chairs and couches in the sitting room were insufficient due to lack of space. Storage space in the approved centre was insufficient and items were stored behind screens in the activities room.

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

The approved centre was not in a good state of repair and maintenance. Issues included chipped paint in toilets where fixtures and fittings had been removed, graffiti on one bedroom wall, stained and marked flooring throughout the approved centre, marks on sink fittings, damaged wall trims in the sub-acute TV room, a broken shower head holder, windows that could not be opened, stained ceiling tiles and improper closure of two fire doors. There was no comprehensive programme of general maintenance or decorative maintenance. Maintenance was provided by the Mercy Hospital and the maintenance of St Michael's Unit was included as part of a planned and proactive maintenance programme for the entire Mercy Hospital. A system was in place to report emerging issues that required reactive maintenance. While maintenance requests were made by the approved centre staff, some of these requests were not attended to.

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

a) **The approved centre premises contained rooms that were malodorous and some mould had formed on the ceilings of two shower rooms, therefore it was not clean, 22 (1)(a).**
b) **The approved centre was in poor structural and decorative condition, 22 (1)(a). The following issues were observed as part of the inspection:**
   - **Chipped paint in bedrooms. Painting was required in some toilets and en suites where toilet roll holders had been removed.**
   - **Flooring throughout the approved centre was stained and marked.**
   - **Wall trims in the sub-acute TV room looked damaged.**
   - **Some windows did not open.**
   - **The shower head in a shower room did not hang up on the wall.**
   - **Drinking water taps were not functioning.**
   - **Graffiti was on one of the bedroom walls.**
   - **Ceiling tiles were stained in the interview room.**
   - **Fire doors on a bedroom and on an interview room were not closing correctly when released from the magnet.**
   - **There were marks on the sinks where soap dispensers had been removed.**
c) **The shower rooms in the approved centre were poorly ventilated, 22 (1)(b).**
d) **The approved centre did not have an adequate programme of routine maintenance, 22 (1)(c).**

e) The registered proprietor did not ensure that the approved centre had adequate and suitable furnishings due to insufficient chairs in the sitting rooms for the number of residents. The two-bedded dormitories in the sub-acute unit only had space for one chair. Resident beds were not of a design and quality to provide a comfortable resting space, 22(2).

f) The registered proprietor did not ensure that the condition of the physical structure and the overall approved-centre environment was developed and maintained with due regard to the specific needs of the residents due to the continued presence of ligature anchor points, missing signage, insufficient storage space and the lack of access to personal and outdoor space for residents, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicine. The policy was last reviewed in July 2023, and included the following requirements:

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

A Medication Prescription and Administration Record (MPAR) was maintained for each resident, ten of which were examined on inspection. All entries in the MPARs were legible. MPARs contained the following: a record of whether the resident had any or no allergies or sensitivities to medications; the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident; the frequency of administration including the minimum dose interval of the medication in respect of PRN (as required) medications; the start or date of discontinuation for each medication; a record of all medications administered to the resident; and the prescribed route of administration

Where a resident's medication was being withheld, the justification was noted in the MPAR and documented in the clinical file. Medication was stored in the appropriate environment as indicated by the label or advised by the pharmacist. A log of the temperature of the refrigeration unit was taken daily for medication requiring refrigeration. Medication dispensed to the residents was stored securely in a locked storage facility unless otherwise specified. Scheduled 2 and 3 controlled drugs were secured separately from medications to ensure further security.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written health and safety policy, a site-specific safety statement and procedures in place. The health and safety policy was last reviewed in July 2023.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and processes in relation to the use of CCTV, which covered the purpose and function of using CCTV for observing residents in the approved centre. The policy was last reviewed in July 2023 and included the purpose and function of using CCTV, in relation to the observation of a resident.

Clear signs to indicate where CCTV cameras were located throughout the approved centre were not placed in all areas. The sub-acute sitting room, the entrance area and the gym all had CCTV cameras; however, there were no signs within the rooms. A resident was monitored solely for the purposes of ensuring the health, safety and welfare of that resident. CCTV cameras used to observe a resident were incapable of recording or storing a resident's image on a tape, disc, hard drive, or in any other form. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity. Images used to observe a resident could be viewed by staff members other than the health professional responsible for the resident. Security guards were able to view a monitor located in the small security room. Video footage from four exterior CCTV cameras were viewed on this monitor but the video footage from 20 other cameras in clinical areas could also be viewed.

The use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services.

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

a) **As not all the locations containing CCTV had corresponding signposting, CCTV was not clearly labelled and evident, 25 (1)(b).**
b) **As not all CCTV cameras had signs indicating that they were in place, the approved centre did not fully disclose the existence and usage of CCTV to residents and their representatives, 25 (2).**
c) **As CCTV cameras were visible to security staff, it was not the case that CCTV was viewed solely by the health professionals responsible for the welfare of the resident 25 (1)(a).**

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 September 2023, and included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty at all times. The numbers and skill mix of staffing in the approved centre was sufficient to meet resident needs. Six multi-disciplinary teams admitted residents to the approved centre. These teams included five general adult teams and one psychiatry of old age team. Each general adult team was assigned to a specific geographical catchment area within Cork city and county which included Macroom and Blarney, Midleton and Youghal, Cobh and Glenville, City North East and City North West.

Each team included nursing, medical, social work, occupational therapy and psychology disciplines. There were some vacant posts across the disciplines; however, effective short-term arrangements were put in place to manage workload. Procedures for recruitment had commenced for each post. Residents also had access to general health services such as physiotherapy, speech and language therapy, dietetics and chiropody as required.

The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. Not all healthcare staff had completed their training in fire safety, basic life support, and the professional management of violence and aggression. The following table shows the number and percentages of staff trained in the four different topics of mandatory training:

Staff Training Table								
Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (38)	30	79%	20	53%	33	87%	37	97%
Consultant Psychiatrist (8)	7	88%	7	88%	8	100%	8	100%
Medical (23)	20	87%	15	66%	21	91%	23	100%
Occupational Therapist (8)	7	88%	8	100%	7	88%	8	100%
Social Worker (10)	9	90%	10	100%	8	80%	10	100%
Psychologist (8)	6	75%	7	88%	7	88%	8	100%

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

a) **Not all staff had completed fire safety training, management of violence and aggression training, and basic life support training, 26 (4).**
b) **Not all staff had completed training in the Mental Health Act (2001) 26 (5).**

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

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

All residents' records were secure, up to date, in good order and are constructed, maintained and used in accordance with national guidelines and legislative requirements. All resident records were physically stored together, where possible. Resident records were reflective of the residents' current status and the care and treatment being provided. 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. Documentation relating to food safety, health and safety and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre provided private facilities and adequate resources to support the Mental Health Tribunal process. The approved centre provided resources and facilities to support residents accessing the Mental Health Tribunals remotely, if required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

A nominated person, based off-site and available to the approved centre, was responsible for dealing with all complaints. Information about the complaints procedure was provided to residents and their representatives in the resident information booklet. Information about the complaints procedure, including how to contact the nominated person, was publicly displayed in the approved centre.

Residents, their representatives, family and next of kin were informed of the methods by which a complaint can be made. The registered proprietor ensured that the quality of the service, care and treatment of a resident was not adversely affected by reason of the complaint being made.

All oral and written complaints were handled promptly and appropriately. Minor complaints were recorded appropriately and there were no formal complaints lodged to the complaints officer since the last inspection. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the resident’s individual care plan.

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating **CRITICAL**

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and site-specific safety statement in relation to risk management and incident management processes. The risk management policy was last reviewed in April 2022. The policy included all the policy related regulation requirements.

The person with responsibility for risk was identified and known by all staff. Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. Clinical risks and corporate risks were identified, assessed, treated, reported and monitored. These risks were documented in the risk registers as appropriate.

Health and safety risks were identified, assessed, treated, reported and monitored by the approved centre with the exception of fire risk which was not comprehensively managed. There were various systems and processes in place to manage fire risk in the approved centre. A fire risk assessment was completed and included in the site-specific safety statement but not all documented control measures to manage risk were being consistently completed. The completion of fire drills was one of the documented control measures. Fire drills should have been conducted on a regular basis in accordance with the local risk management policy but records indicated that only one fire drill had taken place in the approved centre involving 17 staff members. The completion of daily fire checks was another documented control measure, however, daily fire checks only commenced 11 days preceding the inspection date with no records prior. The fire checks that had been completed did not identify that two fire doors on the unit did not shut properly and therefore required reporting.

Ligature point risks were present on the unit and plans to mitigate risk were in place. The approved centre had a local risk register which included a risk assessment concerning non-compliance with the regulation governing premises. A maintenance programme was one of the documented control measures to manage this risk. However, the maintenance programme was not adequately implemented as evidenced by the multiple maintenance issues identified during the inspection and the inconsistent response to maintenance requests.

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

The requirements for the protection of children within the approved centre were appropriate and implemented as required. However, the requirements for the protection of vulnerable adults in the context of sexual safety were not fully implemented. A new sexual safety policy had been developed and approved in June 2023. Training for all staff on the new policy had not occurred at the time of inspection. In addition, adult safeguarding training, mandated for all staff, was completed by 62% of staff only.

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

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

a) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. The risk of non-compliance with Regulation 22: Premises, was not comprehensively treated, as a maintenance programme was not adequately implemented, in accordance with the documented risk assessment, 32(1).**
b) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. The requirements for the protection of vulnerable adults were not implemented as training for all staff in the sexual safety policy had not been implemented, 32(1).**

c) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre as fire drills were not conducted on a regular basis, 32(1).**
d) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. Risk of fire was not adequately treated, as daily fire checks were not consistently undertaken, in accordance with the documented risk assessment, 32(1).**
e) **The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. The fire risk posed by improperly closing fire doors was not identified by staff, 32(1).**

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was 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. The certificate was displayed prominently.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

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

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 of the Mental Health Act 2001 was not applicable to this approved centre. Please see *Section 4.2 Areas of compliance that were not applicable on this inspection* for details.

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 LOW

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy was last reviewed in April 2023, and addressed the following:

- The provision of information to the resident including information about the resident'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 managements that should be followed during an any episode of physical restraint.

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Policies and procedures regarding staff training included the following:

- Who will receive training based on the identified needs of residents who are restrained and staff.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in physical restraint.
- The areas to be addressed with the training programme including the prevention and therapeutic management of violence and aggression, alternative to physical restraint, and trauma informed care.

However, the policies and procedures did not address the following areas to covered in the training programme:

- Cultural competence.
- Human rights, including the legal principles of restrictive interventions.
- Positive behaviour support, including the identification of causes or triggers of the person's behaviours (social, environmental, cognitive, emotional, or somatic).
- The monitoring of the safety of the person during and after the physical restraint.

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

- Documented how the approved centre aims to reduce, or where possible eliminate the use of physical restraint within the approved centre.
- Addressed 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.
- Documented how the approved centre would provide positive behaviour support as a means of reducing or, where possible, eliminating the use of physical restraint within the approved centre.

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.

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

Two orders for physical restraint lasted for a maximum of 10 minutes. In one case where the use of physical restraint lasted longer than 10 minutes, the physical restraint was extended by a renewal order for a further period not exceeding 10 minutes. The episode of physical restraint and the reasons for renewing the order, and the time that the nursing review or medical examination too place, were clearly recorded in the clinical file. The clinical practice forms had been completed by the person who had initiated and ordered the use of physical restraint no later than three hours after each episode and signed by the consultant psychiatrist within 24 hours.

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

As soon as was practicable, and with the resident's consent, the resident's representative was informed of the physical restraint and a record of this communication was placed in the clinical file. The Mental Health Commission was notified via the Comprehensive Information System of the start time and date and the end time and date of each episode of physical restraint in the correct format and within three days of each episode. Staff members of the same gender were present at all times during the episodes of physical restraint. All staff involved in the episodes had undertaken appropriate training in accordance with the approved centre's policy.

The residents were continuously assessed throughout the uses of restraint to ensure their safety, and there was documented evidence that:

- The resident's head and neck were protected and supported where necessary.
- The resident's airway and breathing were not compromised.

Effective communication was maintained with the residents, and the residents' physical and psychological health was monitored for as long as clinically necessary after using physical restraint.

The physical restraint in each instance was ended by the person who had led it. The time, date, and reason for ending the physical restraint was recorded in the clinical file on the date that each episode ended. Where appropriate, an in-person debrief with the resident followed the episode of physical restraint.

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

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

Clinical Governance: The episodes of physical restraint was reviewed by members of the multi-disciplinary team within five working days from the date of the restraint. There was a named senior manager responsible for the approved centre's reduction of physical restraint.

The approved centre was non-compliant with this code of practice because the areas to be addressed within the training programme did not include training in cultural competence, human rights including the legal principles of restrictive interventions, positive behavioural support or the monitoring of the safety of the person during and after the physical restraint, 8.2(b)(iv-vii).

Admission, Transfer and Discharge

COMPLIANT

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

INSPECTION FINDINGS

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

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

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

Discharge: The discharge policy, which was last reviewed in October 2022, included all the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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

Discharge: The clinical file of one resident who had been discharged from the approved centre was examined. The discharge plan included an estimated date of discharge, a follow up plan, reference to early warning signs of relapse and other risks and documented communications with the relevant healthcare provider. The discharge meeting was attended by the resident, key worker, relevant members of the resident's multi-disciplinary team (MDT) and family or representative, where appropriate.

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

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

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 06: Food Safety					
Reason ID : 10005047		**The fact that chemicals were stored in a press within the kitchen that did not have a functioning door indicated that propert facilities were not provided for the storage of food, 6 (1)(b). Amended by SONeill 09/01/2023: changed reference to regulation from 6(1)(a) to (b) as more reason more befitting regulation. See IQR.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Procurement of a new stainless steel chemical press is being progressed through Mercy Estates.	Installation of a new chemical press	Realistic	30/06/2024	A/DON and Mercy Maintenance
Preventative Action	Procurement of a new stainless steel chemical press is being progressed through Mercy Estates.	Installation of a new chemical press	Realistic	30/06/2024	A/DON and Mercy Maintenance
Reason ID : 10005048		**A high standard of hygiene was not maintained in relation to the storage of food as non-food items were stored in the freezer of the acute-unit kitchen, 6 (1)(c).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Laminated signs advising that “no storage of non- food items” is permitted” have been put up on the freezer in the acute unit kitchen.	No storage of non-food items in freezer	Completed	22/04/2024	A/DON and Mercy Maintenance
Preventative Action	Weekly audit by the Catering Supervisor to ensure that	Audit results	Achievable	31/12/2024	Catering Supervisor

	freezer only contains foods				

Regulation 08: Residents' Personal Property and Possessions					
Reason ID : 10005049		The approved centre maintained storage of a laptop, however there was no indication as to who owned it. The laptop did not belong to a current resident and had therefore not been returned to its owner prior to discharge. For this reason, the registered proprietor did not ensure that each resident retained control of their personal property as required, 8(5).			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Laptop was sent to HSE IT department to see if they could ascertain who the owner is. The Patient Private Property Room has been cleaned and tided.	Laptop returned to rightful owner	Realistic	31/05/2024	A/DON,CNM3 and HSE IT department
Preventative Action	The Patient Private Property Room is on the schedule for the Monthly Maintenance Walkthrough with MHU Technical Services Department to ensure that any maintenance issues within the room are addressed in a timely manner. The General Manager has stood up a working group comprising of some	Organised Patient Private Property Room External storage solution in place.	Achievable Realistic	31/12/2024	A/DON, CNM3 and Mercy Technical Services Department Members of the Working Group HOD Social Work, Psychology & OT)

	members of the North Lee Management Team to explore options for External storage solutions for large pieces of luggage and has requested that this solution be in place by 30th June, 2024.				

Regulation 19: General Health					
Reason ID : 10005130		**The general health assessment for one resident on antipsychotic medication did not contain an ECG, 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Director of St Michael's Unit issued a memo to all Medical Staff on 4th March, 2024 requesting that all required documentation is completed when completing General Health checks and patients on antipsychotic medication have an ECG.	Complete documentation	Completed	04/03/2024	Clinical Director
Preventative Action	JSF audit results on Reg 19 General Health discussed at the St Michael's Unit monthly consultants meeting, SMU Governance meeting and delayed discharged to care meetings.	Audit results	Achievable	31/12/2024	Audit Committee, Medical Team
Reason ID : 10005131		**The physical health assessment for one resident did not contain a BMI rating 19(1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Corrective Action The Clinical Director of St Michael’s Unit issued a memo to all Medical Staff on 4th March, 2024 requesting that all required documentation is completed when completing General Health checks to include BMI rating.	Completed documentation	Completed	04/03/2024	Clinical Director
Preventative Action	JSF audit results on Reg 19 General Health discussed at the St Michael’s Unit monthly consultants meeting, SMU Governance meeting and delayed discharged to care meetings.	Audit results	Achievable	31/12/2024	Audit Committee and Medical Team

Regulation 21: Privacy

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

Regulation 22: Premises

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

Regulation 25: Use of Closed Circuit Television					
Reason ID : 10005096		**As not all the locations containing CCTV had corresponding signposting, CCTV was not clearly labelled and evident, 25 (1)(b). As not all CCTV cameras had signs indicating that they were in place, the approved centre did not fully disclose the existence and usage of CCTV to residents and their representatives, 25 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Additional CCTV signs have been ordered for the Unit.	Additional signage	Completed	01/04/2024	A/DON, CNM3
Preventative Action	Quarterly audit of all CCTV and signage	Compliant with regulations	Achievable	31/12/2024	Nursing Staff
Reason ID : 10005098		**As CCTV cameras were visible to security staff, it was not the case that CCTV was viewed solely by the health professionals responsible for the welfare of the resident 25 (1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Security camera feed from the unit was deactivated during the inspection.	CCTV monitors are not visible to any non healthcare professionals	Completed	22/10/2023	A/DON, CNM3
Preventative Action	Staff to ensure that no non healthcare professional can view the CCTV cameras.	Staff to turn off CCTV cameras when not at the nursing station	Achievable	31/12/2024	A/DON, CNM3

Regulation 26: Staffing					
Reason ID : 10005127		**Not all staff had completed fire safety training, management of violence and aggression training, and basic life support training, 26 (4). Not all staff had completed training in the Mental Health Act (2001) 26 (5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Mandatory Training Records are submitted monthly to the HODS and brought to the LMM for discussion and actioned as required. Mandatory Training attendance is reviewed on a monthly basis by the General Manager. Attached details of mandatory training statistics for St Michael's Unit.	100% compliance	Achievable	31/12/2024	All HOD and SMU Staff
Preventative Action	Mandatory Training Records are submitted monthly to the HODS and brought to the LMM for discussion and as required. Mandatory Training attendance is reviewed on a	100% compliance	Achievable	31/12/2024	All HOD's and SMU Staff

	monthly basis by the General Manager. Attached details of mandatory training statistics for St Michael’s Unit.				

Regulation 32: Risk Management Procedures					
Reason ID : 10005115		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. The risk of non-compliance with Regulation 22: Premises, was not comprehensively treated, as a maintenance programme was not adequately implemented, in accordance with the documented risk assessment, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Monthly Maintenance walkthroughs take place on the 1st Wednesday of every month and any painting and routine Maintenance issues identified are logged on the Mercy Maintenance System “Tririga” and tracked until completion. A Standard Operating Procedure on “Maintenance requests and Monthly Maintenance walkthroughs between St Michael’s Unit, Mercy University Hospital Cork and Technical Services Department Mercy	Unit to be well presented and in good decorative condition	Achievable	31/12/2024	A/DON, CNM111, Mercy Technical Services department

	University Hospital Cork"" and an escalation matrix is in place between St Michael's Unit and the Mercy Hospital Cork.				
Preventative Action	Monthly Maintenance walkthroughs take place on the 1st Wednesday of every month and any painting and routine Maintenance issues identified are logged on the Mercy Maintenance System "Tririga" and tracked until completion. A Standard Operating Procedure on "Maintenance requests and Monthly Maintenance walkthroughs between St Michael's Unit, Mercy University Hospital Cork and Technical Services Department Mercy	Unit to be well presented and in good decorative condition	Achievable	31/12/2024	A/DON, CNM111, Mercy Technical Services department

	University Hospital Cork"" and an escalation matrix is in place between St Michael's Unit and the Mercy Hospital Cork.				
Reason ID : 10005116		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. The requirements for the protection of vulnerable adults were not implemented as training for all staff in the sexual safety policy had not been implemented, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Training statistics OT = 100% Psychology – 100% Nursing- 83% Social Work – 50%. Remaining social workers to be trained are booked to do same in April 2024. Medical NCHD's – 65.22% Medical Consultants – 76.47$	100% training record	Achievable	31/12/2024	All HODs
Preventative Action	Sexual Safety Policy Training is facilitated monthly (3rd Friday of every month) in SMU by the HODs and MDT staff To facilitate staff who do not work Fridays an	100% training record	Achievable	31/12/2024	All HOD's

	additional session has been arranged for 9am on Monday 15th April in SMU. Frequency of this training will be reviewed in July 24 as HODs have suggested that most staff would have been captured by then; going forward it would be at a 3/12 frequency The SSP presentations have been recorded and supportive documentation are available to staff in the N Lee shared folder Email sent to all Medical Staff by the CD St Michael's Unit to complete Intercultural Awareness E Learning Programme				
Reason ID : 10005117		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre as an identified fire risk was not treated within an appropriate timeframe. The installation of the smoke seals and the drop down seals on the fire doors had not been completed, 32(1). Amended by SONeill 08/11/2023: The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre as an identified fire risk was not treated within an appropriate timeframe. The**			

		installation of the smoke seals and the drop down seals on the fire doors had not been completed and updated fire escape drawings were not approved , 32(1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Smoke seals and drop down seals on fire doors are now complete.	Completion of fire works	Completed	21/03/2024	Mercy Technical Services department
Preventative Action	The Mercy Technical Services department are currently on site replacing 5 fire doors. To facilitate the service, the doors are replaced one at a time per day.	Installation of fire doors	Achievable	30/06/2024	Mercy Technical Services department
Reason ID : 10005118		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre as fire drills were not conducted on a regular basis, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Fire drills and training by an external fire company were completion on 4th December 2023 and 5th December, 2023	Completion of fire drills and training	Completed	05/12/2023	Apex Fire and all SMU staff
Preventative Action	Quarterly Fire drills and training have been arranged for the following dates in 2024 Feb 13th May 21st August 20th November	Completion of fire drills and training	Achievable	31/12/2024	Apex fire and all SMU Staff

	19th The Mercy University Hospital has a full time emergency response team who respond to any fire alarm activity in SMU. This team has participated in one of the quarterly fire drill training providing staff on the unit real exposure to the process. This can be arranged again through the MUH Fire officer.				
Reason ID : 10005119		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. Risk of fire was not adequately treated, as daily fire checks were not consistently undertaken, in accordance with the documented risk assessment, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Daily Fire checks are overseen by the CNM2 on the Unit	Completion of daily fire checks	Achievable	31/12/2024	CNM2
Preventative Action	Daily Fire checks are overseen by the CNM2 on the Unit	Completion of daily fire checks	Achievable	31/12/2024	CNM2
Reason ID : 10005120		**The registered proprietor did not ensure that the approved centre implemented the risk management policy throughout the approved centre. The fire risk posed by improperly closing fire doors was not identified by staff, 32(1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**

Corrective Action	Smoke seals and drop down seals on fire doors are now complete.	Completion of works	Completed	21/03/2024	Mercy Technical Services department
Preventative Action	The Mercy Technical Services department are currently on site replacing 5 fire doors. To facilitate the service, the doors are replaced one at a time per day.	Installation of fire doors	Achievable	30/06/2024	Mercy Technical Services department

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10005132		**The areas to be addressed within the training programme did not include training in cultural competence, human rights including the legal principles of restrictive interventions, positive behavioural support or the monitoring of the safety of the person during and after the physical restraint, 8.2(b)(iv-vii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A presentation on positive behavior support is in development by Psychology and 1st draft has been completed. This orientation session will be delivered to all staff on St Michael's Unit by 30.06.2024. The St Michael's HOD Restraint Reduction Working Group meeting takes place quarterly where all physical restraint documentation is reviewed ie Physical Restraint Management Booklet / COP Physical Restraint Audit /Clinical Practice Form. The Clinical Director	Compliance with the Code of Practice on Physical Restraint	Achievable	31/12/2024	1.North Lee Head of Psychology and all HOD 2.Clincal Director and Medical Team.

	issued a memo to all medical staff on best practices on the Code of Practice on the Use of Physical Restraint, Mechanical Means of Bodily Restraint, and Seclusion. Restraint practices is a standing agenda item on the monthly North Lee Consultants meeting. The Clinical Director North Lee issued a memo to all staff on 20th March, 2024 asking them to complete the Intercultural Awareness E-learning program on HSE Land.				
Preventative Action	A presentation on positive behavior support is in development by Psychology and 1st draft has been completed. This orientation session will be delivered to	Compliance with Code of Practice	Achievable	31/12/2024	1. North Lee Head of Psychology 2. Clinical Director and Medical Team

	all staff on St Michael's Unit by 30.06.2024. The St Michael's HOD Restraint Reduction Working Group meeting takes place quarterly where all physical restraint documentation is reviewed ie Physical Restraint Management Booklet / COP Physical Restraint Audit /Clinical Practice Form. The Clinical Director issued a memo to all medical staff on best practices on the Code of Practice on the Use of Physical Restraint, Mechanical Means of Bodily Restraint, and Seclusion. Restraint practices is a standing agenda item on the monthly North Lee Consultants meeting. The Clinical Director				

	North Lee issued a memo to all staff on 20th March, 2024 asking them to complete the Intercultural Awareness E-learning program on HSE Land.				

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.

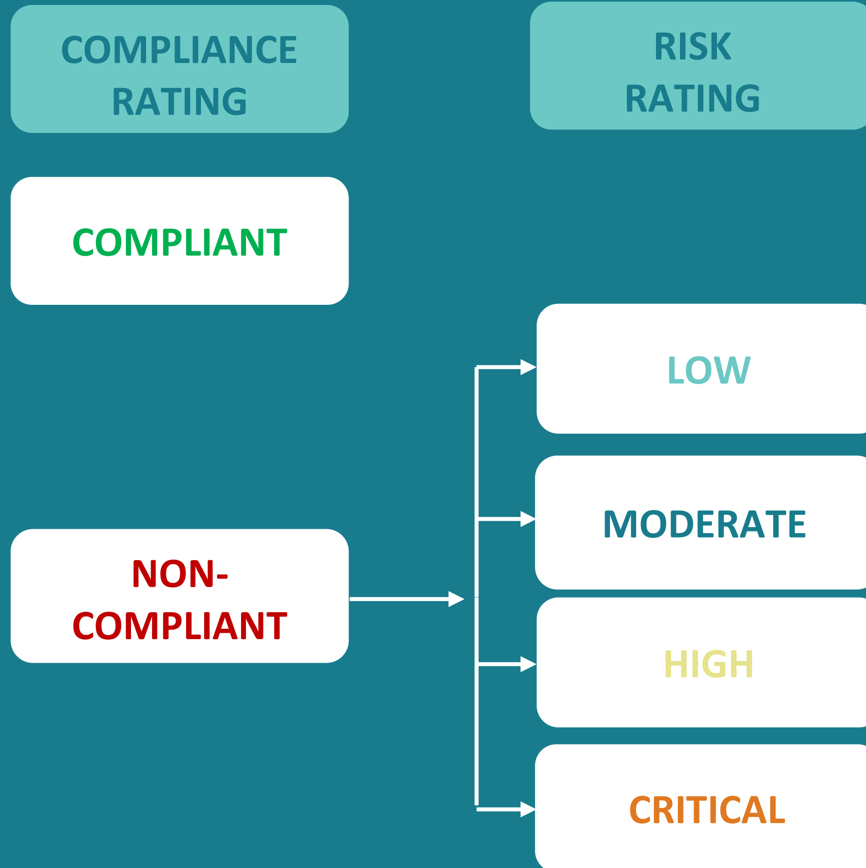
Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services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



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.