# St Vincent's Hospital, Fairview

mhc
coimisiún meabhair - shláinte
mental health commission

Annual Inspection Report 2023

*Promoting Quality, Safety and Human Rights in Mental Health*

# ST VINCENT'S HOSPITAL, FAIRVIEW

St Vincent's Hospital, Richmond Road,
Fairview, Dublin 3

**Date of Publication:** 21st June 2024

ID Number: AC0137

## 2023 Approved Centre Inspection Report (Mental Health Act 2001)

**Approved Centre Type:**
Acute Adult Mental Health Care
Continuing Mental Health Care/Long Stay
Psychiatry of Later Life

**Conditions Attached:**
Yes

**Most Recent Registration Date:**
1 March 2023

**Registered Proprietor:**
St Vincent's Hospital

**Registered Proprietor Nominee:**
Mr Eoin Culliton, Chief Executive

**Inspection Team:**
Carol Brennan-Forsyth, Lead Inspector
Damien Lanigan
Karen McCrohan
Noeleen Byrne
Shayne Wilson

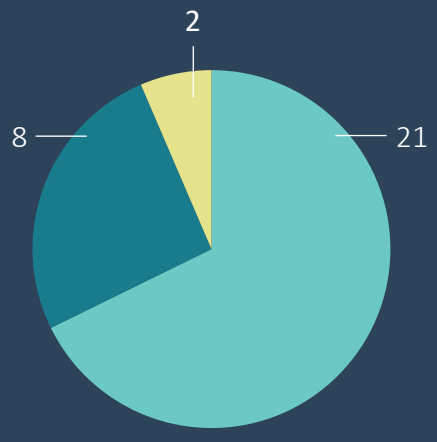
**The Inspector of Mental Health Services:**
Professor James V Lucey MCRN000646

**Inspection Date:**
14 – 17 November 2023

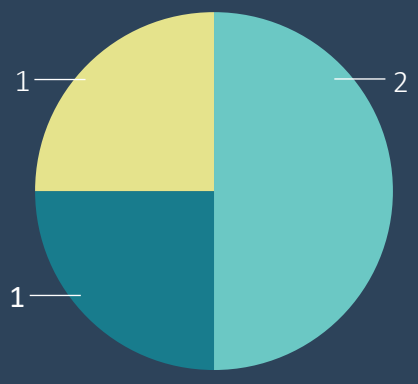
**Previous Inspection date:**
12 – 15 July 2022

**Inspection Type:**
Announced Annual Inspection

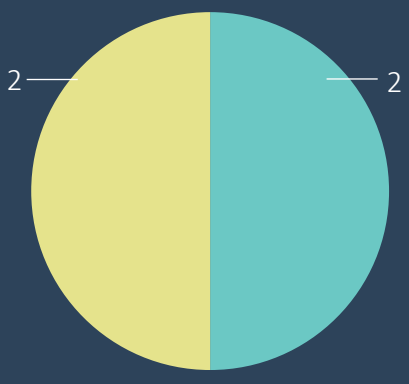
2023 COMPLIANCE RATINGS




REGULATIONS




RULES AND PART 4 OF THE MENTAL HEALTH ACT 2001



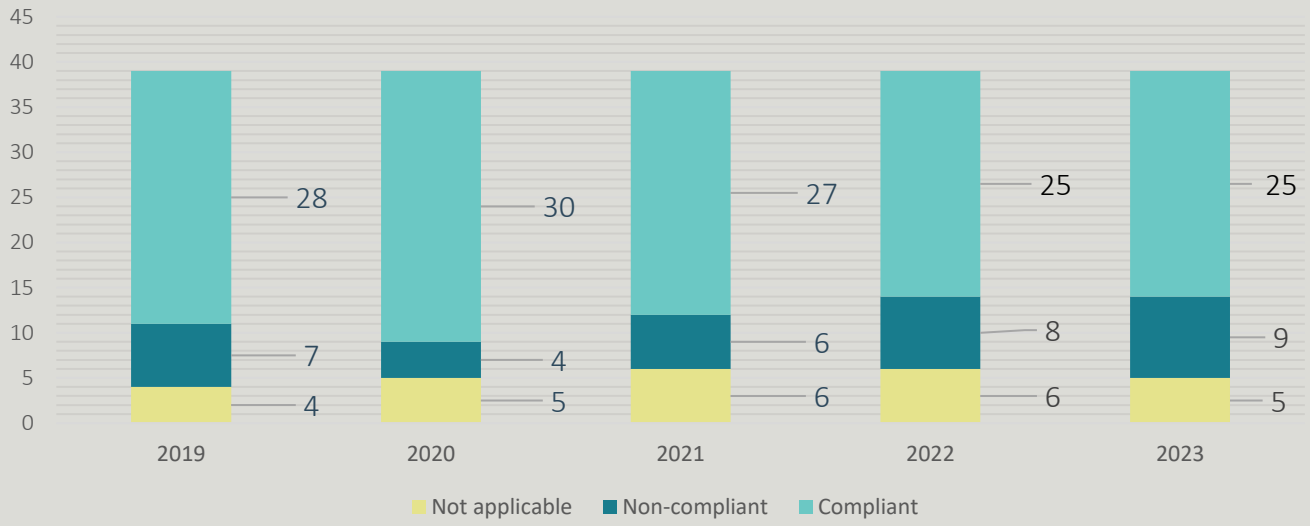

CODES OF PRACTICE

Compliant Non-Compliant Not applicable

## RATINGS SUMMARY 2019 – 2023

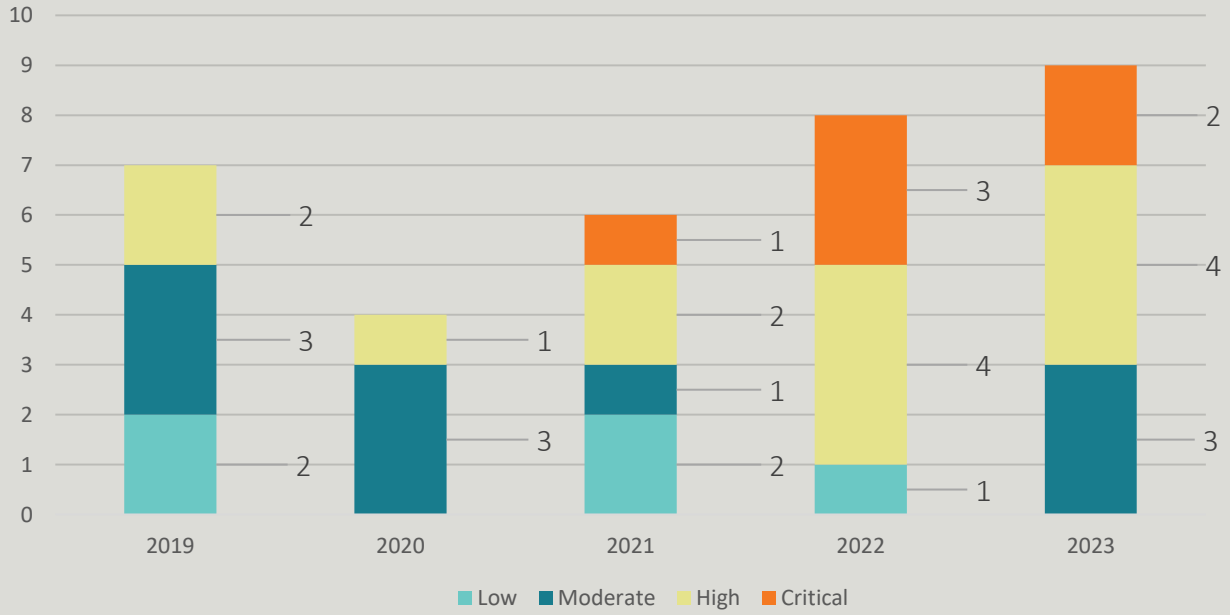
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

### 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



# Contents

# 1.0 Inspector of Mental Health Services – Review of Findings

## Inspector of Mental Health Services

## Professor James V Lucey

## In brief

St Vincent's Hospital, Fairview, was a public voluntary hospital located in a former convent in Farview, North Dublin. It comprised three separate units providing acute adult mental health care, long-stay continuing mental health care and psychiatry of later life (PoLL) services.

There were 45 registered beds in the approved centre, of which 27 were occupied at the time of inspection. Residents were admitted to the approved centre through any of six local consultant-led teams.

| Compliance Summary | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| % Compliance | 80% | 88% | 82% | 76% | 74% |

## Conditions to registration

There was one condition attached to the registration of this approved centre at the time of inspection.

| Conditions | Findings |
|---|---|
| **Condition 1:**<br>*The registered proprietor must implement the Quality Improvement Plan submitted to the Mental Health Commission by the Registered Proprietor on 20 December 2022. The Registered Proprietor shall submit updates in a form and frequency specified by the Commission. The updates must include detail on the governance arrangements relating to how improvements are being overseen and sustained on a continuing basis.* | The approved centre was not in breach of Condition 1. |

## Ongoing escalation and enforcement actions at time of inspection

| Enforcement Action | Date applied | Reasons | Outcome |
|---|---|---|---|
| *Immediate action notice* | *21/07/2022* | *The approved centre was found non-complaint with a risk rating of critical with three regulations. Regulation 16, Regulation 26 and Regulation 32.* | *Approved centre submitted assurances which were unsatisfactory* |
| *Regulatory compliance meeting* | *27/07/2022* | *In line with its regulatory enforcement process, the MHC determined that it was necessary to have a Regulatory Compliance Meeting with representatives of the approved centre.* | *Plans were received at the regulatory compliance meeting. Further information was requested on foot of same.* |
| *Immediate enforcement action* | *27/01/2023* | *Following a focused inspection on 19/01/2023, the approved centre was found non-compliant with Regulation 16 and Regulation 26 with a risk rating of critical for each.* | *Immediate Action Notice followed.* |
| *Condition attached* | *27/01/2023* | *The MHC have identified a repeated pattern of non-compliance with regulations over the course of the previous registration period.* | *The approved centre submitted a Quality Improvement Plan to the MHC. The Registered Proprietor continues to submit updates relating to how improvements are implemented, overseen and sustained on a continuing basis.* |

## Escalation and enforcement actions commenced following this inspection

| Enforcement Action | Date applied | Reasons | Outcome |
|---|---|---|---|
| *Immediate action notice* | *24/11/2023* | *Critical non-compliance with Regulation 16: Therapeutic* | *The MHC is in correspondence with the approved centre. The MHC continues to engage and monitor the* |

| | | | |
|---|---|---|---|
| | | *Services and Regulation 26: Staffing.* | *actions taken on foot of the annual inspection.* |

## 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.
- ***Number of registered nurses in the approved centre*:** Although there were nursing staff shortages, the approved centre was able to use overtime and agency staff to ensure an adequate number of appropriately trained nursing staff to provide safe care and treatment.
- ***Medication safety:*** The ordering, storing, prescription and administration of medication was carried out in a safe manner.
- ***Assessment and management of individual risk*:** All residents had an individual risk assessment and risk management plan that was regularly updated.
- ***Access to essential information*:** The clinical files were in order, and it was easy to find essential information about the person. The Health and Safety Statement was available to staff.
- ***Infection control*:** The service reported that it was aware of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health. The approved centre adopted the policies and protocols for the prevention and management of COVID-19.

However:

- ***Mandatory training:*** Not all medical staff had completed mandatory training in fire safety and the prevention and management of violence and aggression at the time of inspection.
- ***Ligature anchor points:*** Ligature points were not minimised to the lowest level throughout the approved centre.
- ***Maintenance:*** A routine maintenance and renewal programme was not implemented as the approved centre was not kept in a good state of repair externally and internally. The physical structure of the approved centre was not maintained with due regard to the safety of residents: fire doors were missing tumescent strips and a ramp was broken.

## Appropriate care and treatment of residents

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

- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT) which met regularly to discuss residents' care plans. The approved centre was a placement site for student nurses affiliated with Dublin City University.

- ***Discharges:*** The discharge assessment addressed the following: psychiatric and psychological needs; current mental state examination; comprehensive risk assessment and risk management plan; and informational needs.

However:

- ***Appropriateness of environment:*** The approved centre was not in good structural and decorative condition as there was dirty paving in the courtyard, rubbish in the garden and dirt and debris in light wells and light fittings.
- ***Physical assessment:*** Residents' general health needs were not properly assessed every six months. Two assessments inspected did not document the resident's family history; three did not document BMI or waist circumference; one did not document blood pressure; two did not document smoking status; and two did not document nutritional status.
- ***Individual care plans:*** Each resident had an individual care plan (ICP) but not all ICPs had all the required information. One ICP lacked documentary evidence that it had been drawn up with the participation of the resident and their representative, family or next of kin, as appropriate. Four ICPs did not identify appropriate goals for the resident nor the care and treatment required to meet the goals identified. Seven ICPs did not identify the resources required to provide the care and treatment identified.
- ***Therapeutic interventions:*** Residents did not have access to a social worker or occupational therapist. Recruitment campaigns for these posts had been unsuccessful.

## Respect for residents' privacy, dignity and autonomy

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

- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Use of restrictive practices:*** Mechanical restraint, physical restraint and seclusion were used in the approved centre only when less restrictive alternatives were deemed unsuitable. The multi-disciplinary team developed a plan of care for each person restricted, including information on attempts to reduce or eliminate the use of restraint for that person. The approved centre had a reduction of restrictive practices strategy.
- ***Rights-based care:*** The residents were able to make informed, rights-based decisions and choices about their care and treatment, as far as was possible, dependent on their assessed capacity. There was access to advocacy, and relationships with families and friends were encouraged. Consent for personal, therapeutic, and physical care was obtained.

However:

- ***Privacy and dignity:*** Assessment unit bedrooms had been fitted with opaque-frosting windows, which only afforded privacy from the outside while the windows were kept closed. When the

windows were opened there was a clear view into the resident bed areas and there were no curtains on the windows. A person's right to personal dignity was not respected in the seclusion room bathroom as there was no shower curtain or screen there.

## Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Residents were supported to attend Mass onsite, and a chaplain was available for one-to-one sessions and facilitated different spiritual requests.
- ***Information:*** There was an information booklet about the approved centre and what it provided. The residents were given information about their treating team. Information about diagnoses and medication was also provided.
- ***Food quality:*** The quality of the food at mealtimes was good and provided healthy options which were nicely presented.
- ***Recreational activities***: Residents had access to a variety of activities including books, DVDs, CDs, arts and crafts, walking groups and music groups.
- ***Residents' feedback:*** A number of residents gave feedback to the inspection team and expressed a variety of opinions. Six residents spoke with the inspection team and six residents filled out completed a Service User Questionnaire.

However:

- ***Property:*** Records were not always maintained of each resident's personal property and possessions in the approved centre.

## Governance, Leadership and Accountability

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

- ***Structure in place:*** The approved centre was under the overall governance of a Board of Governors who met monthly.
- ***Leadership:*** The Executive Management Team convened three times a month; team membership was comprised of the acting Chief Executive Officer (CEO), the Acting Clinical Director, and the Director of Nursing. The Integrated Quality and Patient Safety Committee (IQPSC) met quarterly.

- ***Clinical governance:*** Clinical supervision arrangements were in place for all clinical staff within the approved centre.
- ***Restrictive practices reduction:*** The approved centre had a multi-disciplinary review and oversight committee for restrictive practices in place. The committee met quarterly to analyse every episode of mechanical restraint, seclusion and physical restraint.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement.
- ***Complaints:*** A complaints process was in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Regular resident community meetings, suggestion boxes, and engagement with the complaints process were the principal mechanisms for resident and carer involvement in the process of quality improvement.
- ***Advocacy services:*** A peer advocacy representative was available to residents. Contact details for this service were displayed in the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last four years of 80%. It has a condition on its registration regarding the governance arrangements for overseeing and sustaining improvements in the approved centre.

However:

- ***Risk:*** Not all health and safety risks were identified on the approved centre's risk register.

# 2.0 Quality Initiatives

## The following quality initiatives were identified on this inspection:

1. The approved centre had introduced 'Safety Pause Awareness' to assist staff in being more proactive about the challenges in providing safe, high-quality care for residents.
2. Staff had completed a 'Making Sense of Hearing Voices Workshop' to encourage a more positive response and understanding of voice-hearing and related experiences.
3. Nursing staff attended a two-day 'Understanding Autism Programme' aimed at enhancing awareness of capacity to care for residents with pervasive neuro-developmental disorders in addition to the experiences of mental illness.
4. Staff undertook RAID (reinforce, appropriate, implode, disruptive behaviours) training, an approach to assist in managing behaviours of concern.
5. Five nurses completed Infection Prevention and Control – Link Practitioners training.
6. The approved centre had introduced regular 'Quality and Safety Walkabouts' to identify issues that needed to be addressed within the approved centre.
7. Due to the shortage of nursing staff and accommodation in Dublin, five bedrooms had been refurbished on campus to accommodate nursing staff overnight.

# 3.0 Overview of the Approved Centre

## 3.1 Description of approved centre

St. Vincent's Hospital was a public voluntary hospital located on Convent Avenue, off Richmond Road in Fairview. The approved centre was located close to Drumcondra village. The main building was a former convent and was built in 1899. Two extensions had been added to the main building since it was originally constructed. The approved centre comprised three separate units. The largest unit was St. Louise's Ward, which was built in 1992. This was a 30-bed admission ward that included a High Observation Unit containing nine beds. The Psychiatry of Older Age (POA) Ward was a 6-bed admission unit for older adults. St. Mary's Ward was a 9-bed ward providing continuing care for people with enduring mental illness. The approved centre had plans to build a new hospital on the grounds of St Vincent's Hospital, building works had not commenced at the time of inspection.

In total, six consultant-led teams admitted residents into the approved centre: Ballymun, Marino/Clontarf, Marino/Tolka, Millmount, North Strand, Rehabilitation and POA. All residents remained under the care and treatment of their respective sector team while in the approved centre. The approved centre was an undergraduate training hospital for student nurses, and it was affiliated with Dublin City University.

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

| Resident Profile | |
|---|---|
| ***Number of registered beds*** | ***45*** |
| **Total number of residents** | **27** |
| Number of detained patients | 5 |
| Number of wards of court | 2 |
| Number of children | 0 |
| Number of residents in the approved centre for more than 6 months | 13 |
| Number of patients on Section 26 leave for more than 2 weeks | 0 |

## 3.2 Governance

The approved centre was under the overall governance of a Board of Governors who met monthly. Minutes from the monthly board meetings were available to the inspection team. Agenda items included: financial reports, heads of discipline reports, the new hospital building updates, human resources reports and board committee reports. The Executive Management Team (EMT) convened three times per month; team membership was comprised of the acting Chief Executive Officer (CEO), the Acting Clinical Director, and the Director of Nursing. Each member of the EMT submitted monthly reports to the Board of Governors. Agenda items from the EMT meetings included: Human Resources and vacant positions, Quality and Risk, audits, the Mental Health Commission, and new hospital building updates.

A risk register was maintained by St. Vincent's Hospital, and it included corporate, health and safety, and structural risks. Examples of risks identified by the approved centre included the condition attached to the approved centre, the quality of the premises, exposure to passive smoking, retention and recruitment of nursing and allied health staff. Risks associated with the lack of access to allied health professionals were identified on the risk register.

The risk register was maintained by two nominated Local Accountable Officers (LAOs), which were the acting Clinical Director and the Assistant Director of Nursing. The Integrated Quality and Patient Safety Committee (IQPSC) met quarterly. This committee was responsible for providing oversight of risk management processes in the risk management policy. At the time of inspection, identified risks were being managed by the Executive Management Team and/or the LAOs. Minutes from the IQPSC were available to the inspection team, agenda items included: Safeguarding, identified risks, the risk register, incidents, cyber security and the approved centre's Quality Improvement Plan. The Clinical Director, Director of Nursing and the Psychology Manager had received training on clinical risk management. A programme of clinical audit was implemented throughout the approved centre.

The approved centre had a multi-disciplinary review and oversight committee for restrictive practices in place. They met quarterly to analyse every episode of mechanical restraint, seclusion and physical restraint. The committee determined if there was compliance with the Rules governing the use of Seclusion and Mechanical Restraint and the Code of Practice on Physical Restraint and with the approved centre's own policy and procedures for each episode reviewed. The committee also identified areas for improvement and consequent actions, the persons responsible, and the timeframes for completion of those actions. The committee produced a report following each meeting. This report was made available to staff to promote on-going learning and awareness, as well as to the Mental Health Commission.

The inspection team met heads of disciplines as part of the inspection process. Staffing shortages were identified. There was no occupational therapy (OT) or social work input into the approved centre. Previous recruitment campaigns had been unsuccessful in filling the vacancies. In terms of line management, both positions were responsible to the clinical director, rather than a manager in their own discipline. In-reach OT services were not provided as the community mental health teams did not have the capacity. There were clinical supervision arrangements in place for all clinical staff within the approved centre. Dietetics and speech and language therapy were provided by a private company. Nursing staff shortages were identified, however, overtime and the use of agency nursing staff helped to mitigate this deficit. The approved centre had access to two pharmacists, two pharmacy technicians and a physiotherapist. At the time of inspection, the approved centre had a full complement of medical staff.

A programme of decorative and structural maintenance, planned preventative maintenance walkabouts, and quality safety walkabouts had commenced since the last inspection. Issues with the premises noted by inspectors on walkabout were rectified by maintenance staff where possible.

Residents had access to advocacy services via the Peer Advocacy in Mental Health service. Notices displaying a named advocate and contact details were displayed in the approved centre. The inspection team received a report from the Peer Advocate during the inspection. Regular resident community meetings, suggestion boxes, and engagement with the complaints process (both formal and informal), were the principal mechanisms evident for resident and carer involvement in the process of quality improvement.

## 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 8: Residents' Personal Property and Possessions | ✓ | | ✓ | | ✓ | | ✓ | | ✗ | Moderate |
| Regulation 15: Individual Care Plan | ✗ | High | ✗ | Moderate | ✗ | High | ✗ | Low | ✗ | High |
| Regulation 16: Therapeutic Services and Programmes | ✓ | | ✓ | | ✓ | | ✗ | Critical | ✗ | Critical |
| Regulation 19: General Health | ✗ | Moderate | ✗ | Moderate | ✗ | Low | ✓ | | ✗ | High |
| Regulation 21: Privacy | ✓ | | ✓ | | ✗ | High | ✓ | | ✗ | High |
| Regulation 22: Premises | ✗ | High | ✗ | Moderate | ✗ | Critical | ✗ | High | ✗ | High |
| Regulation 26: Staffing | ✗ | Moderate | ✓ | | ✗ | Low | ✗ | Critical | ✗ | Critical |
| Regulation 32: Risk Management Procedures | ✓ | | ✓ | | ✗ | Moderate | ✗ | Critical | ✗ | Moderate |
| Rules on the Use of Seclusion | ✓ | | ✓ | | ✓ | | ✗ | High | ✗ | Moderate |

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

## 4.2 Areas that were not applicable on this inspection

| Regulation/Rule/Code of Practice | Details |
|---|---|
| Regulation 17: Children's Education | As the approved centre did not admit children, this regulation was not applicable. |
| Regulation 25: Use of Closed Circuit Television | As CCTV was not in use in the approved centre, this regulation was not applicable. |
| Rules Governing the Use of Electro-Convulsive Therapy | As the approved centre did not provide an ECT service, this rule was not applicable. |
| Code of Practice Relating to Admission of Children Under the Mental Health Act 2001 | As the approved centre did not admit children, this code of practice was not applicable. |
| Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients | As the approved centre did not provide an ECT service, this code of practice was not applicable. |

# 5.0 Service-user Experience

## 5.1 Service-user feedback

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

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

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

The inspection team spoke with six residents in the approved centre. One resident said they enjoyed the art groups and shopping trips. Two residents said the food was 'good', two said the food was 'alright' and one resident said the food was 'not good'. One resident said that 'teatime was too late'. One resident stated that the approved centre needed more staff and two residents indicated they needed access to a social worker. One resident said they felt safe in the approved centre, another said they 'didn't'. One resident said that they knew their multi-disciplinary team and that they were reviewed regularly. One resident said the nurses were approachable, another said that they weren't listened to at community meetings. One resident said they 'loved' being in the approved centre and that their bedroom was 'nice'.

Residents were also offered a Service User Questionnaire, six were completed and returned to the inspection team. Feedback from the questionnaires suggested that five residents understood their individual care plans, one said they didn't. Three said they were involved in setting their own goals, two said they were 'sometimes' involved and one said they were 'never' involved in setting their own goals. Four residents said they were able to discuss worries or concerns with members of staff, two said they could 'sometimes'. Four residents said they always felt safe in the approved centre, one said 'sometimes' and one said they 'never' felt safe in the approved centre.

One resident commented that the approved centre was 'a fine place' and the other said they would like more activities such as outside exercise groups, makeup groups, mindfulness, Reiki, and Reflexology. One resident suggested that they would like external people to run some of the activities and not just nursing staff. Another resident said there weren't enough private rooms in the facility.

On a scale of 1-10 (1 being poor and 10 being excellent), the residents who had completed Service User Questionnaires were asked to rate their overall experience of the care and treatment in the approved centre. One resident responded with a five rating, two with an eight, one with a nine and two with a 10 rating.

## 5.2 Advocacy

The approved centre had an advocacy service. The inspectors received a report from the Peer Advocacy in Mental Health representative outlining feedback from residents.

The feedback provided by service users to the peer advocate documented that nursing staff were mainly 'helpful' and 'kind' and 'supportive' and that the activities programme was varied and enjoyed by the residents. The service users appreciated time in the garden and grounds, which they described as well-kept. The food was reported to be good, but greater variety in the dinner menu would be welcomed.

Residents reported that there were too many agency staff in the approved centre, 'they don't know us, and we don't know them'. One service user reported a long wait to see a dietitian. A service user who had a long stay would welcome input from an OT in their care before discharge.

Residents identified the complaints process as an area for improvement, it was difficult to navigate, 'there didn't appear to be an easily identifiable designated person to write to if an issue couldn't be resolved on the unit'. Service users reported that complaints were not always responded to in a timely manner.

The advocate reported that the premises was described as being old-fashioned and shabby overall, but recent redecoration of some areas was appreciated. It was reported that multi-bedded rooms afford little privacy.

# 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:

- Acting Chief Executive Officer (CEO)
- Acting Clinical Director
- Director of Nursing
- Consultant Psychiatrist
- Assistant Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2
- Nurse Practice Development Co-ordinator
- Personal Assistant to CEO.

Apologies: Principal Psychologist

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

A minimum of two 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. Menus were displayed outside the dining rooms that showed a variety of food on a four-week cycle.

Water fountains were placed on all the wards to provide safe, fresh drinking water to residents at all times and in easily accessible locations.

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. Food was prepared in the main kitchen before being transferred to the wards to be served.

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.

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

**NON-COMPLIANT**

**Risk Rating** MODERATE

(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 September 2023.

Secure facilities were provided for the safekeeping of residents' monies and valuables. Residents' valuables were stored in pouches in the clinic room. Residents' wardrobes also had safes in them. On admission, the approved centre compiled a detailed property checklist with each resident of their personal property and possessions. The property checklist was kept separate to the resident's individual care plan and was available to the resident.

The approved centre had not properly safeguarded one resident's personal property and possessions on assuming responsibility for them. A checklist was not updated on an ongoing basis, in line with the approved centre's policy. One resident's property record listed four items in the approved centre's possession, but only two items were present. No record had been kept of the items having been withdrawn, contradicting the approved centre's policy on safeguarding personal property.

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

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that a record was maintained of each resident's personal property and possessions, 8 (3).**

## 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 books, DVDs, CDs and arts and crafts. Group-based activities included walking groups, music groups, a men's choir, singsongs and garden groups.

**The approved centre was compliant with this regulation.**

## Regulation 10: Religion

**COMPLIANT**

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

### INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as was practicable. A chaplain was available for one-to-one sessions and facilitated different spiritual requests. Catholic mass was held onsite every Wednesday.

**The approved centre was compliant with this regulation.**

## Regulation 11: Visits

**COMPLIANT**

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

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

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

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

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

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

### INSPECTION FINDINGS

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

Visiting times were appropriate and reasonable. Visiting rooms available for visits. Visits were booked in advance, and there were two periods of visiting time during the day. A private visitors room was available to residents, except where there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visitors room was suitable for visiting children.

**The approved centre was compliant with this regulation.**

## Regulation 12: Communication

**COMPLIANT**

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

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

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

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

### INSPECTION FINDINGS

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

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

**The approved centre was compliant with this regulation.**

## Regulation 13: Searches

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

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

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

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

The clinical files of three residents who were searched were inspected. Residents' consent was sought and documented prior to the search taking place. Risk had been assessed prior to the search of the residents. Residents were informed by the person implementing the searches of what was happening during each search and why. A minimum of two clinical staff were always in attendance when the searches were being conducted. The searches were implemented with due regard to residents' dignity and privacy. At least one of the staff members who conducted the searches was of the same gender as each individual resident being searched. Policy requirements were implemented when illicit substances 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 September 2023.

The sudden death of a resident in the approved centre 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 of 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.

The ICPs were developed by the multi-disciplinary team (MDT) following a comprehensive assessment within seven days of admission. Nine of the ICPs were discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family and next of kin, as appropriate. One ICP did not contain evidence of such a discussion having taken place.

Four ICPs did not contain appropriate goals for the resident. Four ICPs did not identify the care and treatment required to meet the goals and the responsibilities required for implementing the care and treatment. Seven of the ten ICPs did not identify the resources required to provide the care and treatment identified.

All ICPs were reviewed by the MDT in consultation with the resident, weekly in an acute setting, and at least every six months for residents in a continuing care facility.

All ICPs were updated following review, 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) **There was no documentary evidence that one ICP had been drawn up and discussed with the participation of the resident and their representative, family or next of kin, as appropriate.**

b) **Four individual care plans did not identify appropriate goals for the resident.**
c) **Four individual care plans did not identify the care and treatment required to meet resident goals.**
d) **Seven individual care plans did not identify the resources required to provide the care and treatment identified.**

## Regulation 16: Therapeutic Services and Programmes

**NON-COMPLIANT**

**Risk Rating** CRITICAL

(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 a range of therapeutic services and programmes that were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents. Each of the three wards had an established therapeutic programme. Therapeutic groups included guided meditation, dialectical behaviour therapy, a physiotherapy group, a decider skills group, art therapy and self-affirmations. There was a psychology group on the Psychiatry of Older Age ward and all residents had one-on-one access to nursing, medical and psychology support. Healthy Ireland also facilitated a group in the approved centre.

However, both the social work and occupational therapy posts in the approved centre were vacant, despite on-going recruitment efforts. As a result, the therapeutic services provided were unable to meet the assessed needs of the residents, as documented in their individual care plans.

**The approved centre was non-compliant with this regulation because residents did not have access to a social worker or an occupational therapist, 16 (1).**

## 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 September 2023.

The file of one resident who had been emergency transferred to another facility were inspected. Full and complete written information on the resident was transferred with them when they were moved. This information included a letter of referral, a list of current medications and a resident transfer form and was provided to a named individual.

Communications between the approved centre and the receiving facility were documented and followed up with a written referral.

**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 was last reviewed in August 2023 and included procedures for responding to medical emergencies, which was last reviewed in April 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, a medication review and dental health.

Two of the five clinical files did not document the resident's family or personal history. Three did not record BMI, weight or waist circumference. One clinical file did not document the resident's blood pressure. Two files did not record smoking status. Two files did not record the resident's nutritional status.

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

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

a) **The registered proprietor did not ensure that each resident's general health needs were assessed every six months as two clinical files did not document family history, 19 (1)(b).**
b) **The registered proprietor did not ensure that each resident's general health needs were assessed every six months as three clinical files did not document body mass index or waist circumference, 19 (1)(b).**
c) **The registered proprietor did not ensure that each resident's general health needs were assessed every six months as one clinical file did not document blood pressure, 19 (1)(b).**
d) **The registered proprietor did not ensure that each resident's general health needs were assessed every six months as two clinical files did not document smoking status, 19 (1)(b).**
e) **The registered proprietor did not ensure that each resident's general health needs were assessed every six months as two clinical files did not document nutritional status, 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 June 2022.

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 translation and interpretation services.

**The approved centre was compliant with this regulation.**

## Regulation 21: Privacy

**NON-COMPLIANT**

**Risk Rating** HIGH

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

### INSPECTION FINDINGS

The approved centre had a written privacy policy in place which was last reviewed in June 2022.

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. Staff appropriately sought the resident's permission before entering their room.

Staff were observed to show discretion when discussing residents' condition or treatment needs during an inspection walkabout.

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. Noticeboards did not display resident names or other identifiable information, and residents were facilitated to make private calls.

None of the bedrooms in the assessment unit had curtains but the windows were fitted with opaque frosting. However, a view into the bedrooms was possible from publicly accessible areas when the windows were in an open position. There was no privacy screen in the seclusion room bathroom to enable resident privacy and dignity while taking a shower or using the toilet.

**The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that the resident's privacy and dignity is appropriately respected at all times.**

## 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 were not minimised as a wheelchair ramp leading from St Louise's ward to the garden was damaged. Ligature works were ongoing in the approved centre but not all ligature risks were minimised to the lowest practicable level as ligature anchor points were observed on walkabout. The approved centre's own ligature risk audit showed ongoing risks.

The approved centre was not kept in a good state of repair externally and internally. A large number of items were reported as needing repair. The gym flooring in St Louise's ward was damaged and badly stained. A drainpipe and was damaged and a bench needed painting in the courtyard. In the cleaners' storeroom, roof tiles were damaged, and walls and flooring were badly stained. Lockers were damaged, the fire strip was missing from the door and the ceiling needed painting in one of the rooms in the assessment unit. In another room on the unit flooring was damaged and marked. On St Mary's ward, the sitting room walls and ceiling had peeling paint and the ceiling was stained. The handle of a bathroom window in one of the bedroom's was broken so the window didn't close. Another bathroom in another

bedroom had exposed wiring where a light fitting had been removed. The smoking room in St Mary's ward had a badly burnt windowsill and frame and there were cigarette burn holes in the chairs.

The centre was free from offensive odours but was not clean or hygienic. The paving in the courtyard area in St Louise's was dirty and had been power washed but not effectively. The bushes in the garden in St Louise's had rubbish under them. Dirt and debris were visible in light wells in St Louise's and in light fittings in St Mary's. The cleaner's storeroom had dirty and stained ceiling tiles and walls; the flooring in St Louise's was also dirty and stained.

A programme of general and decorative maintenance, cleaning, decontamination and repair of assistive equipment was recorded. The maintenance programme was evident on inspection with painting in progress in St Mary's ward. Technical services undertook a monthly walkabout, and a complete jobs log and incomplete jobs log was maintained by Quality Safety.

Rooms were centrally heated with pipe work and radiators guarded or guaranteed not to have high surface temperatures.

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 for the following reasons:**

a) **The registered proprietor did not ensure that the premises were clean and maintained in good structural and decorative condition as there was dirty paving in the courtyard, rubbish in the garden and dirt and debris in light wells and light fittings, 22 (1)(a).**
b) **The registered proprietor did not ensure that the condition of the physical structure was developed and maintained with due regard to the safety of residents as ligatures were not minimised to the lowest practicable level, fire doors had missing tumescent strips and a ramp was broken, 22 (3).**
c) **The registered proprietor did not ensure that a programme of routine maintenance and renewal was implemented as fabrics and decorations in the centre were not kept in a good state of repair externally or internally, 22 (1)(c).**

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

**COMPLIANT**

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in October 2023, and included the following requirements:

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

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 or the Nursing and Midwifery Board of Ireland registration number of every nurse 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 October 2023.

**The approved centre was compliant with this regulation.**

## Regulation 26: Staffing

**NON-COMPLIANT**

**Risk Rating** CRITICAL

(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 on Recruitment, Selection and Vetting of Staff. The policy was last reviewed in May 2021. The centre also a policy on Garda Vetting of Staff which was last reviewed in May 2021. Together, these included all the policy requirements of the regulation.

The number and skill mix of staffing was not sufficient to meet resident needs. At the time of inspection residents did not have access to an occupational therapist or to a social worker. There was no community in-reach provided for these services. Recruitment campaigns for both posts had been unsuccessful. Residents had access to two psychologists in the approved centre. Nursing staff shortages were identified, overtime and the use of agency nursing staff helped to mitigate this deficit. Dietetics and speech and language therapy was provided through a private service.

An appropriately qualified staff member was on duty and in charge at all times, and this was documented. All healthcare staff were trained in the Mental Health Act 2001. However, not all staff had completed mandatory training in basic life support, fire safety and the management of violence and aggression. See table below for the numbers and percentages of staff trained in each subject.

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.

**Staff Training Table**

| Profession | Basic Life Support | | Fire Safety | | Management Of Violence and Aggression | | Mental Health Act 2001 | |
|---|---|---|---|---|---|---|---|---|
| Nursing (38) | 35 | 92% | 37 | 97% | 36 | 95% | 38 | 100% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Medical (29) | 29 | 100% | 24 | 83% | 23 | 79% | 29 | 100% |
| Occupational Therapist (0) | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Social Worker (0) | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Psychologist (2) | 2 | 100% | 2 | 100% | 2 | 100& | 2 | 100% |
| Other (5) Pharmacy & Physiotherapy | 4 | 80% | 5 | 100% | 3 | 60% | 5 | 100% |

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

a) **The registered proprietor did not ensure that the numbers and skill mix of staff were appropriate to the assessed needs of residents as there was no occupational therapist in the approved centre, 26 (2).**
b) **The registered proprietor did not ensure that the numbers and skill mix of staff were appropriate to the assessed needs of residents as there was no access to a social worker, 26 (2).**
c) **The registered proprietor did not ensure that all staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice, because not all staff had completed mandatory training in basic life support, fire safety and the management of violence and aggression, 26 (4).**

## Regulation 27: Maintenance of Records

**COMPLIANT**

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for the maintenance of records. The policy was last reviewed in February 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, up-to-date and in good order, and were stored together where possible. All resident records were reflective of the residents' status and the care and treatment being provided. Resident records were developed and maintained in a logical sequence and were in good order. Records were appropriately secured from loss or destruction, tampering and unauthorised access or use.

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

**The approved centre was compliant with this regulation.**

## Regulation 28: Register of Residents

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 29: Operating Policies and Procedures

**COMPLIANT**

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

### INSPECTION FINDINGS

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

**The approved centre was compliant with this regulation.**

## Regulation 30: Mental Health Tribunals

**COMPLIANT**

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

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

### INSPECTION FINDINGS

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

Resources and facilities were provided by the approved centre to support patients accessing Mental Health Tribunals remotely.

**The approved centre was compliant with this regulation.**

## Regulation 31: Complaints Procedures

**COMPLIANT**

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to the complaints process. The policy was last reviewed in February 2022, and included the process for raising, handling, and investigating complaints from any person, regarding any aspect of the services, care, and treatment provided in or on behalf of the approved centre.

A nominated person responsible for dealing with all complaints was available to the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon thereafter. A new electronic system for logging complaints had been implemented and met all regulatory requirements. 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** MODERATE

(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 written policies and procedures in relation to risk management and incident management. The risk management policy was last reviewed in October 2023 and the incident management policy was last reviewed in September 2023. The policies 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 and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical and corporate risks were identified, assessed, treated, reported, monitored and documented in

the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated. Some ligature anchor points had been removed since the last inspection and where residents were at risk, extra staff were put in place to mitigate the risks. Not all health and safety risks were identified, in one room in the assessment unit a fire door strip was missing. This risk was not documented in the approved centre's risk register.

The approved centre implemented a plan to reduce risks to residents while any works to the premises are ongoing.

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 or mechanical restraint, resident transfer and resident discharge. Multi-disciplinary teams were involved in the development, implementation and review of individual risk management processes. The approved centre held quarterly Integrated Quality and Patient Safety Committee meetings which available disciplines attended. 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 because not all health and safety risks were identified on the approved centre's risk register, 32 (2) (a).**

## 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, with the condition relating to the certificate of registration attached to it, was prominently displayed in the main reception area of St Louisa Ward.

**The approved centre was compliant with this regulation.**

# 8.0 Inspection Findings – Rules

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

## Section 69: The Use of Seclusion

**NON-COMPLIANT**

**Risk Rating** **MODERATE**

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 that was last reviewed in February 2023. The policy was reviewed annually and addressed:

- Who may initiate, and who may 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 that were followed during an episode of seclusion.

The approved centre had a separate written policy on the reduction of the use of seclusion. It was last reviewed in September 2023 and addressed:

- 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 also had a policy and procedures for training all staff involved in seclusion, which addressed:

- Who would receive training based on the identified needs of patients who are secluded and staff.
- The areas to be addressed within the training programme, including alternatives to seclusion, trauma-informed care, cultural competence, human rights and the legal principles of restrictive

intervention, the prevention and therapeutic management of violence and aggression and positive behaviour support that included the identification of causes or triggers of the patient's behaviours.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in seclusion.

**Training and Education:** A written record indicated that staff involved in seclusion had read and understood the policy. All staff who participated, or may participate, in the use of seclusion received the appropriate training in its use and in the related policies and procedures; and this training was in accordance with the approved centre's policy. A record of attendance at training was maintained.

**Monitoring:** A multi-disciplinary review and oversight committee, accountable to the registered proprietor nominee, met quarterly at the approved centre to analyse in detail every episode of seclusion. The committee determined if there was compliance with the rules governing the use of seclusion and with the approved centre's own policy and procedures for each episode of seclusion reviewed. The committee also identified areas for improvement and consequent actions, the persons responsible, and the timeframes for completion of those actions.

The committee also provided assurance to the registered proprietor nominee that each use of seclusion was in accordance with the Mental Health Commission's rules and produced a report following each meeting. This report was made available to staff to promote on-going learning and awareness, as well as to the Mental Health Commission.

**Evidence of Implementation:** Seclusion facilities were cleaned but not furnished or maintained to ensure the patient's right to personal dignity and privacy. The bathroom lacked a privacy screen or other means to ensure patient privacy while using the facilities. There was no anti-barricade door on the bathroom.

The seclusion rooms were constructed to withstand high levels of violence. The room had externally controlled heating and air conditioning and limited furnishings. Staff could clearly observe the patient within the seclusion rooms and monitor the heating. The rooms were 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 rooms were in an area away from communal sitting rooms and sleeping accommodation without being isolated. The seclusion room had a window with a clear view of the outdoor environment without being visible to unauthorised persons outdoors. The patient had ready access to sanitary facilities and sanitary items. All furniture and fittings in the seclusion room were of such a design and quality as not to endanger the safety of the patient. Seclusion facilities were not used as bedrooms and bedrooms were not used as seclusion facilities. Subject to the outcome of a documented, suitable risk assessment, the patient was permitted periods of access to secure outside areas. A record of daily outdoor access was maintained.

The clinical files of three patients who had been secluded were inspected. Seclusion was only initiated by registered medical practitioner (RMP) or the most senior registered nurse (RN) on duty, following as comprehensive an assessment of the patient as was practicable. This included a risk assessment; the outcome was recorded in the clinical file. The RMP or RN recorded the seclusion order in the clinical file

and on the seclusion register. Where seclusion was initiated by a RN, a RMP was notified of the seclusion episode as soon as practicable.

The RMP medically examined the patient as soon as practicable. This examination included an assessment and record of any physical, psychological or emotional trauma caused by the seclusion. 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 this consultation in the clinical file and indicated on the seclusion register that the CP ordered or did not order the continued use of seclusion.

Where the CP ordered the continued use of seclusion, they also advised the duration. The RMP recorded this information on the seclusion register. No seclusion order was made for a period of time longer than four hours from the commencement of the seclusion episode. There were no other less restrictive ways available to manage the patient's presentation. The CP medical examined 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, and this was recorded in the person's clinical file. Where it was the patient's wish in accordance with their ICP, the patient's representative was informed of their seclusion and a record of this communication was entered in the clinical file. Otherwise, no such communication occurred outside the course of that necessary to fulfil legal and professional requirements.

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.

Where close confinement was contraindicated, seclusion was only used when all other options had proven unsuccessful and following risk assessment. The patient was secluded in their own clothing or in clothing which respected their right to dignity, bodily integrity and privacy. The patient was directly observed by a RN for the first hour following the initiation of seclusion. After the first hour, a RN kept the patient under continuous observation and stayed within sight and sound of the seclusion room. Every 15 minutes, the RN recorded the patient's level of distress, their behaviour, their level of awareness, their physical health and whether their bodily needs were being met. Following risk assessment, a nursing review of the patient took place every two hours. During this review, a minimum of two staff members entered the seclusion room and assessed the patient to determine whether to end the episode of seclusion. This assessment and decision was recorded.

A medical examination was carried out by a RMP every four hours. The decision to end or continue seclusion was recorded. For each episode of seclusion, a seclusion care plan for the patient was developed by a RN. The seclusion care plan included personal details, known clinical needs, how de-escalation strategies would continue to be used, the patient's preferences in relation to seclusion if known, signs that the patient's behaviour was no longer deemed an unmanageable risk towards themselves or others, how potential risks may be managed, specific support plans for the patient and details of how the patient's mental health needs would continue to be met while in seclusion. The care plan also included how the patient's bodily needs would be met, medication reviews, monitoring of physical observations and a strategy for ending seclusion.

Where the seclusion order was renewed, this order was made by a RMP under the supervision of the CP or the duty CP following a medical examination. This renewed order did no exceed four hours to a maximum of five renewals (24 hours). Where the seclusion order was renewed beyond 24 hours of continuous seclusion, the CP or the duty CP undertook a medical examination. Where a patient was secluded for more than 72 hours and where the patient had four or more distinct seclusion episodes over a period of five consecutive days, the Mental Health Commission was provided with additional information about the order.

Seclusion was ended by a RMP at any time following discussion with the patient and relevant nursing staff, or by the most senior RN on the ward in consultation with the patient and the RMP. The CP responsible or the duty CP was notified, and the patient was informed of the ending of an episode of seclusion. The time, date and reason for ending seclusion was recorded in the clinical file on the date seclusion was ended.

An in-person debrief followed every episode of seclusion. This debrief was person-centred and gave the patient an opportunity to discuss the seclusion with members of the multi-disciplinary team (MDT) involved in their care. The debrief occurred within two working days of the episode unless the patient preferred otherwise. Where the patient refused to participate in a debrief, this wish was respected and recorded. The debrief included a discussion regarding alternative de-escalation strategies and the patient's preferences that could be applied in the case of future restrictive interventions.

The patient was given the option of having a representative or a nominated support person attend the debrief with them. A record was kept of the offer of debriefing, whether it was accepted and the outcome. The patient's individual care plan was updated to reflect the outcome of the debrief. A record of all attendees at the debrief was recorded in the clinical file. The patient's representative was informed of both the start and ending of the seclusion, except where it was the patient's wish otherwise. Where communication with the representative did not occur, a record explaining why not was entered in the clinical file.

Appropriate emotional support was provided to the patient directly after the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion.

Seclusion was not used to ameliorate operational difficulties such as staff shortages, as a punitive action, where mechanical restraint was also in use, solely to protect property or as a substitute for less restrictive interventions. Each episode of seclusion was reviewed by members of the MDT involved in the patient's care and treatment and documented in the clinical file as soon as practicable. The review included the following: the identification of the trigger or antecedent events which contributed to the seclusion episode; a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support; the identification of alternative de-escalation strategies to be used in future; the duration of the seclusion episode and whether it had been for the shortest possible duration; considerations of the outcomes of the person-centred debrief, if available; and an assessment of the factors in the physical environmental that may have contributed to the use of seclusion.

The MDT review was documented and recorded actions decided upon, and follow-up plans to eliminate or reduce restrictive interventions for the person. 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) **The patient's right to personal dignity was not respected as there was no privacy screen in the seclusion room bathroom, 8.1.**
b) **There was no anti-barricade bathroom door in the seclusion facilities, 8.1 (iii).**

## Section 69: The Use of Mechanical Restraint

**COMPLIANT**

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

### INSPECTION FINDINGS

**Evidence of Implementation:** The clinical file of one patient who was mechanically restrained was inspected. Mechanical restraint was used to address an enduring risk of harm. Mechanical restraint was only used when less restrictive alternatives were not deemed suitable. A risk assessment of the safety and suitability of the mechanical restraint was undertaken and specified the monitoring arrangements and frequency to be implemented during its use. The risk assessment was reviewed and updated at least quarterly in line with the patient's individual care plan (ICP).

The patient's multi-disciplinary team (MDT) developed a plan of care for the patient restrained by mechanical means and included information on attempts to reduce or eliminate the use of restraint. Mechanical restraint was ordered by a registered medical practitioner under the supervision of the responsible consultant psychiatrist (CP) or duty CP.

The patient's clinical file contained a contemporaneous record that specified that there was an enduring risk of harm to self or others, that less restrictive alternatives have not been successful, the type of mechanical restraint, the situation where mechanical restrain was being applied, the duration of the restraint, the duration of the order and the review date.

The registered proprietor appropriately notified the Mental Health Commission about the use of mechanical restraint for enduring risk to self and others.

**The approved centre was compliant with this rule.**

# 9.0 Inspection Findings – Mental Health Act 2001

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

## Part 4 Consent to Treatment

**COMPLIANT**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### INSPECTION FINDINGS

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

A *Form 17 Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent* was completed for both patients. 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

**COMPLIANT**

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

### INSPECTION FINDINGS

**Processes:** The approved centre had a written policy on the use of seclusion that was last reviewed in February 2023. The policy was reviewed annually and addressed:

- The provision of information to the resident, including information about their rights, presented in accessible language and format.
- Who could initiate and who may carry out physical restraint.
- The safety, safeguarding and risk management arrangements that were followed during any episode of physical restraint.

The approved centre had a separate written policy on the reduction of the use of physical restraint that was last reviewed in May 2023 and addressed:

- How the approved centre aimed to reduce, or where possible eliminate, the use of physical restraint.
- 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.

The policy and procedures regarding staff training in physical restraint addressed:

- Who would receive training based on the identified needs of residents who were restrained and staff.
- The areas to be addressed within the training programme, which included training in the prevention and therapeutic management of violence and aggression, alternatives to physical restraint, trauma-informed care, cultural competence, human rights and the legal principles of restrictive interventions, positive behaviour support including the identification of causes or triggers of the patient's behaviours and the monitoring of the safety of the patient during and after the physical restraint.
- The identification of appropriately qualified persons to give the training.
- The mandatory nature of training for those involved in physical restraint.

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

**Monitoring:** A multi-disciplinary review and oversight committee in the approved centre met at least quarterly to determine if there was compliance with the code of practice and with the approved centre's own policies and procedures for each episode of physical restraint reviewed. The committee also identify and documented areas for improvement, and identified the actions, the persons responsible and the timeframes for completion of any actions.

The committee provided assurance to the registered proprietor nominee that each use of physical restraint was in accordance with the Mental Health Commission's code of practice and produced a report following each meeting of the review and oversight committee.

**Evidence of Implementation:** The clinical files of three residents who had been physical 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 on physical restraint. The order confirmed that there were no other less restrictive ways available to manage the resident's presentation and the consultant psychiatrist (CP) or the duty CP was notified as soon as was practicable. This was recorded in 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 no order lasted longer than 10 minutes. The episode of physical restraint and the time that the nursing review or medical examination took place were clearly recorded in clinical file.

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. The CPF signed by the CP or the duty CP within 24 hours.

The resident was informed of the reasons for, and the circumstances which led to the discontinuation of, physical restraint, except where the provision of such information was prejudicial to their mental health, well-being or emotional condition. A record of this communication, or a record explaining why such communication did not occur, was placed in the 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 not informed of the restraint but a record explaining why such communication did not occur 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 within three days of the episode.

Staff involved in the use of physical restraint took into account any relevant entries in the resident's ICP pertaining to the resident's specific requirements or needs in relation to the use of physical restraint.

All staff involved in the episode of physical restraint undertook appropriate training in accordance with policy and staff members of the same gender were present at all times during the episode of physical restraint. The resident was continuously assessed throughout the use of the restraint to ensure their safety. There was documented evidence that the resident's head and neck were protected and supported where necessary, and their airway and breathing was not compromised. Observations were conducted and recorded of vital clinical indicators and effective communication was maintained with the resident. The resident's physical and psychological health was monitored for as long as clinically necessary after using physical restraint.

The person who led the physical restraint ended the restraint. The time, date and reason for ending the physical restrain were recorded in the clinical file on the date that the restraint ended. An in-person debrief with the resident who was restrained follow every episode of physical restraint, or, where the resident wished not to participate in such a debrief, that wish was respected.

The debrief was person-centred, structured and gave the resident the opportunity to discuss the physical restraint with members of the multi-disciplinary team (MDT) involved in their care and treatment. The debrief occurred within two working days and included a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future. It also included a discussion of the resident's preferences in relation to which restrictive intervention they would not like to be used. Residents were given the option of having their representative or their nominated support person attend the debrief with them and their decision was recorded in the clinical file. The resident's ICP was updated to reflect the outcome of the debrief and the resident's stated preferences.

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

The episodes of physical restraint were recorded in the residents' clinical files and in the CPF. A copy of the CPF was placed in the clinical file and was available to the Mental Health Commission on request.

The episodes of physical restraint were reviewed by members of the MDT within five working days from the date of the restraint. The review included the identification of the trigger events which contributed to the restraint episode, 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 and an assessment of the factors in the physical environment that contributed to the use of restraint.

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

**The approved centre was compliant with this code of practice.**

## Admission, Transfer and Discharge

**COMPLIANT**

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

### INSPECTION FINDINGS

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

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

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

**Discharge:** The discharge policy, which was last reviewed in June 2022, 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 inspected. A key worker system was in place. The resident had been admitted on the basis of a mental illness or disorder and an admission assessment was completed. The assessment included the presenting problem, past psychiatric history, family history, medical history, current and historic medication, social and housing circumstance, current mental health state, a risk assessment, a full physical examination and any other relevant information.

**Transfer:** The approved centre was compliant with Regulation 18: Transfer of Residents.

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

The discharge assessment included psychiatric and psychological needs, an examination of the resident's current mental state, the resident's informational needs and a comprehensive risk assessment and risk management plan. The discharge was coordinated by the key worker. A comprehensive discharge summary was issued within 14 days of the discharge.

The discharge summary included details of the resident's 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 and risk issues such as signs of relapse. A timely follow-up appointment was arranged.

**The approved centre was compliant with this code of practice.**

## Appendix 1: Corrective and Preventative Action Plan

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

## 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.

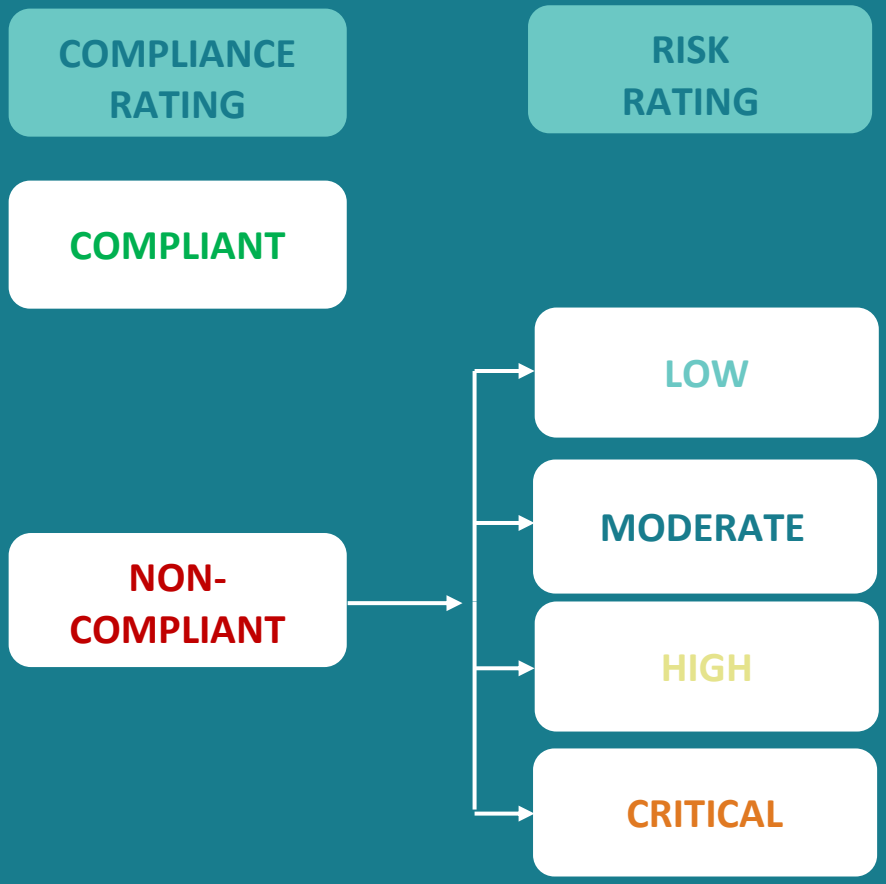
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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