St John of God Hospital

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mental health commission

Annual Inspection
Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

ST JOHN OF GOD HOSPITAL

Stillorgan, Co Dublin, A94 YX77

Date of Publication: 21st June 2024

ID Number: AC0126

2023 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care
Psychiatry of Later Life
Mental Health Care for People with Intellectual Disability

Conditions Attached:
None

Most Recent Registration Date:
17 May 2022

Registered Proprietor:
St John of God Hospital CLG

Registered Proprietor Nominee:
Ms Sarah Almasry, Interim Chief Executive

Inspection Team:
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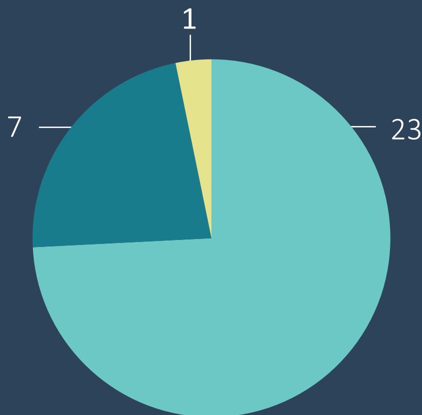
Professor James V Lucey MCRN000646

Inspection Date:
28 November – 1 December 2023

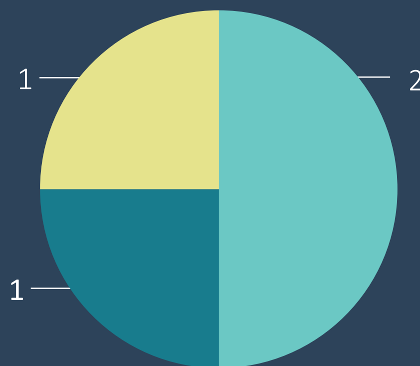
Previous Inspection date:
26 – 29 April 2022

Inspection Type:
Announced Annual Inspection

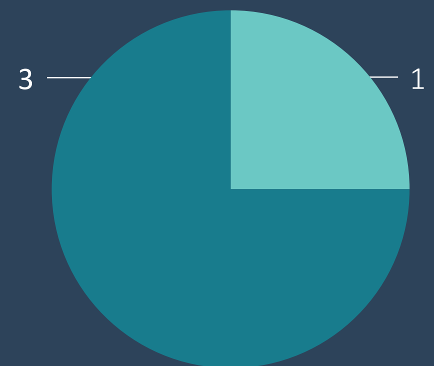
2023 COMPLIANCE RATINGS



REGULATIONS



RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



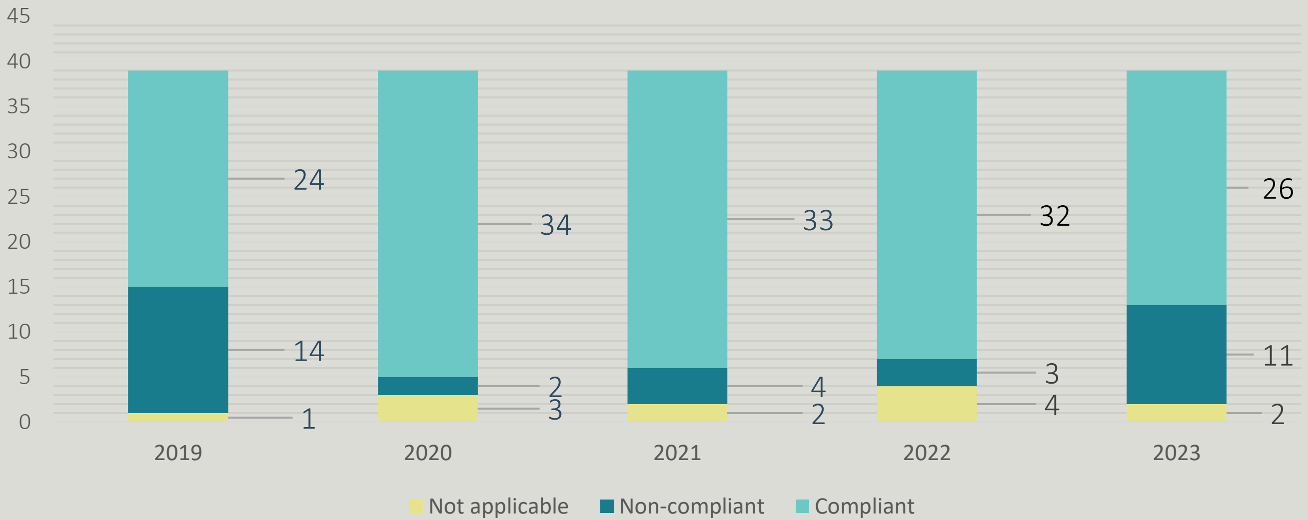
CODES OF PRACTICE

Compliant | Non-Compliant | Not applicable

RATINGS SUMMARY 2019 – 2023

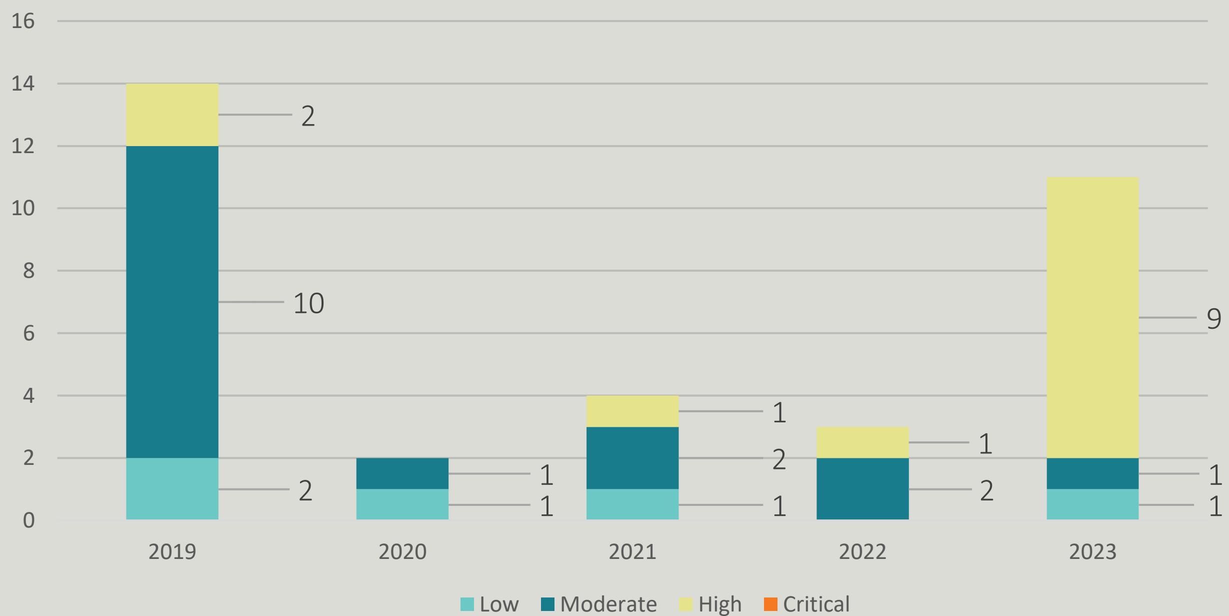
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Professor James V Lucey

In brief

St. John of God Hospital CLG was located off the Stillorgan dual carriageway in County Dublin. It provided mental health care for adults and later life care. There were seven separate wards and nine general adult psychiatric treating teams. Generally, residents were admitted to a ward under the care of a named treating consultant psychiatrist and a multi-disciplinary team (MDT). The approved centre was registered for 168 beds and at the time of the inspection accommodated 140 residents.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	63%	94%	89%	91%	70%

Conditions to registration

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

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

Enforcement Action	Date applied	Reasons	Outcome
Immediate action notice 10000290	*02/08/2023*	*This action notice was issued prior to the inspection. Following the admission of a child, for the purposes of seclusion, the MHC issued this immediate action notice as the service had not*	*Approved centre submitted audits which demonstrated failure to comply with rules and codes. Provided plan to address this non-compliance. However, would not commit to no additional admission of children being admitted to the adult*

		demonstrated how it has complied with the Rules Governing the Use of Seclusion, Code of Practice on Physical Restraint, and the Code of Practice Relating to the Admission of Children under the Mental Health Act 2001.	*unit so Regulatory Compliance Meeting was scheduled.*
Regulatory compliance meeting 1000230	*06/10/2023*	*This action notice was issued prior to the inspection. Approved centre would not commit to no additional admission of children being admitted to the adult unit so Regulatory Compliance Meeting was scheduled.*	*Approved centre gave commitment that it was not policy to admit children to the adult unit.*
Immediate action notice	*20/12/2023*	*This action notice was issued following the inspection. On inspection the approved centre was non-compliant with 12 Regulations/Rules/Codes of Practice and one of these, Regulation 19: General Health, was risk rated as critical.*	*The approved centre outlined measures to comprehensively address identified non-compliance with Regulation 19: General Health*

Safety of people in the approved centre

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

- ***Cleanliness***: The approved centre, including toilets, bathrooms and kitchens, were clean.
- ***Fire safety:*** There were no identified concerns with fire safety in the approved centre.
- ***Number of registered nurses in the approved centre*****:** There were sufficient staff in all the departments except nursing. At the time of inspection, the eleven bed Riversdale ward was closed due to nursing staff shortages.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*****:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Maintenance:*** There was a maintenance programme and there were no safety hazards in the approved centre.
- ***Infection control*****:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Ligature risks:*** were not minimised to the lowest practical level based on risk assessment.
- ***Mandatory training:*** Not all staff were trained in fire safety, safeguarding, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Access to essential information*****:** While residents' records were secure and up-to-date, residents' records were not kept in good order and were not easy to retrieve, as some documents were stored in a back-pocket of the paper files and some files had loose pages.
- ***Access to essential information: Register of Residents:*** The approved centre's register of residents did not contain the diagnosis on admission or the diagnosis on discharge of all residents.

Appropriate care and treatment of residents

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

- **Appropriateness of environment:** The layout and the decoration of the approved centre was of a high standard.
- ***Multi-disciplinary team working:*** Residents were admitted to a ward under the care of a named treating consultant psychiatrist and a multi-disciplinary team (MDT). These teams comprised of occupational therapy, social work, nursing, and psychology staff. Four MDTs also had a pharmacist. All other teams had access to a liaison pharmacist, who was assigned to the team, but didn't attend the MDT meetings.
- ***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:

- ***General Health:*** The six-monthly health assessments documented a physical examination, family history, personal history, blood pressure, nutritional status, and medication review. Regulation 19: General Health was risk rated high and the following deficits were found on inspection in a sample of five clinical files inspected: Residents' general health needs were not appropriately assessed every six months due to:
  a) Four inspected files did not document dental health.
  b) No inspected files documented smoking status.
  c) Two inspected files did not document body-mass index, weight, or waist circumference.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) and all ICPs were a composite set of documents. The following discrepancies were found on inspection in a sample of ten individual care plans inspected: Three of ten residents did not have a documented set of goals developed by the multi-disciplinary team, two of ten residents did not have their care and treatment, or therapeutic interventions documented, and there was no proof that three of ten residents' individual care plans were reviewed by the multi-disciplinary team.

- ***Discharges:*** The clinical file of one resident who had been discharged from the approved centre was examined. An estimated date of discharge was recorded in the resident's individual care plan, but there was no evidence of a discharge plan or a discharge summary in the resident's clinical file.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** Accommodation varied from ward to ward. There were 42 single ensuite bedrooms that were used to meet the assessed needs of patients.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** Residents' dignity and privacy were respected.
- ***Use of restrictive practices:*** The approved centre had a reduction of restrictive practices strategy. Mechanical Restraint was not used in the approved centre. Physical Restraint and separately seclusion was used in the approved centre only when less restrictive alternatives were deemed unsuitable. The approved centre was not compliant with the Code of Practice on Physical Restraint for five different reasons. In addition, the approved centre was not compliant with the Rule on Seclusion for eight reasons in a sample of three seclusion episodes inspected.
- ***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.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise different religions 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***: The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities were accessible on weekdays and during the weekend.
- ***Residents' feedback:*** The majority of residents were very complimentary about the environment, food, and therapeutic and recreational activities provided, and the care they received. Thirty-two residents spoke with the inspection team, and the inspection team received thirty-four completed feedback questionnaires from residents. *(Please refer to section 5.0 of the report for detailed service-user feedback).*

- **However: Rights-based care: Child Admission:** The clinical file of one child who had been admitted to the approved centre for the purpose of seclusion was inspected. Age-appropriate facilities were not provided as the child was admitted to an adult approved centre. There was no evidence that provisions were in place to ensure the right of the child to have their views heard. Appropriate accommodation was not designated as the child was admitted to an adult approved centre for the purpose of seclusion.

Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was managed by the St John of God Hospital CLG with an independent Board of Directors and an interim Chief Executive who reported to the board.
- ***Leadership:*** The executive management team within the approved centre met monthly. The chief executive, the clinical director, the director of nursing, the head of finance, the human resource manager and the chief operations officer were on the executive management team. The clinical leads for social work, psychology, occupational therapy, and pharmacy had not attended these meetings in 2023. As line manager of the clinical leads, the clinical director was clinical representative and a member of the executive management team during this period. A review of the management team structures was underway at the time of the inspection.
- ***Clinical governance:*** There was a Clinical Governance, Quality and Safety Executive committee that met monthly and a number of sub-committees. The Clinical Effectiveness & Quality Improvement working group was made up of at least six staff members who met formally six-weekly and informally as required.
- ***Restrictive practices reduction:*** The approved centre had a reduction of restrictive practices strategy.
- ***Risk:*** There were clear processes within the organisation for the management of risk. Each ward had its own dashboard or area on the hospital wide Information Technology system known as Datix. Each ward held a local risk register and applicable risks were escalated to the corporate risk register, which was regularly reviewed by the operational management team.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement. The approved centre had implemented four quality initiatives since the last inspection,
- ***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. The complaints, compliments, and feedback systems were publicly displayed and were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** The Peer Advocate in Mental Health representative attended the hospital weekly.
- ***Regulatory compliance and engagement:*** The approved centre has had a high average compliance rate of 86% over the last 4 years. The compliance rate decreased by 23% since last year. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

However:

- ***Safety: Risk:*** Ligature points were not minimised to the lowest practical level, based on risk assessment and not all staff were trained in fire safety, basic life support, management of violence and aggression, and the Mental Health Act 2001.
- ***Safety: Risk Management Procedures:*** Was not compliant and was risk rated high for the following deficits: Not all health and safety risks had been identified, analysed, evaluated or treated because a ligature audit had not been carried out on all open units. Not all corporate risks had been treated because eleven registered beds were not in use at the time of the inspection, and, separately: five actions required to mitigate the financial sustainability risk, which was rated extreme, were listed as "yet to be designed".
- ***Restrictive practices reduction: Physical Restraint:*** The approved centre was not compliant with the Code of Practice on Physical Restraint for five reasons in a sample of three physical restraint episodes inspected, one reason was: an in-person debrief did not occur within two working days of two episodes of physical restraint.
- ***Restrictive practices reduction: Seclusion:*** The approved centre was not compliant with the Rule on Seclusion for eight reasons in a sample of three seclusion episodes inspected, one reason was: no in-person debrief or multi-disciplinary review had followed one episode of seclusion.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A psychoeducational initiative entitled the “Healthy Relationships Group” for female inpatients age 18-25 years old commenced in October 2023. This group explored what constitutes healthy interpersonal relationships and how to recognise signs of abusive or coercive behaviour.

2. An inter-agency Sexual Safety Working Group was established in September 2023 to oversee safeguarding of vulnerable adults in the approved centre.

3. Dialectic behaviour therapy and compassion focused therapy were made available to residents again in 2023, having not been available since the onset of the COVID-19 pandemic.

4. The nursing department introduced an adaptation programme for international nurses who did not qualify in Ireland. This programme allowed international nurses achieve registration with the Nursing and Midwifery Board of Ireland. This recruitment initiative addressed some of the nursing staff deficits in St. John of God Hospital CLG.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

St. John of God Hospital CLG was located off the Stillorgan dual carriageway in County Dublin. Originally built in 1882, the campus was set amongst expansive well-matured greenery and gardens. There were seven separate wards or suites and nine general adult psychiatric treating teams. Three additional adult teams for the Cluain Mhuire Services also provided care and treatment to residents under their care in the approved centre.

St. Camillus suite was designated for the assessment, care, and treatment of residents with an addiction disorder. St Brigid's unit provided for the assessment and treatment of eating disorders and general adult mental health care. St. Peter's suite was allocated for residents who presented in an acute phase of their illness and who required intensive nursing and medical care. St. Peter's also had a seclusion facility. St. Paul's and St. Joseph's suites also served acute admissions but had lower levels of therapeutic security than St. Peter's suite. The Carrickfergus suite was a specialist suite for psychiatry of later life residents.

Residents were admitted to a suite under the care of a named treating consultant psychiatrist and a multi-disciplinary team (MDT). These teams comprised of occupational therapy, social work, nursing, and psychology staff. Four MDTs also had a pharmacist. All other teams had access to a liaison pharmacist, who was assigned to the team, but didn't attend the MDT meetings. All residents had access to the pharmacy department which provided a community pharmacy service for outpatients and for residents upon discharge. There was a pastoral care team, a multi-faith room and a church on site. Occupational therapy was provided directly in the suites and in a dedicated occupational therapy corridor, with group rooms, activity rooms and an occupational therapy kitchen.

Accommodation varied from suite to suite. There were 42 single ensuite bedrooms that were used to meet the assessed needs of patients. Residents were usually accommodated in a single room upon admission and transferred to shared accommodation shortly afterwards. These were double bedrooms and to a lesser degree four bedded rooms.

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

Resident Profile	
Number of registered beds	***168***
Total number of residents	**140**
Number of detained patients	6
Number of wards of court	3
Number of children	0
Number of residents in the approved centre for more than 6 months	7
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

St. John of God Hospital was founded by the Hospitaller Order of Saint John of God and was a subsidiary of Saint John of God Hospitaller Ministries CLG. The approved centre was managed by the St John of God Hospital CLG with an independent Board of Directors and an interim Chief Executive who reported to the board. Two core committees, the Business and Audit Committee and Clinical Governance, Quality and Safety Committee, were comprised of board members who met on alternate months, six times a year each. A third committee, Governance, Performance & Nominations Committee convened at least twice a year.

The executive management team within the approved centre met monthly and comprised the chief executive, the clinical director, the director of nursing, the head of finance, the human resource manager, and the interim chief operations officer. The clinical leads for social work, psychology, occupational therapy, and pharmacy had not attended these meetings in 2023. As line manager of the clinical leads, the clinical director was clinical representative and a member of the executive management team during this period. A review of the management team structures was underway at the time of the inspection. There was a Clinical Governance, Quality and Safety Executive committee that also met monthly. Sub-committees included the Risk Committee, Health and Safety Committee, Clinical Audit Committee, Seclusion and Restraint Reduction Committee, Patient Satisfaction, Complaints and Compliments group, and the Clinical Effectiveness & Quality Improvement working group. The Clinical Effectiveness & Quality Improvement working group was comprised of at least six staff members who met formally six-weekly and informally as required. Quality improvement activities included supporting participants in quality improvement training, identifying projects relevant to strategic priorities, disseminating stories of improvement, and identifying ways of rewarding improvers and researchers.

There were clear processes within the organization for the management of risk. There was a risk manager who had overall responsibility for risk and incident management. Each suite had its own dashboard or area on the hospital-wide Information Technology system known as Datix. Each suite held a local risk register and there were defined processes for escalation and de-escalation of risks to and from the organisational risk register which was reviewed regularly by the operational management team. Not all risks were identified, analysed, evaluated, or treated because three of the six open suites had no ligature audit completed. Risks were further escalated to the corporate risk register if required, which was specifically for risks pertaining to St. John of God Hospital with oversight from the CEO. Not all corporate risks were effectively treated at the time of the inspection because one suite was closed due to staffing issues. Separately, five actions required to mitigate financial sustainability risks were documented as “to be designed”. There was a new risk register called the enterprise risk register introduced since the last inspection. The risks included on that register were from all facets of the St. John of God CLG group. Incident management was also the responsibility of the risk manager. There were clear processes for reporting and reviewing incidents and near misses. Any incident risk rated as moderate or higher was reviewed by the Local Incident Management Team.

There was an organisational chart defining key personnel, lines of responsibility and accountability. Clinical staff comprised of medical personnel, health and social care professionals, pharmacy, and nursing staff. There were sufficient staff in all the departments except nursing. At the time of inspection, the eleven bed Riversdale suite was closed due to nursing staff shortages. There were active recruitment campaigns on-going to address the issue. There was a twelve-week adaptation programme for nurses who trained outside

Ireland, to come to Saint John of God Hospital and undertake a period of adaptation. On successful completion of this programme these candidates are eligible for registration with the Nurse and Midwifery Board of Ireland. There were blended educational and clinical practice modules on the conversion course. There were plans to increase the intake of nurses on that programme and continue all other recruitment activities to reopen Riversdale unit by April 2024. There were clinical leads for each discipline. The leads for occupational therapy, social work, psychology, and pharmacy managed a clinical load with time reserved for their management and clinical supervision functions. Each of these disciplines reported to the clinical director who also managed medical staff. There was a director of nursing who managed all nursing staff. Each department had its own professional meetings, supervision, and peer support structures. The approved centre was also a teaching and placement facility for both undergraduate and postgraduate students. There was a primary affiliation with University College Dublin (UCD) for both medical and nursing students.

The Peer Advocate in Mental Health representative attended the hospital weekly. The approved centre had a Consumer and Carer's Council (CCC). In line with core values of the hospital, this group sought to act in an advocacy role by representing the views, experiences and needs of residents and their families, and to work in partnership with hospital management to improve and develop patient-centred and recovery-orientated services. Membership of this group was open to former residents (six months post discharge), carers, outpatients, and members of the public. The group met at least six times a year.

The complaints, compliments, and feedback systems were publicly displayed. Formal complaints were dealt with by a complaints officer who was based in the approved centre. Each resident received an admission pack with included a patient satisfaction survey.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 15: Individual Care Plan	✗	High	✓		✓		✓		✗	High
Regulation 19: General Health	✗	Moderate	✗	Moderate	✗	Low	✗	Moderate	✗	High
Regulation 22: Premises	✗	Low	✓		✓		✓		✗	High
Regulation 26: Staffing	✗	Moderate	✓		✓		✗	Moderate	✗	Moderate
Regulation 27: Maintenance of Records	✗	Moderate	✓		✓		✓		✗	High
Regulation 28: Register of Residents	✗	Moderate	✗	Low	✓		✓		✗	Low
Regulation 32: Risk Management Procedures	✓		✓		✓		✓		✗	High
Rules Governing the Use of Seclusion	✗	Moderate	✓		✓		✓		✗	High
Code of Practice for the Use of Physical Restraint	✗	Moderate	✓		✓		✗	High	✗	High
Code of Practice for the Admission of Children	✓			N/A	✗	Moderate		N/A	✗	High
Code of Practice for the Admission, Transfer and Discharge	✗	Moderate	✓		✗	High	✓		✗	High

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

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children’s Education	As no child with educational needs had been admitted to the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As the approved centre did not use mechanical means of bodily restraint, this rule was not applicable.

5.0 Service-user Experience

5.1 Service-user feedback

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

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

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.

Thirty-two residents availed of the opportunity to speak with the inspection team. The vast majority of residents who met with the inspection team were very happy with their care and treatment, the quality of the accommodation, food, therapeutic and recreational activities provided in St. John of God Hospital. Some areas of concern were expressed by individual residents, including tight spaces in bathrooms on Carrickfergus suite, insufficient hot water for showers on Carrickfergus suite (this was relayed to management at the time of the inspection and remedied during the inspection), and insufficient therapeutic programmes on St Peter's suite.

The inspection team received thirty-four completed feedback questionnaires from residents. Twenty-one of these indicated residents were orientated on admission, were involved in all aspects of care planning, were respected, and had their dignity and privacy upheld by staff, residents could speak to staff about any issues they were having and rated the standard of care as eight or above. Some comments included in the questionnaire were "this hospital provides a positive nurturing environment, couldn't be more satisfied" and "staff are very good and compassionate".

From the completed questionnaires received, eleven residents indicated they didn't always feel safe in the approved centre. Twelve residents indicated they would like more therapeutic and recreational activities. Thirteen residents indicated they were not involved in all aspects of care planning. Sixteen residents indicated they couldn't always give feedback to staff or make complaints.

5.2 Advocacy

The approved centre had an advocacy service.

The inspection team contacted the advocate did not receive a report from the advocate. The advocate visited residents in the approved centre on a weekly basis. The process for advocate feedback was to provide monthly reports to hospital management.

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:

- Interim Chief Executive Officer
- Interim Chief Operations Officer
- Senior Pharmacist
- Director of Nursing
- Deputy Director of Nursing
- Senior Psychologist
- Catering Manager

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

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

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

The approved centre was compliant with this regulation.

Regulation 5: Food and Nutrition

COMPLIANT

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

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

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups of the food pyramid. Residents had at least two choices for meals from a five-weekly menu cycle.

Safe, fresh drinking water was available to residents at all times from water dispensers in easily accessible locations throughout the approved centre.

The nutritional and dietary needs of residents with special dietary requirements were assessed and addressed in the resident’s individual care plan.

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

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

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

INSPECTION FINDINGS

Residents were provided with appropriate emergency personal clothing that considered their preferences, dignity, bodily integrity, religious and cultural practices. The approved centre had ready prepared packs of clothing that included underwear, tops and bottoms and could be accessed at any time by staff from any unit. There were ample supplies of supplementary clothing, a log of stock and an account with a nearby retailer to replenish stocks as necessary.

Residents changed out of night clothes during daytime hours, unless their individual care plan specified otherwise.

The approved centre was compliant with this regulation.

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for residents' personal property and possessions. The policy was last reviewed in March 2022.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities, including lockers and safes, were provided for the safekeeping of the resident's monies and valuables, as necessary. Residents were advised to keep property to a minimum and to send valuables home or to the cash office.

On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The checklist was updated on an ongoing basis, in line with the approved centre's policy. The property checklist was kept separate to the resident's individual care plan and was available to the resident.

Residents were supported to manage their own property, unless this posed a danger to the resident, or others as indicated in their individual care plan or in accordance with the approved centre's policy.

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. Recreational activities were accessible on weekdays and during the weekend. Activities included television, books, board games, arts and crafts, yoga, Zentangle, table quizzes and Pilates. Other activities and facilities that were available outside the wards included gym sessions, the Irish Heart Foundation's 'Slí na Slainte' walk, a pitch and putt course, a tennis court, a football field, and a basketball court.

The approved centre was compliant with this regulation.

Regulation 10: Religion

COMPLIANT

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

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. A Roman Catholic church in the approved centre held regular services and those services were streamed via CCTV to the wards. Two chaplains were accessible to residents and a multi-faith room accessible to all residents had scriptures from numerous religious denominations. A list of ministers of various faiths that could be contacted was available on request.

The approved centre was compliant with this regulation.

Regulation 11: Visits

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

Visiting times were appropriate and reasonable. Visiting times were displayed on notice boards and in the resident information booklet. Visits outside of the visiting hours were facilitated if required. Visits frequently took place in the hospital café and a private visitors room was available to residents. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visitors room was suitable for visiting children.

The approved centre was compliant with this regulation.

Regulation 12: Communication

COMPLIANT

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for communication. The policy was last reviewed in February 2022.

Residents on all wards had access to a phone box and a mobile ward phone, unless otherwise risk-assessed with due regard to the resident’s well-being, safety, and health. The clinical director or senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation.

Regulation 13: Searches

COMPLIANT

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the conducting of searches. The policy was last reviewed in March 2022, 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. Where consent was not received, this was documented and the process relating to searches without consent was implemented. 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. In all three of the searches inspected, 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 are found as a result of a search.

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 protocols for the care of residents who are dying. The policy was last reviewed in February 2023.

The clinical file of one resident who had died suddenly in the approved centre was inspected. The death 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.

All deaths of any resident within the approved centre were notified to the Mental Health Commission as soon as was practicable and no later than within 48 hours of the death occurring.

The approved centre was compliant with this regulation.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

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

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

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents. Specific sections were allocated for needs, goals, treatment, care, resources required, as well as space for reviews. The ICPs were stored within the clinical file, were identifiable and uninterrupted and were not amalgamated with progress notes.

Three ICPs did not contain a documented set of goals developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. The documented goals in these three ICPs were the same as the goals identified for those residents on previous admissions. The other seven ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin, as appropriate.

All ICPs identified goals for the resident, but two of the ten inspected did not identify the care, treatment or therapeutic interventions required to meet those goals. Seven of the ICPs were reviewed by the MDT in consultation with the resident weekly in an acute setting, but three of the ICPs did not contain a review by the MDT. As a result, those three ICPs were not updated as indicated by the resident's changing needs, conditions, circumstances, and goals.

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

a) **The registered proprietor did not ensure that three of ten residents had a documented set of goals developed by the multi-disciplinary team, 15.**
b) **Two of ten residents did not have their care and treatment, or therapeutic interventions documented, 15.**
c) **The registered proprietor did not ensure that that three of ten residents' individual care plans were reviewed by the multi-disciplinary team, 15.**

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

There was an occupational therapy corridor, where residents from the various suites attended by arrangement. Examples of group programmes included; Mindfulness and Mindful Movement, Recovery and Wellness Recovery Action Planning (WRAP), Relaxation, Morning Lectures: Self Care/Self Compassion, Life Skills, and a Bereavement Loss & Change group. Specific therapy programmes were provided in specialist suites for eating disorders and addiction issues.

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 operational policy and protocols for the transfer of residents. The policy was last reviewed in November 2023.

The clinical file of one resident who had been transferred to a general hospital was inspected. Full and complete written information on the resident was transferred when they moved from an approved centre to another facility. This information consisted of a letter of referral, including a list of current medications and a resident transfer form , and was sent to a named individual.

The approved centre was compliant with this regulation.

Regulation 19: General Health

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which included procedures for responding to medical emergencies, which was last reviewed in November 2022.

The approved centre had an emergency trolley and staff had access at all times to an automated external defibrillator (AED).

Residents received appropriate general health care interventions in line with their individual care plans. Residents' general health needs were monitored and assessed as indicated by the residents' specific needs and not less than every six months.

Five clinical files were examined in relation to the provision of general health services during the inspection process. The six-monthly health assessments documented a physical examination, family history, personal history, blood pressure, nutritional status, and medication review.

Four of the five health assessments reviewed did not document the resident's dental health; and none of the health assessments documented the resident's smoking status; and two of the five general health assessments did not document the resident's body-mass index, weight, or waist circumference.

Residents on anti-psychotic medication had an annual assessment of their glucose regulation, blood lipids, prolactin, and electrocardiogram heart function.

Adequate arrangements were in place for residents to access general health services and for their referral to other health services as required.

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

a) **The residents' general health needs were not appropriately assessed every six months as four of five inspected files did not document dental health, 19 (1)(b).**
b) **The residents' general health needs were not appropriately assessed every six months as no inspected files documented smoking status, 19 (1)(b).**
c) **The residents' general health needs were not appropriately assessed every six months as two of five inspected files documented body-mass index, weight, or waist circumference, 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 policy and procedures in place for the provision of information to residents. The policy was last reviewed in November 2023.

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

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

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

The approved centre was compliant with this regulation.

Regulation 21: Privacy

COMPLIANT

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

INSPECTION FINDINGS

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

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

The approved centre was compliant with this regulation.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards such as large open spaces, steps and stairs, slippery floors and hard and sharp edges and surfaces were minimised in the approved centre. Ligature points were not minimised to the lowest practicable level based on risk assessment. High risk ligature anchor points were observed on the Carrickfergus suite, St Paul's suite and St Brigid's suite.

The approved centre was kept in a good state of repair externally and internally. A programme of general and decorative maintenance, cleaning, decontamination, and repair of assistive equipment was recorded. The centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed not to have high surface temperatures. Current national infection control guidelines were followed.

The approved centre had sufficient toilets and showers for all residents, including assisted toilets. A designated cleaning room and sluice room, as well as assistive devices and equipment to address resident

needs, were in place in the approved centre. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

The approved centre was non-compliant with this regulation because the overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff, and visitors, as ligature risks were not minimised to the lowest practical level based on risk assessment, 22(3).

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in April 2022, and included the following requirements:

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

All residents had a Medication Prescription and Administration Record (MPAR). Ten MPARs were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including a record of any allergies or sensitivities to medications, the frequency of administration, all medications administered and the date of discontinuation of each medication. The Medical Council registration number of every medical practitioner prescribing medication to the resident was also recorded.

All entries in the MPARs were legible and included the signature of the medical practitioner or nurse prescriber for each entry. Medication was reviewed or rewritten at least every six months, or more frequently in the event of any significant change in the resident's care or condition. When medication was 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. Schedule 2 and 3 controlled drugs were locked in a separate cupboard from other medicinal products.

The approved centre was compliant with this regulation.

Regulation 24: Health and Safety

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written policy and processes for 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 November 2023 and included the purpose and function of using CCTV, in relation to the observation of a resident.

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

The use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras used to observe residents in the wards were incapable of recording or storing a resident's image in any form; CCTV cameras used in the main corridors recorded footage only as part of the approved centre's security protocols. Images used to observe residents could only be seen by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating **MODERATE**

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

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

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

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

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

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

INSPECTION FINDINGS

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

The numbers and skill mix of staffing in the approved centre were sufficient to meet resident needs. There were nine multi-disciplinary teams in the approved centre. These included medical, nursing, psychology, social work, occupational therapy, and pharmacy staff. There was access to other specialist services such as a dietitian and speech and language therapist via private procurement arrangements.

An appropriately qualified staff member was on duty at all times. Not all healthcare staff were trained in basic life support, fire safety, the management of violence and aggression or the Mental Health Act 2001. The Mental Health Act 2001, the associated regulation (S.I. No.551 of 2006), and all other relevant Mental Health Commission documentation were available to staff throughout the approved centre. The table below gives a breakdown of the numbers and percentages of staff trained in each of the four mandatory subjects.

Staff Training Table

Profession	Basic Life Support		Fire Safety		Management Of Violence and Aggression		Mental Health Act 2001	
Nursing (97)	85	88%	79	81%	73	75%	95	98%
Consultant Psychiatrist (9)	9	100%	6	67%	4	44%	9	100%

Medical (10)	7	70%	7	70%	7	70%	8	80%
Occupational Therapist (7)	7	100%	7	100%	5	71%	7	100%
Social Worker (8)	7	88%	8	100%	7	88%	8	100%
Psychologist (7)	7	100%	7	100%	7	100%	6	86%
Pharmacist (8)	8	100%	7	88%	8	100%	8	100%

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

a) **Not all staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice as some staff were not trained in fire safety, basic life support or the management of violence and aggression, 26(4).**
b) **Not all staff were trained in the Mental Health Act 2001, 26 (5).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for the maintenance of records. The policy was last reviewed in March 2022. The policy covered the following provisions:

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

Residents' records were secure and up to date but were not kept in good order. Not all resident records were physically stored together, as the approved centre used electronic and paper records. Resident records were not developed and maintained in a logical sequence or in good order. The paper records were not maintained in a logical sequence as a pocket on the back of the folder where the documents were stored made documents difficult to find. Some of the clinical files inspected had loose pages.

All resident records were reflective of the residents' status and the care and treatment being provided. Records were appropriately secured from loss or destruction, tampering and unauthorised access or use. Documentation of food safety, health and safety and fire inspections were maintained.

The approved centre was non-compliant with this regulation because the residents' clinical files were not maintained so as to ensure ease of retrieval, as some documents were stored in a back-pocket of the paper files and some files had loose pages, 27 (1).

Regulation 28: Register of Residents

NON-COMPLIANT

Risk Rating **LOW**

(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 kept an electronic documented register of residents, which was up to date. The register did not contain all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006. Specifically, it did not record all residents' diagnosis on admission (or provisional diagnosis where diagnosis is not available) or all residents' diagnosis on discharge.

The approved centre was non-compliant with this regulation because the register of residents did not contain the diagnosis on admission or the diagnosis on discharge of all residents, 28 (2).

Regulation 29: Operating Policies and Procedures

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 30: Mental Health Tribunals

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

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

The approved centre was compliant with this regulation.

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating HIGH

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

- The roles and responsibilities for risk management and the implementation of the risk management policy within the approved centre.
- The process for identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register and the record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

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

The risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Clinical risks were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate; however, there were outstanding health and safety risks.

Ligature audits had not been carried out for three of the six units occupied by residents at the time of the inspection. Structural risks were not removed or effectively mitigated. Ligature anchor points identified as high risk on ligature audits were not reduced to the lowest practicable level of risk.

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

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

The approved centre was non-compliant with this regulation for the following as not all health and safety risks had been identified, analysed, evaluated or treated because a ligature audit had not been carried out for three of the six units occupied, 32 (1).

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

An up-to-date certificate of registration was prominently displayed in the approved centre foyer.

Where changes had arisen in relation to the information detailed in the certificate of registration, this was communicated to the Mental Health Commission.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 59: The Use of Electro-Convulsive Therapy

COMPLIANT

Section 59
(1) A programme of electro-convulsive therapy shall not be administered to a patient unless either –
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable to give such consent –
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.
(2) The Commission shall make rules providing for the use of electro-convulsive therapy and a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such rules.

INSPECTION FINDINGS

Processes:
The approved centre had a written policy and procedures in relation to the use of Electro-Convulsive Therapy (ECT) for involuntary patients. The policy had been reviewed annually and was dated June 2023. It contained protocols that were developed in line with best international practice, including:

- How and where the initial and subsequent doses of Dantrolene were stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite. The ECT suite had a private waiting room, an adequately equipped treatment room and an adequately equipped recovery room. High-risk patients were treated in a rapid-intervention area.

ECT machines were regularly maintained and serviced and a record of maintenance was kept. An electroencephalogram (EEG) could be monitored on two channels. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia were prominently displayed.

A named consultant psychiatrist (CP) had overall responsibility for ECT management. A named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical file of one involuntary patient who was receiving ECT was examined. The CP assessed the patient's capacity to consent to receiving treatment, and this was documented in the patient's clinical file.

The patient was deemed unable to consent to receiving ECT. ECT was administered according to section 59(1)(b) of the Mental Health Act 2001. A *Form 16: Electroconvulsive Therapy Involuntary Patient (Adult) – Unable to Consent* was completed by two CPs for each ECT programme. The form was placed in the patient's clinical file and a copy of it was sent to the Mental Health Commission within five days.

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

The patient's cognitive functioning was monitored throughout each ECT programme. The CP reviewed the patient's progress and the need for continuation in consultation with the patient.

A pre-anaesthetic assessment was documented in the clinical file, and an anaesthetic risk assessment was recorded. Anaesthetic agents used and the patient's response and recovery were recorded, signed by the anaesthetist, and placed in the clinical file. ECT was only given by a registered medical practitioner and was administered by a constant current, brief pulse ECT machine. The ECT record was completed after each treatment, then placed in the clinical file signed by the registered medical practitioners administering ECT. The ECT register was completed on conclusion of the ECT programme. All pre ECT assessments including capacity to consent, pre-anaesthetic assessments, anaesthetic risk and mental state were detailed and documented in the clinical file. All post ECT assessments, including clinical status and patient progress were detailed and documented in the clinical file after each ECT session. The reasons for continuing or discontinuing ECT were recorded. Copies of all cognitive assessments were placed in the clinical file.

The approved centre was compliant with this regulation.

Section 69: The Use of Seclusion

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of seclusion. It had been reviewed annually and was dated March 2023. The policy addressed the following:

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

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

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

The approved centre had a policy in relation to the training of staff in relation to the use of seclusion. The policy addressed the following:

- Who will receive training based on the identified needs of persons who are secluded and staff.
- The areas to be addressed in the training programme.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in seclusion.

Training and Education: All staff who participated, or may participate, in the use of seclusion had received the appropriate training in its use and in the related policies and procedures. A record of attendance at training was maintained.

However, not all medical staff had signed a written record to show they had read and understood the policy.

Monitoring: A multi-disciplinary review and oversight committee, accountable to the registered proprietor nominee, was established to analyse in detail every episode of seclusion. The committee met at least quarterly and determined compliance with the rules governing the use of seclusion and with the approved centre's own policies and procedures for each episode of seclusion reviewed. The committee also identified and documented areas for improvement and actions, assured the registered proprietor nominee that seclusion was being carried out in accordance with the Mental Health Commission's Rules and produced a report following each meeting to promote on-going learning and awareness with staff.

Evidence of Implementation: Seclusion facilities were furnished, maintained and cleaned to ensure the patient's inherent right to personal dignity and to respect their privacy. The seclusion room was constructed to withstand high levels of violence with the potential to damage the physical environment. There were no ligature points or electrical fixtures. However, the bathroom door of the seclusion suite was not an adequate anti-barricade door.

The seclusion room allowed staff to clearly observe the patient within. Heating and air conditioning were externally controlled in the room. There were limited furnishings, all of which met current health and safety requirements. The room was large enough to support the patient and a team of staff. The patient had sight of a clock displaying the time, day and date.

As far as possible, the seclusion room was set away from communal sitting rooms and bedrooms, without being isolated. A window in the room gave a clear view of the outdoor environment, without being visible to unauthorised persons outside.

The patient had ready access to sanitary facilities and sanitary items, as appropriate. All furniture and fittings in the seclusion room were designed not to endanger the safety of the patient. Seclusion facilities were not used as bedrooms and bedrooms are not used as seclusion facilities. Following documented, suitable risk assessments, the patient had periods of access to secure outside areas and a record of daily outdoor access was maintained.

The clinical files of three patients who had been secluded were inspected. Seclusion was initiated by the most senior registered nurse (RN) on duty, following as comprehensive an assessment of the patient as practicable. This included a risk assessment, the outcome of which was recorded in the clinical file. The seclusion order was recorded in the clinical file and on the seclusion register. A registered medical practitioner (RMP) was notified of the seclusion episode within 30 minutes and medically examined the patient within two hours of the commencement of the episode. This included an assessment and record of any physical, psychological or emotional trauma caused to the patient as a result of the seclusion. No

later than 30 minutes following the medical examination, the RMP contacted the patient's consultant psychiatrist (CP) or the duty CP to inform them of the episode of seclusion. The RMP recorded the outcome of this discussion in the clinical file.

Where the CP ordered the continued use of seclusion, they also ordered the duration. No seclusion order was made for a period of time longer than four hours from the commencement of the seclusion episode. The CP's order confirmed that there were no less restrictive ways available to manage the patient's presentation. The CP undertook a medical examination of the patient and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The examination was recorded in the clinical file.

The patient was informed of the reasons for, likely duration of, and circumstances which lead to the discontinuation of seclusion, except where such information was prejudicial to their mental health, well-being or emotional condition. A record of this communication, or an explanation of why it did not occur, was recorded in the clinical file. In accordance with the patient's wish, their representative was informed of the seclusion and a record of this communication, or an explanation of why it did not occur, was entered in the clinical file.

The registered proprietor appropriately notified the Mental Health Commission of the start time and date and the end time and date of each episode of seclusion.

The clothing worn in seclusion respected the patient's right to dignity, bodily integrity and privacy. Bodily searches were only undertaken in exceptional circumstances, following a risk assessment and the outcome was recorded in the clinical file. Bodily searches were undertaken in the presence of more than one staff member and respected the dignity, bodily integrity and privacy of the patient. Gender, cultural sensitivity and the patient's preferences were respected.

Patients placed in seclusion were kept under direct observation by a RN for the first hour of seclusion, and under continuous observation and within sight and sound of a RN after the first hour. A written record of the patient was made by a RN every 15 minutes. Following risk assessment, a nursing review of the patient took place every two hours to assess whether the episode of seclusion could be ended. The assessment and decision were recorded. A medical examination was carried out by a RMP every four hours. The decision to end or continue seclusion was recorded. Upon commencement of an episode of seclusion, an appropriate seclusion care plan for the patient was developed by a RN.

The seclusion order was renewed by an order made by a RMP under the supervision of the CP or the duty CP following a medical examination, for a further period not exceeding four hours to a maximum of five renewals (24 hours) of continuous seclusion. Seclusion was ended by a RMP or RN at any time following discussion with the patient and a RMP or relevant nursing staff. The patient and the CP or duty CP were notified of the ending of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date seclusion was ended.

In one of the three inspected clinical files, an in-person debrief did not follow the episode of seclusion. No record was kept of the offer of a debriefing, whether it was accepted nor the outcome. The patient's

individual care plan (ICP) was not updated to reflect the outcome of the debrief nor the patient's preferences in relation to restrictive interventions going forward. No record of attendees present at the debrief was recorded in the clinical file.

In one of the three inspected clinical files, a debrief had been carried out but not all points to be addressed in the debrief were addressed. Specifically, the patient was not given an opportunity to have their representative attend the debrief.

Where the patient's representative was informed of their entering seclusion, the representative was also informed of the ending of the episode of seclusion as soon as practicable. A record of this communication, or an explanation why it did not occur, was entered in the clinical file. Appropriate emotional support was provided to the patient in the direct aftermath of the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion.

Seclusion was not used to ameliorate operational or staffing difficulties, as a punitive action, with mechanical restraint, solely to protect property or as a substitute for less restrictive interventions.

Two of the inspected episodes of seclusion were not reviewed by members of the multi-disciplinary team (MDT) involved in the patient's care and treatment and this was documented in the clinical file no later than five working days after the episode of seclusion. The MDT review recorded actions decided upon, and follow-up plans to eliminate or reduce restrictive interventions for the patient who had been secluded. However, there was no evidence of a debrief or MDT review document in the clinical file relating to one of the episodes inspected. Consequently, there was no record of actions decided upon or follow-up plans to eliminate or reduce restrictive interventions for the third patient.

The registered proprietor appointed a named senior manager who was responsible for the approved centre's reduction of seclusion.

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

a) **There was no record indicating that all staff involved in seclusion had read and understood the policy on seclusion, 10.2 (b).**
b) **The bathroom door in the seclusion suite was not an anti-barricade door, 8.1 (iii).**
c) **No in-person debrief or multi-disciplinary review had followed one episode of seclusion, 7.6 (i)–(vi).**
d) **No record was kept of the offer of a debriefing following one episode of seclusion, whether the offer was accepted and what the outcome was. The individual care plan was not updated to reflect the outcome of the debrief, and in particular, the patient's preferences in relation to restrictive interventions going forward, 7.8.**
e) **The clinical file of one patient who had been secluded did not include a record of the attendees present at the debrief following the episode of seclusion, 7.9.**

f) An in-person debrief that followed one episode of seclusion did not give the patient the option of having their representative or nominated support person attend the debrief, nor was an explanation recorded in the clinical file, 7.6 (vi).

g) One episode of seclusion was not reviewed by members of the multi-disciplinary team involved in the patient's care and treatment nor documented in the clinical file as soon as practicable or no later than five working days, 10.3.

h) As the multi-disciplinary team review was not documented, one episode of seclusion had no record of actions decided upon or follow-up plans to eliminate, or reduce, restrictive interventions in the patients clinical file, 10.4.

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

a) the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment; and
b) The consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.

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

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

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

a) the patient gives his or her consent in writing to the continued administration of that medicine, or
b) where the patient is unable to give such consent –
   i. the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and
   ii. the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

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

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

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

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

INSPECTION FINDINGS

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

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

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

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

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

10.0 Inspection Findings – Codes of Practice

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

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

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

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

Use of Physical Restraint

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy on the use of physical restraint. The policy had been reviewed annually and was dated March 2023. It addressed the following:

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

The approved centre had a written policy on the reduction of the use of physical restraint. It was last reviewed in March 2023 and addressed:

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

The approved centre had a policy in relation to the training of staff in relation to the use of seclusion. The policy addressed the following:

- Who would receive training based on the identified needs of residents who are restrained and staff.
- All the areas to be addressed within the training programme.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in physical restraint.

Training and Education: All staff who participated, or may participate, in the use of physical restraint had received the appropriate training in its use and in the related policies and procedures, and this training in accordance with the approved centre's policy. A record of attendance at training was maintained. However, a record was not maintained indicating that all staff involved in physical restraint had read and understood the policy.

Monitoring: A multi-disciplinary review and oversight committee in the approved centre which met at least quarterly and determined that there was compliance with the code of practice on the use of physical restraint and with the approved centre's own policies and procedures relating to physical restraint. The committee also identified and documented areas for improvement and the actions, persons responsible and the timeframes for the completion of actions. The committee assured the registered proprietor nominee that each use of physical restraint accorded with the Mental Health Commission's code of practice and produced a report following each meeting.

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. Physical restraint was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) in accordance with the approved centre's policy. The order confirmed that there were no other less restrictive ways available to manage the resident's presentation. The consultant psychiatrist (CP) or the duty CP was notified as soon as was practicable and this was recorded in the clinical file. The RMP completed a medical examination of the resident no later than two hours after the start of an episode of physical restraint and the order lasted a maximum of 10 minutes.

The relevant section of the clinical practice form (CPF) was completed by the person who initiated and ordered the use of physical restraint as soon as was practicable and no later than three hours after the conclusion of the episode of physical restraint. However, in none of the files inspected was the resident informed of the reasons for, and the circumstances leading to the discontinuation of, the physical restraint, nor was there an explanation why this information was withheld entered in the resident's clinical file.

As soon as was practicable, and in accordance with the resident's wish and their individual care plan (ICP), the resident's representative was informed of the restraint and a record of this communication was placed in the clinical file. The Mental Health Commission was appropriately notified of the start time and date and the end time and date of each episode of physical restraint.

Staff involved in the use of physical restraint took into account, where possible, any relevant entries in the resident's ICP pertaining to their specific requirements or needs in relation to the use of physical restraint. Staff members of the same gender were present at all times and all staff involved in the physical restraint had undertaken appropriate training in accordance with the approved centre's policy. The resident was continuously assessed throughout the use of the restraint to ensure their safety, and evidence of the observations were placed in the clinical file. Where residents were restrained in the prone position, this was recorded in their clinical file.

The person who led the physical restraint ended the restraint. The time, date and reason for ending the physical restraint was recorded in the clinical files on the date that the restraint ended.

An in-person debrief did not occur within two working days for two of the inspected episodes of physical restraint. The debriefs gave each resident an opportunity to discuss the physical restraint with members of the multi-disciplinary team (MDT) involved in their care and treatment; however, the details of these conversations were not appropriately recorded. There was not a record of a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the

future, nor of a discussion regarding each of the resident's preferences in relation to which restrictive intervention they would not like to be used, should a restrictive intervention be necessary in future. The ICP of two residents were not updated to reflect the outcome of the debrief, and in particular, their preferences in relation to restrictive interventions going forward.

A record of all attendees who were present at each debrief was recorded in the clinical files. Appropriate emotional support was provided to the resident following each episode of physical restraint and support was offered to other persons who may have witnessed the restraint.

The separate episodes of physical restraint were recorded in the clinical files and in the CPFs, and a copy of the CPF was placed in the clinical files. The MDT reviewed the episodes of physical restraint within five working days from the date of the restraint. The review included:

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

The MDT recorded actions decided upon, and follow-up plans to eliminate or reduce restrictive interventions for the residents. A named senior manager was responsible for the approved centre's reduction of physical restraint.

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

a) **Residents were not informed of the reasons for and the circumstances which lead to the discontinuation of the physical restraint, nor was there a record explaining why this had not occurred, 3.8.**
b) **An in-person debrief did not occur within two working days of two episodes of physical restraint, 5.3 (ii).**
c) **The in-person debrief of two episodes of physical restraint did not include a discussion regarding alternative de-escalation strategies nor a discussion regarding the resident's preferences, 5.3 (iv)–(v).**
d) **Two of the resident's individual care plans were not updated to reflect the outcome of the debrief and in particular their preferences in relation to restrictive interventions going forward, 5.5.**
e) **There was no written record to indicate that all staff involved in physical restraint had read and understood the policy on the use of physical restraint, 7.2 (b).**

Admission of Children

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy in relation to the admission of a child, which was last reviewed in July 2020. It addressed the following:

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

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

Evidence of Implementation: The clinical file of one child who had been admitted to the approved centre for the purpose of seclusion was inspected.

Age-appropriate facilities and a programme of activities appropriate to the child's age and ability were not provided. Provisions were in place to ensure the safety of the child and to respond to the child's special needs as a young person in an adult setting, but provisions were not in place to ensure the right of the child to have their views heard.

Staff having contact with the child had undergone Garda or police vetting and copies of the Child Care Act 1991, Children Act 2001, and Children First guidelines were available to relevant staff. Staff observation acknowledged gender sensitivity and observation arrangements, including assignment of designated staff member, were provided as considered clinically appropriate.

The child had access to age-appropriate advocacy services. Their rights were explained and information about the ward and facilities were provided in a form and language they could understand. Attempts were made to explain the use of seclusion to the child and their parents were made aware. However, the child was noted as being under a high level of distress and consequently the clinical file did not record their understanding of the explanation given.

Appropriate accommodation was not designated for the child, as the seclusion facilities were not age appropriate.

The specialist child and adolescent mental health team retained clinical responsibility for the resident while they were an inpatient in the approved centre. The child and adolescent consultant psychiatrist

and multi-disciplinary team provided in reach care and were responsible for the care and treatment provided to the resident during their treatment in the approved centre. The Commission was notified of all children admitted to approved centres for adults within 72 hours of admission using the associated notification form. Consent for treatment was obtained from one or both of the child's parents.

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

a) **Age-appropriate facilities were not provided as the child was admitted to an adult approved centre, 2.5 (b).**
b) **There was no evidence that provisions were in place to ensure the right of the child to have their views heard, 2.5 (c)(iii).**
c) **Appropriate accommodation was not designated as the child was admitted to an adult approved centre for the purpose of seclusion, 2.5 (d)(iii).**

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

COMPLIANT

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

INSPECTION FINDINGS

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

- How and where the initial and subsequent doses of Dantrolene were stored.
- The management of cardiac arrest.
- The management of anaphylaxis.
- The management of malignant hyperthermia.

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

Evidence of Implementation: The approved centre had a dedicated ECT suite with a private waiting area, adequately equipped treatment room and an adequately equipped recovery room.
High-risk residents were treated in a rapid-intervention area. There was a facility for monitoring EEG on two channels and the ECT machines were regularly maintained with a record of maintenance and confirmation of machine-servicing kept.

Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia were prominently displayed. A named consultant psychiatrist (CP) had overall responsibility for ECT management and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

Appropriate information on ECT, both in a booklet and verbally, was given by the CP to enable the resident to make a decision on consent. Information was provided on likely adverse effects of ECT, including the risk of cognitive impairment and amnesia and other potential side-effects. The information was provided in clear and simple language that the resident could understand, and in other language or Irish sign language if necessary.

The clinical file of one resident who voluntarily underwent ECT treatment was inspected. Subject to the urgency of the clinical circumstances, the resident was given 24 hours to reflect on the information about ECT treatment. The resident was informed of their right to access an advocate of their choosing at any stage. All their questions were answered and this was documented. ECT was only administered with the

resident’s consent and the CP assessed and was satisfied with the resident’s capacity to consent before obtaining it.

A written record of the assessments of capacity to consent to ECT were placed in the resident’s clinical file, and written consent for each ECT programme, including anaesthesia, and each ECT treatment session, including anaesthesia, was obtained by a CP or a registered medical practitioner (RMP) under the supervision of a CP prior to each treatment session. This was recorded in the resident’s clinical file.

The programme of ECT was only prescribed by the responsible CP. The prescription for ECT was recorded in the clinical file. The treating CP or the CP responsible for ECT discussed the initial stimulus dose in advance of the treatment. A cognitive assessment was completed before each programme of ECT and the resident’s clinical status was assessed before and after each ECT treatment session. The resident’s cognitive functioning was monitored throughout ECT programme. The cognitive assessment was in line with best international practice and completed after each ECT programme. The CP reviewed the resident’s progress with the resident and discussed the need for the continuation of ECT.

A pre-anaesthetic assessment was recorded in the clinical file. Anaesthetic risk was assessed and recorded by the anaesthetist and any variation in risk was recorded before treatment. A consistent anaesthetic induction agent was used throughout the programme of ECT unless indicated otherwise. The doses of anaesthetic agents used, the resident’s response, monitor recordings before and immediately after treatment and the resident’s recovery were recorded, dated, signed by the anaesthetist and placed in the clinical file.

The resident’s clinical file and forms required by this code of practice were made available to all staff involved in ECT. ECT was only given by a CP or a RMP under the supervision of a CP. ECT was administered by a constant-current, brief-pulse ECT machine. Stimulus dosing or recommended starting dose regimes were used and documented in the ECT record. The ECT register was completed on conclusion of the programme and a copy was placed in the resident’s clinical file.

Pre-ECT assessments, the ECT record completed after each treatment, the anaesthesia record after each session and the post-ECT assessments were placed in the clinical file. The reasons for continuing or discontinuing ECT were recorded and copies of all cognitive assessments were placed in the clinical file.

The approved centre was compliant with this regulation.

Admission, Transfer and Discharge

NON-COMPLIANT

Risk Rating HIGH

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

INSPECTION FINDINGS

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

Admission: The admission policy, which was last reviewed in November 2023, included all of the policy-related criteria for this code of practice.

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

Discharge: The discharge policy, which was last reviewed in February 2023, included all of the policy-related criteria for this code of practice.

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

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

Evidence of Implementation:

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

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. An estimated date of discharge was recorded in the resident's individual care plan but there was no evidence of a discharge plan in their clinical file. As a result, no record was kept of communication with the relevant healthcare provider, a follow-up plan or a reference to early warning signs of relapse and risks. There was no evidence in the clinical file to suggest a discharge meeting with relevant staff had taken place.

A discharge assessment was not completed. The resident’s psychiatric and psychological needs, current mental state examination, comprehensive risk assessment and risk management plan, social and housing needs were not addressed on discharge. Nursing notes documented their informational needs and the discharge was coordinated by a key worker, but no preliminary discharge summary was sent to the relevant healthcare provider within three days nor was a comprehensive discharge summary issued within 14 days.

There was no evidence of a discharge summary in the resident’s file. As a result, details of their diagnosis, prognosis, medication, mental state at discharge, outstanding health or social issues, follow-up arrangements, the names and contact details of key people for follow-up, risks issues such as signs of relapse or the names of family member or carer involved in the discharge process were not recorded. No timely follow-up appointment was made.

The approved centre was non-compliant with this code of practice because there was no evidence of a discharge plan or a discharge summary in the resident’s clinical file, 38.4.

Appendix 1: Corrective and Preventative Action Plan

Regulation 15: Individual Care Plan					
Reason ID : 10005234	The registered proprietor did not ensure that three of ten residents had a documented set of goals developed by the multi-disciplinary team, 15. Two of ten residents did not have their care and treatment, or therapeutic interventions documented, 15. The registered proprietor did not ensure that that three of ten residents' individual care plans were reviewed by the multi-disciplinary team, 15.				
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	Communication with the Multidisciplinary Team (MDT) to ensure that they understand the requirement to have documented set of goals, documented care & treatment or therapeutic interventions and individual care plans for review by the MDT. Monitoring of non-compliance through the Compliance Committee.	Auditing of Compliance.	Achieveable.	30/08/2024	Clinical Director
Preventative Action	Continuous monitoring	Auditing of Compliance	Achievable	30/08/2024	Clinical Director

Regulation 19: General Health					
Reason ID : 10005237		**The residents' general health needs were not appropriately assessed every six months as four of five inspected files did not document dental health, 19 (1)(b). The residents' general health needs were not appropriately assessed every six months as no inspected files documented smoking status, 19 (1)(b). The residents' general health needs were not appropriately assessed every six months as two of five inspected files documented body-mass index, weight, or waist circumference, 19 (1)(b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All patient records have been updated and the missing information was inserted - evidence sent to the MHC in Jan 2024 as requested post inspection	Al records updated	Achievable and complete	13/05/2024	Clinical Director
Preventative Action	• To Support compliance an additional template will be added to the Mental Health Information System (MHIS) to act as an addendum to the current physical health assessment. • Scoping of the possibility of changing the e-mail reminders attached to the current MHIS physical health assessment will be	Circulation of Learning notice - complete Registrar training & Induction records Ongoing review and monitoring of Clinical audit results. Monitoring of compliance since new addendum to MHIS template introduced. Successful recruitment of new post .	Achievable Recruitment and availability of resource may be a barrier to implementation.	30/09/2024	Assigned Consultant Psychiatrist , Director of Nursing & Clinical Director

	completed. Where possible, this e-mail will be updated to request that the registrar also completes the additional template created. These e-mail reminders are sent to the Registrar and Consultant of every patient about 160 days post admission, reminding them that a physical exam, which should be completed every 180 days, is due for the patient. These reminders are then sent are sent on a daily basis after the time period lapses. • A learning notice has been circulated to all consultants and registrars outlining the changes to the process. Owner: Prof Jennifer Hoblyn – Completed. • Information on				

	Regulation 19 and the 6 Monthly Physical Health review will be included in each registrar induction. This will include the process for Saint John of God Hospital. Owner: Prof Jennifer Hoblyn. Completed 10th January 2024 and on an ongoing basis at each 6 monthly induction for Registrars. • A Clinical Audit will be developed for the monitoring of this aspect of clinical care and a proposal submitted to the Clinical Audit Committee for Approval. • A Clinical Audit will be conducted every 3 months to ensure that six monthly physical health assessments are completed in line with Regulation 19 –				

	any non-compliances identified during these audits will action planned accordingly. • A Quality Assurance Manager post has been approved and funded for Q1 2024. This post will oversee and monitor systems for upholding and enhancing quality and standards, and ensuring the highest possible standards of care are delivered in Saint John of God Hospital Clg. Post currently advertised.				

Regulation 22: Premises					
Reason ID : 10005226		**The overall approved centre environment was not developed and maintained with due regard to the safety and well-being of residents, staff, and visitors, as ligature risks were not minimised to the lowest practical level based on risk assessment, 22 (3).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Ligature audit schedule for 2024 including Ligature remediation plan has been developed and is being implemented to complete the audits for all open units/wards in Saint John of God Hospital, once annually. Ligature risk assessments are being reviewed in all open units with prioritisation of remediation plan for identified high risks.	An audit on the adherence of the procedures in policy.	Achievable	31/08/2024	Head of Operations and Technical Services Manager
Preventative Action	Continuous Ligature audit cycle is to be implemented for all open units in Saint John of God Hospital, once annually. Periodic review of Ligature risk assessments for	An audit on the adherence of the procedures in policy.	Achievable	31/12/2024	Director of Nursing, Healthcare Risk Officer, Clinical Nurse Managers

	all open units ensuring continuous risk evaluation and mitigation.				

Regulation 26: Staffing					
Reason ID : 10005232		**Not all staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice as some staff were not trained in fire safety, basic life support or the management of violence and aggression, 26(4). Not all staff were trained in the Mental Health Act 2001, 26, (5).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	A compliance rating has been issued to the relevant Heads of department with a request to ensure non-compliant staff attend upcoming training. Additional training sessions have been scheduled to enable staff attendance.	Compliancy ratings will be provided to HOD's monthly. These will also be reviewed monthly at management team meetings and escalated where necessary. Corrective action will be taken where compliancy does not improve.	These actions are both achievable and realistic.	30/06/2024	Head of Departments and interim Human resources Manager
Preventative Action	Compliancy ratings will be provided to HOD's monthly. These will be monitored at Local departmental meetings. These will also be reviewed monthly at management team meetings. Preventative action will be taken to monitor and	Monthly statistics will be provided to HOD's to update them on their department's compliance. Training compliance will be a focus monthly at the management team meeting. Heads of departments will be asked to report on reasons for non	These actions are both achievable and realistic.	31/12/2024	Interim HR manager

	measure compliancy. Non compliancy will be escalated as appropriate should staff not attend or if HOD's fail to make the necessary improvements.	compliances within their dept. and feedback to the management team.			

Regulation 27: Maintenance of Records					
Reason ID : 10005227		**The residents' clinical files were not maintained so as to ensure ease of retrieval, as some documents were stored in a back-pocket of the paper files and some files had loose pages, 27 (1).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Administration resource allocation to manage healthcare records and file loose documentation.	Monitoring of roster to ensure continued allocation of resource Audit of Healthcare records	Achievable and complete	13/05/2024	Administration Co-Ordinator
Preventative Action	Medical Records Officer to educated nursing and administrative staff re maintenance and management of healthcare records . Medical Records Officer to review and update policy document "Standards & Recommended Practices for Healthcare Records" and to circulate to all staff once updated	Record to be maintained to ensure staff understand maintenance of records PPG's. Approval & circulation of Updated Policy	Achievable.	31/07/2024	Administration co-Ordinator Medical Records officer

Regulation 28: Register of Residents					
Reason ID : 10005228		**The register of residents did not contain the diagnosis on admission or the diagnosis on discharge of all residents, 28 (2).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Communicate with the Multidisciplinary Teams regarding the requirement of including diagnosis on the register following admission and discharge for all residents. Monitoring will be undertaken to ensure compliance that the register contains the diagnosis on admission and discharge for all residents.	A weekly audit will be under taken to identify any non-compliance.	Achievable	31/05/2024	Clinical Director
Preventative Action	Raise all non-conformances following audit with the assigned Consultant.	Weekly audit.	Achieveable.	31/05/2024	Clinical Director

Regulation 32: Risk Management Procedures

Reason ID : 10005229		Not all health and safety risks had been identified, analysed, evaluated or treated because a ligature audit had not been carried out for three of the six units occupied, 32 (1).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The audits for the three remaining units have been completed since the inspection.	The audits for the three remaining units have been completed since the inspection.	Achieved	31/05/2024	Clinical Audit Committee
Preventative Action	The audits for the three remaining units have been completed since the inspection and the actions arising are now being reviewed by the Risk Management Committee.	Ligature Audits for the remaining three units have been completed.	Achievable	30/08/2024	Head of Operations.

Rules Governing the Use of Seclusion					
Reason ID : 10005245		**There was no record indicating that all staff involved in seclusion had read and understood the policy on seclusion, 10.2 (b). No in-person debrief or multi-disciplinary review had followed one episode of seclusion, 7.6 (i)–(vi). No record was kept of the offer of a debriefing following one episode of seclusion, whether the offer was accepted and what the outcome was. The individual care plan was not updated to reflect the outcome of the debrief, and in particular, the patient's preferences in relation to restrictive interventions going forward, 7.8. The clinical file of one patient who had been secluded did not include a record of the attendees present at the debrief following the episode of seclusion, 7.9. An in-person debrief that followed one episode of seclusion did not give the patient the option of having their representative or nominated support person attend the debrief, nor was an explanation recorded in the clinical file, 7.6 (vi). One episode of seclusion was not reviewed by members of the multi-disciplinary team involved in the patient's care and treatment nor documented in the clinical file as soon as practicable or no later than five working days, 10.3. As the multi-disciplinary team review was not documented, one episode of seclusion had no record of actions decided upon or follow-up plans to eliminate, or reduce, restrictive interventions in the patients clinical file, 10.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• Monthly audit of all episodes of physical restraint to determine compliance with the Rules. • Individualised compliance reports to each MDT regarding any non-compliances with MDT Documentation. • Individualised compliance reports to Consultant	• Completion of individualised reports will be confirmed via the Clinical Governance Quality and Safety Executive Committee. • Copies of these reports will be kept on file.	Achievable	31/05/2024	• Chair of the Seclusion and Restraint Reduction Committee

	Psychiatrists regarding any non-compliances with medical documentation. • Individualised compliance reports to CNM2's regarding any non-compliances with nursing documentation. • Escalation to relevant line managers regarding consistence non-compliance after three individualised reports which do not show evidence of improvement.				
Preventative Action	• Review of effectiveness of corrective actions at the Seclusion and Restraint Reduction Committee on a Quarterly basis. • Implementation of a new EPR (Civica Care Records) which will provide mandatory fields for completion in relation to the requirements of the	• Review of monthly audit results to determine effectiveness of corrective actions (i.e. improvement in compliance rating over a period of time). • Implementation of the new EPR will be confirmed via management team meetings. •	• Achievable & Realistic	31/12/2024	• Chair of the Seclusion and Restraint Reduction Committee • Co-Chair of the EPR Steering Group

	Rules. Also dashboards/reports will be available via the EPR on compliance with the Rules – these will be monitored by the Seclusion and Restraint Reduction Committee to ensure compliance.	Quarterly review by the Seclusion and Restraint Reduction Committee			
Reason ID : 10005246		**The bathroom door in the seclusion suite was not an anti-barricade door, 8.1 (iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	1. Replacement of door with an anti-barricade door to be costed and submitted for approval. 2. Risk Register for the Ward to be updated to reflect the potential risk an individual to barricade themselves into this room and associated controls.	• Confirmation from post holders that actions have been completed.	Achievable	31/05/2024	1. Technical Services Manager 2. CNM2
Preventative Action	Replacement of the Door	Confirmation from the post holder that the action has been completed.	Realistic/ dependent on quote / contingent on supplier lead in times, availability of goods etc.	31/12/2024	Technical Services Manager

Code of Practice on the Use of Physical Restraint in Approved Centres					
Reason ID : 10005240		**Residents were not informed of the reasons for and the circumstances which lead to the discontinuation of the physical restraint, nor was there a record explaining why this had not occurred, 3.8. An in-person debrief did not occur within two working days of two episodes of physical restraint, 5.3 (ii). The in-person debrief of two episodes of physical restraint did not include a discussion regarding alternative de-escalation strategies nor a discussion regarding the resident's preferences, 5.3 (iv)–(v). Two of the resident's individual care plans were not updated to reflect the outcome of the debrief and in particular their preferences in relation to restrictive interventions going forward, 5.5. There was no written record to indicate that all staff involved in physical restraint had read and understood the policy on the use of physical restraint, 7.2 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	• Monthly audit of all episodes of physical restraint to determine compliance with the code of practice. • Individualised compliance reports to each MDT regarding any non-compliances with MDT Documentation. • Individualised compliance reports to Consultant Psychiatrists regarding any non-compliances with medical documentation. • Individualised	Completion of individualised reports will be confirmed via the Clinical Governance Quality and Safety Executive Committee. Copies of these reports will be kept on file.	Achievable	31/05/2024	• Chair of the Seclusion and Restraint Reduction Committee)

	compliance reports to CNM2's regarding any non-compliances with nursing documentation. • Escalation to relevant line managers regarding consistence non-compliance after three individualised reports which do not show evidence of improvement.				
Preventative Action	• Review of effectiveness of corrective actions at the Seclusion and Restraint Reduction Committee on a Quarterly basis. • Implementation of a new EPR (Civica Care Records) which will provide mandatory fields for completion in relation to the requirements of the CoP. Also dashboards/reports will be available via the EPR on compliance with the COP – these will be	• Review of monthly audit results to determine effectiveness of corrective actions (i.e. improvement in compliance rating over a period of time). • Implementation of the new EPR will be confirmed via management team meetings. • Quarterly review by the Seclusion and Restraint Reduction Committee	Achievable - in line with EPR project implementation timeline	30/06/2025	• Chair of the Seclusion and Restraint Reduction Committee • Co-Chair of the EPR Steering Group

	monitored by the Seclusion and Restraint Reduction Committee to ensure compliance.				

COP Relating to Admission of Children under the Mental Health Act 2001.					
Reason ID : 10005223		**Age-appropriate facilities were not provided as the child was admitted to an adult approved centre, 2.5 (b).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Admission policy to the hospital reviewed to include that it is not the policy of Saint John of God Hospital to accept admission of children (i.e. under the age of 18) to the adult approved centre.	Approval of the updated policy.	Achievable - Complete	13/05/2024	Director of Nursing
Preventative Action	Continued clinical risk assessment of each referral received to determine the likelihood that any admission to Ginesa Suite would require transfer to the adult centre for the utlisation of the seclusion. Referrals that are deemed to have a high risk of this, will be refused on the basis that the service cannot meet	Monitoring of the request for child admission to the adult approved centre.	Achievable	31/12/2024	Responsible Consultant Psychiatrist - CAMHS Consultant Psychiatrist

	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
	the needs of the individual.				
Reason ID : 10005224		**There was no evidence that provisions were in place to ensure the right of the child to have their views heard, 2.5 (c)(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Child appropriate advocacy services are available to young people Debriefs will be conducted after use of restrictive practice which will include enabling the young person to express their views.	• Restrictive practices area audited monthly to ensure compliance with the COP/Rules for same. • YAP (Young person advocacy service) provides a monthly report on issues discussed in advocacy sessions.	Achievable and complete	13/05/2024	Responsible Consultant Psychiatrist - CAMHS Consultant Psychiatrist
Preventative Action	Child appropriate advocacy services are available to young people Debriefs will be conducted after use of restrictive practice which will include enabling the young person to express their views.	Restrictive practices area audited monthly to ensure compliance with the COP/Rules for same. YAP (Young person advocacy service) provides a monthly report on issues discussed in advocacy sessions.	Achievable and complete	13/05/2024	Responsible Consultant Psychiatrist - CAMHS Consultant Psychiatrist
Reason ID : 10005225		**Appropriate accommodation was not designated as the child was admitted to an adult approved centre for the purpose of seclusion, 2.5 (d)(iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Admission policy to the hospital reviewed to include	Approval of the updated policy.	Achievable and complete	13/05/2024	Director of Nursing

	that it is not the policy of Saint John of God Hospital to accept admission of children (i.e. under the age of 18) to the adult approved centre.				
Preventative Action	Continued clinical risk assessment of each referral received to determine the likelihood that any admission to Ginesa Suite would require transfer to the adult centre for the utlisation of the seclusion. Referrals that are deemed to have a high risk of this, will be refused on the basis that the service cannot meet the needs of the individual.	Monitoring of the request for child admission to the adult approved centre	Achievable	31/12/2024	Responsible Consultant Psychiatrist - CAMHS Consultant Psychiatrist

Code of Practice on Admission, Transfer and Discharge to and from an approved centre					
Reason ID : 10005222		**There was no evidence of a discharge plan or a discharge summary in the resident's clinical file, 38.4.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Clinical Director will communicate with the Consultant Psychiatrists and Multidisciplinary Teams regarding the requirement for the inclusion of Discharge Plans with the Patient's Clinical File.	Weekly Audit of Discharges change from monthly to weekly.	Achievable	31/05/2024	Clinical Director
Preventative Action	Continuous monitoring of compliance through the audit results at the monthly Compliance Meeting and address non-compliance. Auditing will increase from monthly to weekly.	Audit results.	Achievable.	31/05/2024	Clinical Director

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to “visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate”.

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

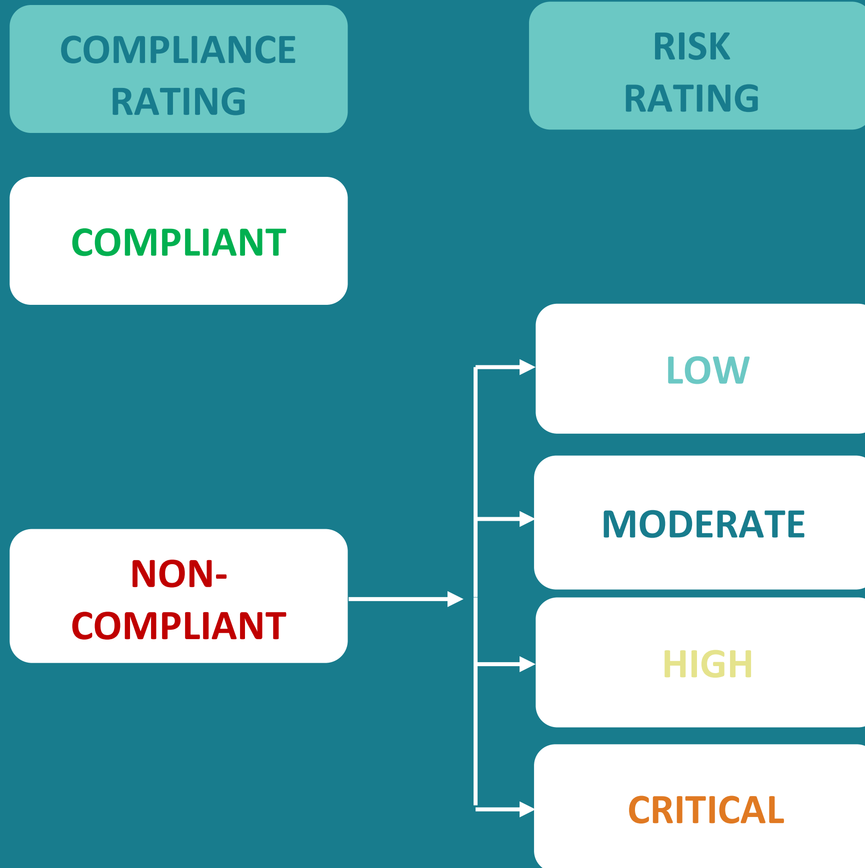
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.