Department of Psychiatry, Midland Regional Hospital, Portlaoise

Annual Inspection Report 2023

Promoting Quality, Safety and Human Rights in Mental Health

DEPARTMENT OF PSYCHIATRY, MIDLAND REGIONAL HOSPITAL, PORTLAOISE

Dublin Road, Portlaoise, Co Laois, R32RW61

Date of Publication: 21st June 2024

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2023 Approved Centre Inspection Report (Mental Health Act 2001)

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

Conditions Attached:
Yes

Most Recent Registration Date:
1 March 2023

Registered Proprietor:
HSE

Registered Proprietor Nominee:
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Inspection Team:
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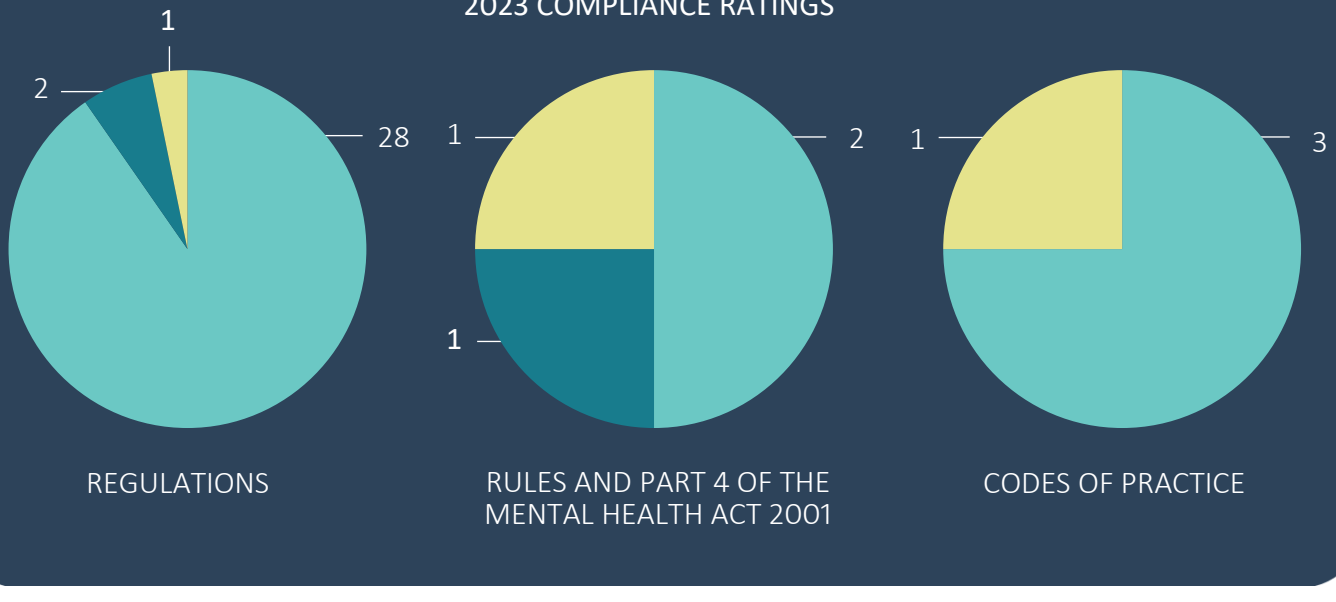
Inspection Date:
28 November – 1 December 2023

Previous Inspection date:
26 – 29 July 2022

Inspection Type:
Announced Annual Inspection

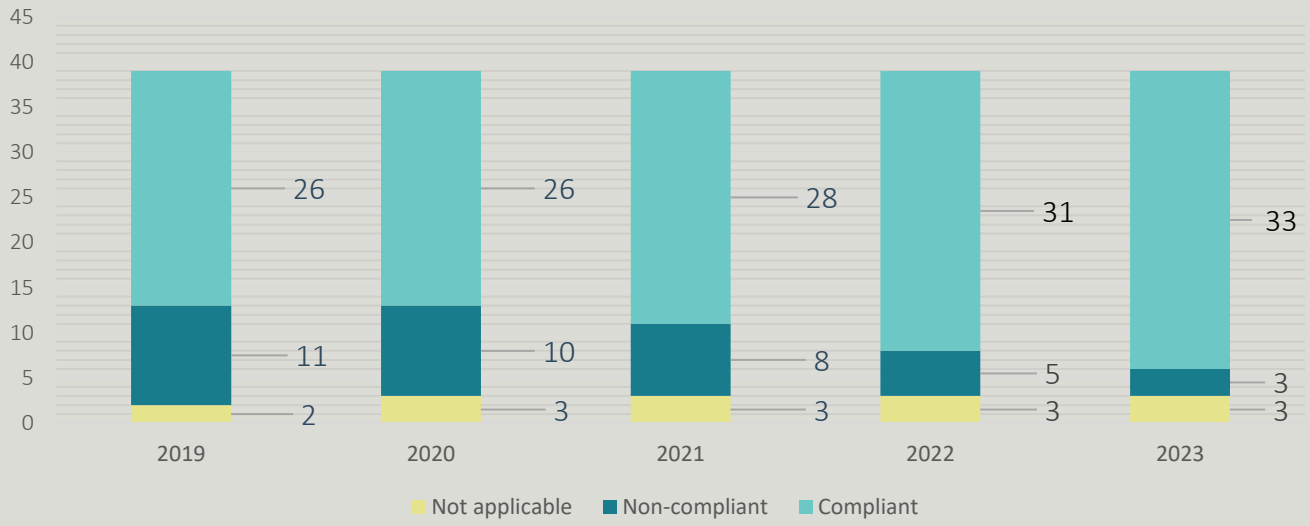
2023 COMPLIANCE RATINGS



RATINGS SUMMARY 2019 – 2023

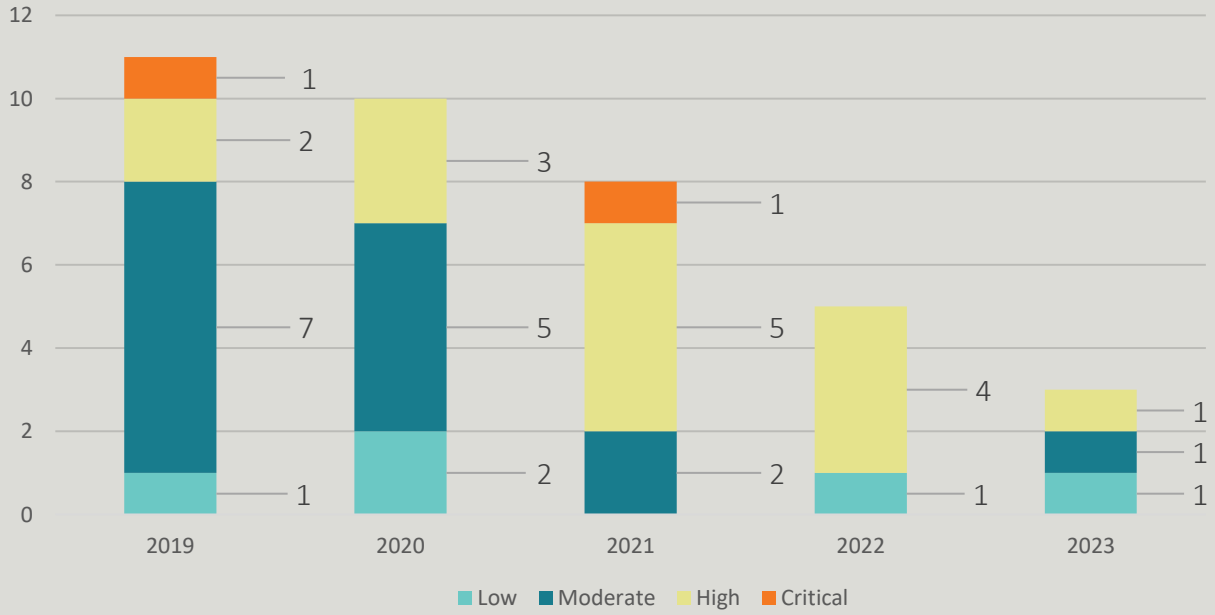
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2019 – 2023



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

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2019 – 2023



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services **Professor James V Lucey**

In brief

The approved centre was located within the campus of the Midlands Regional Hospital in Portlaoise town. It was a purpose-built facility and had been operational as a mental health facility since 2004. The approved centre served the population of both Laois and Offaly and provided ten acute mental health beds for Kildare Mental Health Service. Seven sector teams had admitting privileges: Portlaoise (two teams), Tullamore (two teams), Birr, Psychiatry of Later Life and Mental Health for Intellectual Disability. One team from Kildare provided the care and treatment for residents from this service.

A number of single bedrooms, dormitories and a seclusion room had been refurbished since the previous inspection and works were continuing to upgrade all remaining areas of the approved centre.

Compliance Summary	2019	2020	2021	2022	2023
% Compliance	70%	72%	78%	86%	92%

Conditions to registration

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

Conditions	Findings
Condition 1: *The registered proprietor shall implement and bring to completion the costed, funded and timebound plan to address ligatures in the approved centre in line with the dates set out in the project plan, as submitted to the Mental Health Commission on 4 October 2021.*	The approved centre was not in breach of Condition 1.

Ongoing escalation and enforcement actions at time of inspection

None.

Escalation and enforcement actions commenced following this inspection

None.

Safety of people in the approved centre

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

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

However:

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

Appropriate care and treatment of residents

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

- ***Initial assessments****:* All residents had a comprehensive initial assessment on admission.
- ***Physical assessment****:* Each resident had a physical examination on admission. All residents who were in the approved centre for more than six months had a physical examination and were monitored in accordance with clinical guidelines.

- ***Individual care plans:*** Each resident had an individual care plan that documented the resident's needs; goals that had been decided with the resident's input; and appropriate interventions to address those goals. Each individual care plan had been reviewed on a regular basis.
- ***Multi-disciplinary team working:*** Residents had access to a multi-disciplinary team (MDT) and there were regular multi-disciplinary team meetings to discuss residents' care plans. There was a social worker, occupational therapist and psychologist on the team.
- ***Therapeutic interventions:*** Therapeutic interventions were evidence-based and in line with residents' individual care plan. Interventions included a weekly psychology group, an occupational therapy group, a social work group and a weekly educational group facilitated by a doctor.
- ***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 kept in a good state of repair, internally or externally. Floors were heavily potted. The gardens required tidying as cigarette butts and litter were enmeshed in weeds. Some windows were evidently dirty on the outside. Walls marked by wear and tear were evident and required painting.

Respect for residents' privacy, dignity and autonomy

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

- ***Sleeping accommodation:*** There were a small number of single en suite bedrooms in each ward; accommodation mainly consisted of four-, five- and six-bed dormitories.
- ***Interactions between staff and residents:*** Staff in the approved centre were noted to respect the dignity and privacy of the residents. Staff appearance and dress were appropriate, and staff showed discretion and respect for confidentiality when discussing the resident's condition or treatment needs.
- ***Privacy and dignity:*** There were privacy screens on bedroom doors and residents were facilitated to make private calls. Noticeboards did not show residents' names, and it was not possible for the public to see into the approved centre. Clinical files were securely stored.
- ***Use of restrictive practices:*** The approved centre was compliant with the code of practice on physical restraint and the rules governing seclusion. 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:*** Not all bathrooms and showers had locks on the inside of the door.

- ***Use of restrictive practices:*** Mechanical restraint was not carried out in compliance with the rules governing its use. The plan of care for each person restrained by mechanical means did not include information on attempts to reduce or eliminate the use of restraint for the person. Clinical files did not contain all required contemporaneous records. The multi-disciplinary review and oversight committee did not carry out required tasks regarding each use of mechanical restraint, such as determining compliance with the rules and policies, identifying areas for improvement and actions to be taken, assuring the registered proprietor nominee that each use of mechanical restraint accorded with the rules or producing a report following each meeting.

Responsiveness to residents' needs

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

- ***Environment:*** There was suitable and sufficient heating in day areas and in bedrooms. Rooms were ventilated, and all private and communal areas were adequately sized and furnished to remove excessive noise. Lighting in communal rooms was sufficiently bright and positioned to facilitate all resident and staff requirements. Appropriate signage and sensory aids were provided to support resident orientation needs.
- ***Private areas and areas for socialisation:*** There were areas in the approved centre where residents could socialise with each other. There were also private spaces which the resident could access. There was enough room for residents to freely move around.
- ***Cultural and spiritual support.*** Residents' rights to practise religion were facilitated. Ministers from the Church of Ireland and the Roman Catholic Church visited regularly. All faiths were accommodated if requested.
- ***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 range of recreational activities such as walks, television, books, jigsaws, newspapers, movie nights and art.
- ***Support groups:*** There were a variety of support groups available to residents, including decider skills, mindfulness, art therapy, social groups, chair yoga, a relaxation technique group and wellness recovery action plans.
- ***Residents' feedback:*** The residents were complimentary about the environment and the care they received. They praised the food, the activities and the space and privacy given to them. Residents stated that they were always offered a copy of their individual care plans and saw their doctor regularly.

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 remit of the Laois/Offaly Management Team within the wider Area 8 Community Healthcare Organisation (CHO).
- ***Leadership:*** The approved centre management team convened a monthly business meeting, known as the Approved Centre Governance Group. This group included membership from across the multi-disciplinary and interdisciplinary teams.
- ***Restrictive practices reduction:*** The approved centre had a reduction of restrictive practices strategy.
- ***Risk:*** Persons with responsibility for risk working directly in the approved centre were known by staff. Incidents were reported and risk assessed. A risk review meeting was held monthly or more often if required. The approved centre held a local risk register that was reviewed monthly and where indicated, risks had been escalated to the senior management team to be included on their risk register.
- ***Quality improvement:*** Regular audits had been completed and there was a focus on continuous improvement.
- ***Policies:*** All operating policies and procedures requiring a three-yearly review were reviewed appropriately.
- ***Staff training:*** All staff had received mandatory training. Clinical supervision was provided for medical staff and the health and social care professional groups.
- ***Complaints:*** A complaints process was in place and the complaints procedure, including how to contact the nominated person, was publicly displayed.
- ***Residents' involvement in their own care:*** As far as possible residents were involved in their own care. Feedback from residents was given either directly to staff or through community meetings.
- ***Advocacy services:*** A peer advocacy representative was available to residents in the approved centre.
- ***Regulatory compliance and engagement:*** The approved centre has had an average compliance rate over the last four years of 82%. Compliance has improved by 6% since the previous year and has been continuously improving for the past four years. The approved centre continues to engage positively with the regulatory process and the Mental Health Commission.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. A 'Delayed Discharge Group' has been formed and meets every 6-8 weeks.

2. A representative from SHINE along with nurse management and Clinical Nurse Specialist (CNS) staff from the recovery programme provided information sessions to service users attending the recovery programme.

3. Building on the initial implementation of Safewards, leaders were appointed to decrease restrictive practices by using ten associated interventions designed to improve the safety of everyone; by reducing conflict (physical, verbal aggression, absconding) and containment (forced medication, seclusion, and restraint) events.

   Additionally, a 'Comfort Box' was provided for both wards as part of a Restrictive Practice Reduction Strategy and two new bean bags, suitable for seclusion, were also provided.

4. The unit filing room was upgraded from an Alphabetical to Numerical system which has enhanced patient confidentiality and introduced a new tracking file management system. Resident file layout has also been updated for ease of access.

5. The Psychiatric Consultation Liaison Service (PCLN) service has extended since March 2023, to a seven-day service running from 9am-9pm in the Midland Regional Hospital, Portlaoise (MRHT).

6. Library facilities on the ward for service users has been updated with new current fiction and nonfiction titles, and a toy box has been improved for children in the main visitor's room.

7. The information booklet for the Department of Psychiatry was updated in May 2023, and an Electro-Convulsive Treatment (ECT) booklet was introduced.

8. Initial planning has been undertaken in relation to displaying resident's artwork in an 'Art Gallery' space within the Department of Psychiatry. It is hoped that this will lessen the clinical type of atmosphere, and allow for a period of contemplation for residents, staff and families visiting.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

The approved centre was located within the campus of the Midlands Regional Hospital in Portlaoise town. It was a purpose-built facility and had been operational as a mental health facility since 2004. The approved centre served the population of both Laois and Offaly and provided ten acute mental health beds for Kildare Mental Health Service. Seven sector teams had admitting privileges; Portlaoise (two teams), Tullamore (two teams), Birr, Psychiatry of Later Life and Mental Health for Intellectual Disability. One team from Kildare provided the care and treatment for residents from this service.

The approved centre was divided into wards, male and female. There were a small number of single en suite bedrooms in each and accommodation mainly comprised of four, five and six bedded dormitories. Not all, but most dormitories had an en suite bathroom facility. Both the male and female wards had a seclusion room.

A number of single bedrooms, dormitories and a seclusion room had been refurbished since the previous inspection and works were continuing to upgrade all remaining areas of the approved centre. New furniture and beds had been procured. Anti-ligature works and a ligature reduction programme were ongoing. Both wards had communal sitting and group rooms. There was a shared multi-disciplinary meeting room and a shared dining room. Since COVID-19 meals were served to each cohort separately. Group therapeutic activities and programmes were facilitated in a well-proportioned and tastefully decorated activity room located in a link corridor. There was a shared internal garden. There was also a separate small garden in the male ward, which required staff supervision that was used occasionally.

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

Resident Profile	
Number of registered beds	***46***
Total number of residents	**37**
Number of detained patients	8
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	4
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

The approved centre known as the Department of Psychiatry (DOP), was part of the wider Area 8, Community Healthcare Organisation (CHO). This encompassed Laois/Offaly, Longford/Westmeath and Louth/Meath. Within the CHO an overarching Leadership and Management team managed three distinct Senior Management Teams. The governance of the DOP, Portlaoise was under the remit of the Laois / Offaly Management Team, along with one other approved centre and the community mental health services. Minutes of these team meetings indicated agenda items such as the operational and business management of the relevant approved centres. Also discussed were the results of Mental Health Commission inspections, human resources and recruitment issues, as well as any risk issues escalated to the CHO group. The Quality and Patient Safety (QPS) group also met monthly. This group reviewed the corrective and preventative actions proposed to the Mental Health Commission in terms of regulation non-compliances, discussed the outcomes of the audit programme and addressed the introduction of quality initiatives within the service. The risk register was also reviewed by the QPS committee.

At a local level the approved centre management team convened a monthly business meeting, known as the Approved Centre Governance Group (ACG). This group included membership from across the multi-disciplinary and interdisciplinary teams. There was a representative from hospital administration, the quality and risk advisor, maintenance management and heads of service. The meeting was chaired by the Principal Social Worker and reported directly to the Laois Offaly Management Team. Agenda items included the key changes to the risk register, complaints and compliments, policies and procedures, health and safety, infection prevention and control, delayed discharges, audits, incident reporting data, quality initiatives, Mental Health Commission reporting and findings to include Corrective Action & Preventative Action Plans (CAPA). A separate meeting was convened monthly just prior to the ACG that focussed solely on risk management.

Governance questionnaires completed by heads of discipline and interviews conducted with heads of discipline all, apart from medical personnel, identified potential staffing concerns. There had been occasional nursing shortages, but these were managed and mitigated by the use of regular agency nurses, mental health nurse retirees who had returned to work and through overtime. At the time of inspection, plans were underway to address the need for occupational therapy with the imminent appointment of a senior grade occupational therapist. Also, within psychology there was three community mental health teams that had vacancies. Within the approved centre psychology provision was managed through the triage of all referrals and cross cover was provided for those most in need. There were Senior Clinical Psychologists and Staff Grade psychologists present on the unit on a weekly basis who engaged in individual and group work with residents. However, there was acknowledgement from the principal psychologist that demand for psychological services exceeds supply.

Clinical staff who worked directly in the approved centre were ward based nurses, health care assistants and two clinical nurse specialists in the recovery programme. Occupational therapy, social work and psychology staff all provided some input into the recovery programme. There was a peer support worker from the Midlands Louth Meath Recovery Education Service who worked in the approved centre one day a week. Each treating sector team provided in-reach care and treatment to their residents. Medical staff were

available on call and there was always at least one doctor on duty in the approved centre, with a consultant psychiatrist also available on call.

A steering group comprising medical and nurse management established regular meetings with nurse management colleagues in the Midland Regional Hospital, Portlaoise (MRH, Portlaoise) to examine the effectiveness of interagency services and resolve any common issues at the earliest opportunity. This group primarily focused on the emergency department but also discussed other identified issues. This has enhanced working relationships across the departments and has proven mutually beneficial. Pharmacy services were provided by the MRH, Portlaoise and there was a named dedicated pharmacist for the approved centre. Catering and general maintenance services were also provided by the MRH, Portlaoise. Additionally, there was a hospital wide Fire Safety Management Group with representation from the Department of Psychiatry. This group met quarterly and had developed a Fire Emergency Response Team (FERT) protocol.

There was a risk advisor available to the approved centre who was readily known by staff. The person with overall responsibility for risk was identified as the registered proprietor. There were key staff working directly in the approved centre who managed risks and the processes around risk management. A separate meeting for risk was held monthly or more often if required. The approved centre held a local risk register that was reviewed monthly and where indicated, risks had been escalated to the senior management team to be included on their risk register.

Several quality improvement initiatives had commenced since the last inspection. A restrictive practice reduction strategy had commenced and policies and practices around the use of seclusion, physical restraint and searches had been improved. In keeping with the new requirements, a new oversight group has been established in the DOPP to review all episodes of seclusion and physical restraint. This group meet every month and reviewed every episode of restrictive practice to ensure it was consistent with the rules and codes as set out by the Mental Health Commission (MHC). This group has reviewed and updated the policies in relation to seclusion, mechanical and physical restraint along with all relevant paperwork. This group has also developed a restrictive practice reduction policy relating to seclusion and physical restraint. The oversight meeting occurs on a monthly basis and reviews incidents of seclusion, restraint and searches. Safe Wards had been implemented on Male Admission and on Female Admission, and this had also contributed towards decreasing restrictive practices, by reducing conflict and containment events.

An enhanced and extended seven–day week, 24-hour assessment service is provided in a purpose-built assessment room in the reception area of the approved centre. This has been instigated in conjunction with mental health liaison nurses and the emergency department, Midlands Regional Hospital, Portlaoise.

Considerable effort was expended in delivering actual and planned training with regard to mandatory training and the additional training requirements to fully support the implementation of the new rules on seclusion, physical and mechanical restraint. Training sessions on care planning also continued for all staff. At the time of inspection, the approved centre's results in relation to the requirements of the individual care planning, was found to have improved. This was reinforced by feedback received from residents interviewed, who were knowledgeable about and were facilitated to engage with their individual care

planning processes. This finding was also supported in the data from the service user experience questionnaires.

The continued refurbishment and upgrading of the facilities on a planned and phased basis was another ongoing quality improvement since the previous inspection. While some works had not been completed, it was evident that this was being delivered in time bound phases with a planned commencement of the final phase (Phase Five) by the end of Quarter 1, 2024. The relocation and provision of a new female seclusion room had been completed at the time of inspection, with the male seclusion room scheduled for refurbishment in the next planned phase. Additionally, a more readily accessible de-escalation space had been identified that could separately facilitate either female or male residents in the adjacent link corridor, if required.

The area lead for mental health engagement position was vacant at the time of inspection. Feedback from residents was given either directly to staff or through community meetings, for which there were minutes. The complaints procedures were publicly displayed, and the complaints management process was transparent. A small number of complaints had been escalated to the designated complaints officer.

All required infection control measures were in place to either prevent or mitigate and manage instances of Covid-19 and Clostridium difficile as required.

3.3 Reporting on the National Clinical Guidelines

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

4.0 Compliance

4.1 Non-compliant areas on this inspection

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

Regulation/Rule/Act/Code	Compliance/Risk Rating									
	2019		2020		2021		2022		2023	
Regulation 21: Privacy	✗	Moderate	✗	Moderate	✗	High	✓		✗	Low
Regulation 22: Premises	✗	High	✗	High	✗	High	✗	High	✗	High
Rules: Mechanical Restraint		N/A		N/A		N/A		N/A	✗	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 had not admitted any children since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As no children had been admitted to the approved centre since the last inspection, this code of practice was not applicable.

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.

Feedback about the service was gathered from resident questionnaires and four residents who availed of the opportunity to speak with inspection team. The verbal feedback included the following quotes:

Residents stated:

- 'Food was good, there were good choices, drinks available during the day'
- 'Bedroom is perfect – access to room when I want'
- 'I have enough to do during the day'
- 'I see my doctor regularly - every week'
- 'Always offered a copy of my care plan'
- 'I have space and privacy and I feel safe here'

Other comments in terms of suggested improvements included:

- 'More activities could be offered at the weekend'
- 'The garden could be nicer, especially if it had a no-smoking area'
- 'Few times I couldn't get admitted – I feel the service is under resourced'
- I felt that one doctor wasn't positive towards me – took my leave away'

5.2 Advocacy

The approved centre had an advocacy service.

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

6.0 Feedback Meeting

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

- Executive Clinical Director/Clinical Director
- Assistant Director of Nursing
- Area Director of Nursing
- Clinical Nurse Manager 3
- Clinical Nurse Manager 2 x 2
- Clinical Nurse Manager 1 x 2
- General Manager
- Principal Social Work Manager
- Occupational Therapy Manager

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

7.0 Inspection Findings – Regulations

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

The following regulations are not applicable

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

Regulation 4: Identification of Residents

COMPLIANT

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

INSPECTION FINDINGS

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.

Water coolers provided safe, fresh drinking water to residents at all times in easily accessible locations throughout the approved centre.

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

The approved centre was compliant with this regulation.

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

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

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

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

(2) This regulation is without prejudice to:

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

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

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

INSPECTION FINDINGS

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

Hygiene was maintained to support food safety requirements.

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

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for residents' personal property and possessions. The policy was last reviewed in December 2020.

A resident's personal property and possessions were safeguarded when the approved centre assumed responsibility for them. Secure facilities were provided for the safekeeping of the resident's monies and valuables, as necessary.

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

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

The approved centre was compliant with this regulation.

Regulation 9: Recreational Activities

COMPLIANT

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

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile. Examples of recreational activities provided included walks, television, books, jigsaws, newspapers, movie nights and art. Recreational activities were accessible on weekdays and during the weekend and based on resident's preferences.

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' right to practice religion was facilitated within the approved centre insofar as was practicable. Ministers from the Church of Ireland and the Roman Catholic Church visited regularly. All faiths were accommodated if requested.

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 July 2023.

Visiting times were flexible and not fixed. Visiting times were displayed in the approved centre and visits outside of the visiting hours were facilitated if required. A private visitors room was available to residents, unless there was an identified risk to the resident, an identified risk to others or a health and safety risk. Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visitors room was suitable for visiting children. There was a separate family room with modern furniture and a toy box

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 January 2023.

Residents in both wards had access to their own mobile devices, a landline and an electronic tablet. 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 January 2022, and included all requirements related to:

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

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

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

The clinical file of one resident who had died in the approved centre was inspected. The end-of-life care provided to the resident was appropriate to their physical, emotional, social, psychological and spiritual needs. This was documented in the resident's individual care plan. Religious and cultural practices were respected, insofar as is practicable. The privacy and dignity of residents was protected. Representatives, family, next-of-kin and friends were involved, supported and accommodated during end-of-life care.

The clinical files of two residents who had died suddenly were inspected. The deaths were managed in accordance with the residents' religious and cultural practices, with dignity and propriety and in a way that accommodated the residents' 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

COMPLIANT

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

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

INSPECTION FINDINGS

Ten individual care plans (ICPs) were reviewed on inspection. All ICPs were a composite set of documents. 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. 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.

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

The approved centre was compliant with this regulation.

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

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

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

INSPECTION FINDINGS

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

Clinical nurse specialists coordinated a recovery programme which provided therapeutic interventions delivered by members of the residents' multi-disciplinary teams. Interventions included decider skills, mindfulness, art therapy, social groups, chair yoga, a relaxation technique group and wellness recovery action plans. There was also a weekly psychology group, an occupational therapy group, a social work group and a weekly educational group facilitated by a doctor.

Services that were not provided internally were available to residents by referral.

The approved centre was compliant with this regulation.

Regulation 18: Transfer of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and protocols for the transfer of residents. The policy was last reviewed in January 2023.

Full and complete written information on the resident was transferred when they moved from an approved centre to another facility. A letter of referral and resident transfer form were provided to a named individual upon transfer.

The approved centre was compliant with this regulation.

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

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

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

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

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

INSPECTION FINDINGS

The approved centre had a general health policy which was last reviewed in January 2022. The health policies also included procedures for responding to medical emergencies, which was last reviewed in March 2021.

The approved centre had an emergency trolley or tray and staff had access at all times to an automated external defibrillator.

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.

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

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

The approved centre was compliant with this regulation.

Regulation 20: Provision of Information to Residents

COMPLIANT

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

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

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

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

(d) details of relevant advocacy and voluntary agencies;

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place for the provision of information to residents. The policy was last reviewed in March 2023.

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

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

Residents were provided with written and verbal information on their diagnosis, and the medication information sheets and verbal information were provided in a format appropriate to resident needs. Medication information sheets included all relevant information on indications for use and any possible side-effects. Residents had access to interpretation and translation services. Community support groups also attended the approved centre and facilitated groups and information sessions.

The approved centre was compliant with this regulation.

Regulation 21: Privacy

NON-COMPLIANT

Risk Rating LOW

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

INSPECTION FINDINGS

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

An assisted bathroom on the female ward could not be locked from the inside and had to be externally locked by a staff member. The thumb lock on a new shower door in one of the four-bed rooms had seized and could not lock.

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

The approved centre was non-compliant with this regulation as not all bathrooms and showers had locks on the inside of the door.

Regulation 22: Premises

NON-COMPLIANT

Risk Rating HIGH

(1) The registered proprietor shall ensure that:

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

Sufficient spaces were provided for residents to move about, including outdoor spaces. Hazards such as large open spaces, steps and stairs, slippery floors and hard and sharp edges and surfaces were minimized in the approved centre. Ligature points were not minimised to the lowest practicable level. There was some damage observed on one fire door The bathrooms on the female ward had been refurbished to minimise ligature points but the bathrooms on the male ward had yet to be similarly improved, although plans were in place to complete this work.

The approved centre was not kept in a good state of repair externally and internally. Floors were heavily pitted. Cigarette butts and litter were evident in the gardens. Some windows were dirty on the outside. Walls were marked by wear and tear and needing painting. However, it was noted that there were plans in place to resolve most of the issues observed.

A programme of general and decorative maintenance, cleaning, decontamination and repair of assistive equipment was recorded. The centre was clean, hygienic, and free from offensive odours. Rooms were

centrally heated with pipe work and radiators guarded or guaranteed not to have high surface temperatures. Current national infection control guidelines were followed.

The approved centre had sufficient toilets and showers for all residents, including assisted toilets. A designated cleaning room and sluice room, as well as assistive devices and equipment to address resident needs, were in place in the approved centre. All resident bedrooms were appropriately sized to address the resident needs and furnished to support resident independence and comfort.

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

a) **Ligatures were not reduced to the lowest practicable level based on risk assessment, 22(3).**
b) **The approved centre was not kept in a good state of repair internally or externally, 22(1)(a).**

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

COMPLIANT

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

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

INSPECTION FINDINGS

The approved centre had a written policy and procedures in relation to ordering, proscribing, storing and administration of medicine. The policy was last reviewed in April 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 administering resident medication, including routes of medication.

All residents had a Medication Prescription and Administration Record (MPAR). 10 MPARs were examined on inspection. All MPARs contained a detailed record of appropriate medication management processes, including a record of any allergies or sensitivities to medications, the frequency of administration, all medications administered and the date of discontinuation of each medication. The Medical Council registration number of every medical practitioner prescribing medication to the resident was also recorded.

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

Medication was crushed only at the direction of the resident's medical practitioner and with a documented reason. The pharmacist was consulted about this preparation, and it was documented within the MPAR.

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 January 2023.

The approved centre was compliant with this regulation.

Regulation 25: Use of Closed Circuit Television

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

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

The use of CCTV had been disclosed to the Mental Health Commission and the Inspector of Mental Health Services. CCTV cameras used to observe residents were incapable of recording or storing a resident's image on a tape, disc, hard drive or in any other form. Images used to observe residents could only be seen by the health professional responsible for the resident. CCTV was not used to monitor a resident if they started to act in a way that compromised their dignity.

The approved centre was compliant with this regulation.

Regulation 26: Staffing

COMPLIANT

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

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

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

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

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

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

INSPECTION FINDINGS

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

The numbers and skill mix of staffing in the approved centre were sufficient to meet resident needs. Nursing staff numbered 47 in total. There were nine occupational therapists and eight social workers working directly in the approved centre.

An appropriately qualified staff member was on duty at all times. The service had worked hard to schedule its training and had succeeded. All healthcare staff were trained in basic life support, fire safety, the management of violence and aggression, and the Mental Health Act 2001. All outstanding training was scheduled for completion.

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 (47)	47	100%	47	%	47	100%	47	100%
Consultant Psychiatrist (11)	11	100%	11	%	11	100%	11	100%

Medical (25)	23	92%	23	%	24	96%	25	100%
Occupational Therapist (9)	9	100%	8	89%	9	100%	9	100%
Social Worker (8)	8	100%	8	100%	8	100%	8	100%
Psychologist (3)	3	100%	3	100%	3	100%	3	%
Other MDT (0)	0	%	0	%	0	%	0	%

*All outstanding training was scheduled for completion on a rolling monthly training schedule.

The approved centre was compliant with this regulation.

Regulation 27: Maintenance of Records

COMPLIANT

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

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

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

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

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

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures for the maintenance of records. The policy was last reviewed in March 2023. The policy covered the following provisions:

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

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.

The approved centre was compliant with this regulation.

Regulation 28: Register of Residents

COMPLIANT

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

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

INSPECTION FINDINGS

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

The approved centre was 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 had a dedicated tribunal room and adequate resources to support the Mental Health Tribunal process. Staff attended mental health tribunals and provided assistance as necessary when resident required assistance to attend or participate in the process. The tribunal room had access to remote facilities to allow virtual meetings if required.

The approved centre was compliant with this regulation.

Regulation 31: Complaints Procedures

COMPLIANT

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

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

A nominated person was responsible for dealing with all complaints in the approved centre. Information was provided about the complaints procedure to residents and their representatives at admission or soon thereafter. The complaints procedure and 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

COMPLIANT

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

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

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

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

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

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

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

(e) Arrangements for responding to emergencies;

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

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

INSPECTION FINDINGS

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

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

Responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation. The person with responsibility for risk was identified and known by all staff and the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical corporate and health and safety risks were identified, assessed, treated, reported, monitored and

documented in the risk register as appropriate. Refurbishment plans were being implemented to removed or effectively mitigate structural risks, including ligature points.

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, mechanical restraint, specialised treatment (ECT), resident transfer and resident discharge. Multi-disciplinary teams were involved in the development, implementation and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. The requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

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

The approved centre was compliant with this regulation.

Regulation 33: Insurance

COMPLIANT

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

INSPECTION FINDINGS

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

The approved centre was compliant with this regulation.

Regulation 34: Certificate of Registration

COMPLIANT

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

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration with all the conditions to registration attached. The certificate was displayed prominently.

The approved centre was compliant with this regulation.

8.0 Inspection Findings – Rules

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

Section 69: The Use of Seclusion

COMPLIANT

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

INSPECTION FINDINGS

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

- Who may initiate, and who may carry out, seclusion.
- The provision of information to the patient which must include information about the patient's rights, presented in accessible language and format.
- The safety, safeguarding and risk management arrangements that must be 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 aims 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 includes 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 furnished, maintained and cleaned to ensure the patient's right to personal dignity and privacy. Residents had sight of a clock displaying the time, day and date. The seclusion rooms were constructed to maintain resident safety. There were no ligature points or electrical fixtures. 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 seclusion rooms were in an area removed from communal sitting rooms and sleeping accommodation without being isolated. Residents who had been secluded, 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 person in seclusion. Seclusion facilities were not used as bedrooms and bedrooms were not used as seclusion facilities.

Three episodes of seclusion were reviewed on inspection. Each episode inspected, reflected that seclusion was only used in rare and exceptional circumstances and in residents' best interests when the resident posed an immediate threat of serious harm to self or others. Seclusion was only initiated by a registered medical practitioner (RMP) or the most senior registered nurse (RN) on duty, following as comprehensive an assessment of the patient, and after all other interventions to manage the residents' unsafe behaviour had been considered. This included a risk assessment; the outcome of which was recorded in the clinical file. The RMP or RN recorded the seclusion order both 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 each resident in seclusion 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. The CP medical examined the resident and signed the seclusion register within 24 hours of the commencement of the seclusion episode. The examination was recorded in the clinical file. The resident 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 person's wish in accordance with their ICP, the resident's representative was informed of their seclusion and a record of this communication was entered in the clinical file.

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

Each resident was secluded in their own clothing which respected the right of the person to dignity, bodily integrity and privacy. The resident was directly observed by a RN for the first hour following the initiation of seclusion. After the first hour, a RN kept the resident under continuous observation and stayed within sight and sound of the seclusion room. Every 15 minutes, the RN recorded the resident'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 resident took place every two hours. During this review, a minimum of two staff members entered the seclusion room and assessed the resident 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 resident 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 resident's preferences in relation to seclusion if known, signs that the resident's behaviour is no longer deemed an unmanageable risk towards themselves or others, how potential risks may be managed, specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion. The care plan also included how the resident's bodily needs would be met, medication reviews, monitoring of physical observations and a strategy for ending seclusion.

The seclusion order was renewed by an order made by a RMP under the supervision of the CP or the duty CP following a medical examination. 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 and 72 hours of continuous seclusion, the CP or the duty CP undertook a medical examination. Following the medical examination, the CP discontinued the use of seclusion unless they ordered its continued use. Where a resident was secluded for more than 72 hours, the Mental Health Commission was provided with additional information.

Seclusion was ended by a RMP at any time following discussion with the resident and relevant nursing staff, or by the most senior RN on the ward in consultation with the resident and the RMP. The CP responsible or the duty CP was notified, and the resident 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 resident 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 resident preferred otherwise. Where the resident refused to participate in a debrief, this wish was respected and recorded. The debrief included a discussion regarding alternative de-escalation strategies and the resident's preferences that could be applied in the case of future restrictive interventions.

The resident 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 resident'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 resident's representative was informed of both the start and ending of the seclusion, except where it was the resident patient's wish otherwise. Appropriate emotional support was provided to the resident directly after the episode. Staff also offered support, if appropriate, to other persons who may have witnessed the seclusion.

The approved centre was compliant with this rule.

Section 69: The Use of Mechanical Restraint

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 mechanical restraint which was last reviewed in February 2023.

Evidence of Implementation: The clinical file of one patient who had been mechanically restrained was inspected. Mechanical restraint was used to address an identified clinical need and was only used when less restrictive alternatives were not deemed suitable. Mechanical restraint was only used following a risk assessment of the safety and suitability of the mechanical restraint for the patient. This risk assessment specified the monitoring arrangements and frequency with which the restraint was implemented, and a copy of the risk assessment and record of the monitoring of the person were available. The risk assessment was reviewed and updated at least quarterly in line with the patient's individual care plan.

The patient's multi-disciplinary team developed a plan of care for the patient but did not include information on attempts to reduce or eliminate the use of restraint. The mechanical restraint was ordered by a registered medical practitioner under the supervision of the patient's consultant psychiatrist (CP) or the duty CP. The clinical file contained a contemporaneous record that specified:

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

However, the clinical file did not record the duration of the restraint, the duration of the order or the review date.

A multi-disciplinary review and oversight committee met at least quarterly to review all persons at the approved centre who were the subject of Part 4 of these rules in the previous quarter to determine the appropriateness of the use of this restrictive practice. The committee did not determine if there was

compliance with the rules on the use of mechanical restraint or with the approved centre's own policies and procedures for each episode reviewed. The committee did not identify areas for improvement nor the actions, the persons responsible or the timeframes for completion of any actions. The committee did not provide assurance to the registered proprietor nominee that each use of mechanical restraint was in accordance with the Mental Health Commission's Rules. No report was produced following each meeting of the review and oversight committee.

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

a) **The multi-disciplinary team developed a plan of care for the patient restrained by mechanical means but did not include information on the reduction or elimination of the use of the restraint, 10.2 (iii).**
b) **The clinical file did not contain a contemporaneous record that specified the duration of the restraint, 10.5 (v).**
c) **The clinical file did not contain a contemporaneous record that specified the duration of the order, 10.5 (vi).**
d) **The clinical file did not contain a contemporaneous record that specified the review date, 10.5 (vii).**
e) **The multi-disciplinary review and oversight committee did not determine if there was compliance with the rules on the use of mechanical restraint for each episode reviewed, 10.6 (i).**
f) **The multi-disciplinary review and oversight committee did not determine if there was compliance with the approved centre's own policies and procedures relating to mechanical restraint, 10.6 (ii).**
g) **The multi-disciplinary review and oversight committee did not identify and document any areas for improvement, 10.6 (iii).**
h) **The multi-disciplinary review and oversight committee did not identify the actions, the persons responsible or the timeframes for completion of any actions, 10.6 (iv).**
i) **The multi-disciplinary review and oversight committee did not provide assurance to the registered proprietor nominee that each use of mechanical restraint was in accordance with the Mental Health Commission's rules, 10.6 (v).**
j) **The multi-disciplinary review and oversight committee did not produce a report following each meeting of the review and oversight committee, 10.6 (vi).**

9.0 Inspection Findings – Mental Health Act 2001

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

Part 4 Consent to Treatment

COMPLIANT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INSPECTION FINDINGS

The clinical 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 or equivalent of both patients, and that both patients were deemed unable to consent to receive further treatment

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 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 physical restraint which was last reviewed in January 2023. It addressed the following:

- The provision of information to the resident.
- Who can initiate and who may implement physical restraint.
- Child protection process where a child is physically restrained.

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.

Evidence of Implementation: The clinical files of three residents who had been physically restrained were inspected. The resident was only physically restrained in rare, exceptional circumstances and in the best interests of the resident, where they posed an immediate threat of serious harm to themself or to others. Physical restraint was only used after all alternative interventions to manage the resident's unsafe behaviour had been considered. Use of physical restraint was based on a risk assessment. Cultural awareness and gender sensitivity were demonstrated when considering the use of and when using physical restraint.

Physical restraint was initiated by a registered medical practitioner (RMP) or a registered nurse (RN) or other members of the resident's multi-disciplinary team (MDT) in accordance with the policy on physical restraint. A designated staff member was responsible for leading the physical restraint and for monitoring the head and airway of the resident.

The consultant psychiatrist (CP) or the duty CP was notified as soon as was practicable, and this was recorded in clinical file. A RMP completed a medical examination of the resident no later than three hours after the start of an episode of physical restraint. The order for physical restraint lasted a maximum of 30 minutes.

The episode of physical restraint was recorded in the clinical file and a clinical practice form was completed by the person who initiated and ordered the use of physical restraint no later than three hours after episode. The clinical practice form was signed by the CP within 24 hours.

In one case, the resident was informed of the reasons for, likely duration of, and circumstances leading to the discontinuation of physical restraint. In two other cases, such information was deemed prejudicial to

the resident's mental health, well-being or emotional condition, and the reason for not informing the resident was documented in clinical file.

As soon as practicable and with the resident's consent, or where the resident lacks capacity and cannot consent, the resident's next of kin or representative was informed of the use of physical restraint and a record of the communication was placed in the clinical file. The next of kin or representative were not informed in cases where the resident did not wish it, and this was documented in the clinical file.

A staff member of the same sex as the resident was present at all times during the episode of physical restraint. The resident was given an opportunity to discuss the episode with members of their MDT. A completed clinical practice form was placed in the resident's clinical file and each episode of physical restraint was reviewed by members of the MDT and documented in the clinical file no later than two working days after the episode.

The approved centre was compliant with this code of practice.

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

COMPLIANT

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

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures on the use of Electro-Convulsive Therapy (ECT) for voluntary patients. The policy had been reviewed annually and was dated January 2021. It contained protocols that were developed in line with best international practice, including:

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

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

Evidence of Implementation: The approved centre had a dedicated ECT suite with a private waiting area, adequately equipped treatment room, and an adequately equipped recovery room. High-risk residents were treated in a rapid-intervention area. The ECT suite had facility for monitoring electroencephalogram (EEG) on two channels. The ECT machines were regularly maintained and a record of maintenance kept. Materials and equipment in the ECT suite, including emergency drugs, were in line with best international practice. Up-to-date protocols for the management of cardiac arrest, anaphylaxis and malignant hyperthermia were prominently displayed. A named consultant psychiatrist (CP) had overall responsibility for ECT management and a named consultant anaesthetist had overall responsibility for anaesthesia. At least two registered nurses were in the ECT suite at all times, one of whom was a designated ECT nurse.

The clinical files of two residents who had voluntarily undergone ECT were inspected. Appropriate information on ECT was given to the residents by the CP prior to consent. This information covered the nature of the treatment of ECT, a description of the process of ECT, the purpose of treatment with ECT, the intended benefits of ECT treatment, possible consequences of not receiving ECT and treatment alternatives to ECT.

The resident received confirmation that they would be offered alternative treatment to ECT if they decided to withhold consent. Information was provided on likely adverse effects of ECT, including the risk of cognitive impairment, amnesia and other potential side-effects. This information was provided both orally and in writing, in simple language that the resident could understand. If necessary, the information was available in other languages.

Subject to the urgency of their clinical circumstances, the resident was given 24 hours to reflect on the information. They were informed of their right to an advocate of their choosing at any stage. The resident could ask questions at any time and their questions were answered and documented.

The resident was considered able to give their consent for ECT, including anaesthesia. The CP assessed the resident's capacity to ensure they understood the nature of ECT, why ECT was proposed, the benefits and risks of ECT, alternatives to ECT and the broad consequences of not receiving ECT. The CP also assessed that the resident could retain information long enough to make a decision on whether or not to receive ECT, could make a free choice to receive or refuse ECT and could communicate their decision to consent to ECT.

Written record of the assessments of capacity to consent as well as the resident's consent to each programme of ECT, including anaesthesia, were recorded in the resident's clinical file. This included confirmation that all elements above were discussed with resident; confirmation that the resident had been given all relevant information; and confirmation that the resident understood that they can withdraw their consent at any time during treatment session. All consent was obtained by a CP or a registered medical practitioner (RMP) under supervision of CP prior to each ECT treatment session. This was recorded in clinical file.

The programme of ECT was only prescribed by the responsible CP. The prescription for ECT recorded in clinical file. The record included the reason for the decision to use ECT, alternative therapies that were considered or proved ineffective, documentation of discussion with resident and their next of kin or representative, an examination of the resident's current mental state examination and the assessments referred to in this code of practice.

An initial stimulus dose was discussed and considered by the treating CP and CP responsible for ECT in advance of the treatment and prescribed accordingly. A cognitive assessment was completed before each programme of ECT. The resident's clinical status was assessed before and after each ECT treatment session, and their cognitive functioning was monitored during and after ECT programme.

The CP, in consultation with the resident, reviewed the resident's progress and need for continuation of ECT. If the programme of ECT was terminated, this reason was documented in clinical file. A pre-anaesthetic assessment was recorded in clinical file, which included a detailed medical history and full physical exam.

Anaesthetic risk was assessed and recorded by the anaesthetist and the variation in risk was recorded before treatment. A consistent anaesthetic induction agent was applied throughout programme of ECT. Doses of the anaesthetic agents used, the resident's response, monitor recordings before and immediately after treatment and recovery were recorded, dated and signed by anaesthetist and placed in the clinical file.

The resident's clinical file and forms required by this code of practice were made available to all staff involved in ECT. ECT was only given by a CP or a RMP under the supervision of a CP. ECT was administered by a constant-current brief-pulse ECT machine. The same ECT machine was used throughout programme,

or a rationale for using a different ECT machine was recorded in clinical file. Stimulus dosing or the recommended starting dose regimes were used and documented in ECT record.

The ECT register was completed on conclusion of a programme of ECT and a copy placed in the clinical file. This file also contained pre-ECT assessments, post-ECT assessments, the ECT record, the anaesthesia record of each session and copies of all cognitive assessments.

Adverse events during or following ECT were addressed in full and recorded. Reasons for continuing or discontinuing ECT were recorded.

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 written policies; one in relation to admission and transfer, and another in relation to discharge.

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

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

Discharge: The discharge policy, which was last reviewed in February 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 and discharge policy and the transfer policy.

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

Evidence of Implementation:

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

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

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

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

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

The approved centre was compliant with this code of practice.

Appendix 1: Corrective and Preventative Action Plan

Regulation 21: Privacy					
Reason ID : 10005377		Not all bathrooms and showers had locks on the inside of the door.			
	Specific	Measurable	Achievable/Realistic	Time-bound	Post-Holder(s)
Corrective Action	All bathroom and showers are to be fitted with locks inside of the door.	This work was completed directly following the inspection by the Mental Health Commission in December 2023.	Achievable	04/12/2023	Maintenance Manager.
Preventative Action	Monthly Quality and Hygiene walkabouts with the Maintenance Manager, CNM3 and MHA Administrator will take place to ensure compliance with Regulation 21. Ward CNM2s have been made aware of non-compliance with Regulation 21 relating to locks on the inside of bathrooms/showers and are to complete weekly checks to ensure locks have not seized and are in working order.	Any non-compliance highlighted during the Quality and Hygiene walkabout will be identified in the audit and actioned as appropriately by the CNM3 for immediate attention. Immediate maintenance request will be logged on any faulty or seized locks by the CNM2.	Realistic	04/12/2023	Maintenance Manager, CNM3, MHA Administrator and CNM2.

Regulation 22: Premises					
Reason ID : 10005375		**Ligatures were not reduced to the lowest practicable level based on risk assessment.**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Approved Centre has a schedule of phased ligature works which is ongoing and developed in conjunction with HSE Estates and RKD Architects. Three phases of this work have been completed in the Approved Centre since year end 2023.	Phase 4 of ligature works has been commissioned and is due to commence in Quarter 3, 2024. (Schedule attached.) The six bed High Observation Area and two rooms, all in the male admission ward, are prioritised for completion in the next phase of works. This will ensure all bedrooms are completed throughout the department.	Achievable	30/11/2024	Maintenance Manager, HSE Estates and Senior Management Team.
Preventative Action	Ligature rooms that have not had works completed are now included as part of the risk assessment on admission for all service users. A Psychiatric Registered Nurse is always present in the	The ligature audit completed in February 2024 identifies all ligatures to be addressed in the Approved Centre, and this has been shared with HSE Estates and RKD	Achievable	30/04/2024	ADON, CNM3, CNM2, Consultants and NCHD.

	High Observation Area on the male admission unit in the Approved Centre. All staff are made aware of the current status of the anti-ligature work on an ongoing basis.	Architects. The audit on Code of Practices for Admission, Transfers and Discharge captures risk assessments completed on admission.			
Reason ID : 10005376		**The approved centre was not kept in a good state of repair internally or externally, 22 (1)(a).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	Phase 4 of ligature works will include replacement of damaged flooring in the Approved Centre. The external courtyard is included for upgrading in Phase 4 of the ligature works also (Attached draft plan).	Phase 4 ligature works due to commence in August 2024 (Scheduled attached).	Achievable	09/08/2024	Maintenance Manager, HSE Estates and Senior Management Team.
Preventative Action	Quality and hygiene audits are conducted in the Approved Centre. These capture areas which are not kept in a good state of repair both internally and externally and are completed on a monthly basis.	Findings of the hygiene audit are actioned by the CNM3, and the appropriate manager is requested to provide a corrective action plan to address the non-compliances identified.	Achievable	31/01/2024	Maintenance Manager, ADON, CNM3, Senior Management Team and HSE Estates.

Rules Governing the Use of Mechanical Means of Bodily Restraint					
Reason ID : 10005378		**The multi-disciplinary team developed a plan of care for the patient restrained by mechanical means but did not include information on the reduction or elimination of the use of the restraint, 10.2 (iii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The multi-disciplinary team will review each episode of mechanical means of restraint at the weekly ICP meeting. This discussion will include information on how the Approved Centre is attempting to eliminate and reduce the use of mechanical restraint for the person, and consider other less restrictive means to care. The Approved Centre has updated the policy on mechanical means of bodily restraint and circulated to all staff of the Approved Centre. The Approved Centre has	All episodes of mechanical restraint will be audited and findings will be disseminated to the consultants and the relevant sector. Any areas of non-compliance will be discussed directly with the team involved for immediate action to ensure compliance with the Rules Governing the use of Mechanical Means of Bodily Restraint.	Achievable	31/01/2024	Registered Proprietor Nominee, Executive Clinical Director, Area Director of Nursing, ADON, CNM3, Heads of Discipline, ACG, Oversight Committee and CMT.

	developed a pro forma which will assist in compliance on the rules governing the use of mechanical means of bodily restraint.				
Preventative Action	Each episode of mechanical restraint will be audited to ensure compliance with the Rules Governing the use of Mechanical Means of Bodily Restraint. Each episode of mechanical restraint will be reviewed by the Oversight Committee for the Approved Centre at their monthly meeting to ensure compliance with the Rules Governing the use of Mechanical Means of Bodily Restraint and the policy of the Approved Centre relating to the use	All relevant staff of the Approved Centre to complete HSELand training on The Rules Governing the use of Mechanical Means of Bodily Restraint. All relevant staff of the Approved Centre will attend training provided by an identified external expert on restrictive practices, which includes information on elimination and reduction of restraint. These sessions have been scheduled on six dates which run up to October 2024. The Approved	Achievable	31/05/2024	Registered Proprietor Nominee, Executive Clinical Director, Area Director of Nursing, ADON, CNM3, Heads of Discipline, ACG, Oversight Committee and CMT.

	of Mechanical Means of Bodily Restraint. The Approved Centre's CNM3 will bring audit findings to the monthly Catchment Management Team for discussion, with corrective actions put in place to address any non-compliance identified.	Centre's Oversight Committee will produce quarterly reports on restrictive practices to include mechanical means of bodily restraint and highlight any non-compliances with the Rules Governing the use of Mechanical Means of Bodily Restraint and corrective actions to ensure compliance with the Rules.			
Reason ID : 10005379		**The clinical file did not contain a contemporaneous record that specified the duration of the restraint, 10.5 (v). The clinical file did not contain a contemporaneous record that specified the duration of the order, 10.5 (vi). The clinical file did not contain a contemporaneous record that specified the review date, 10.5 (vii).**			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	All episodes of mechanical means of bodily restraint will be prescribed by the treating consultant in the clinical file and include details on the duration of the restraint, the duration of the	Each episode of mechanical restraint will be an identified need on the individual ICP for the person and reviewed at the weekly meeting. All episodes of mechanical restraint will be audited and	Achievable	31/01/2024	Registered Proprietor Nominee, Executive Clinical Director, Area Director of Nursing, ADON, CNM3, Heads of Discipline, ACG, Oversight Committee and CMT

	order and a review date on the mechanical restraint. The Approved Centre has updated the Policy on Mechanical Means of Bodily Restraint, and circulated to all staff of the Approved Centre. The Approved Centre has developed a pro forma which will assist in ensuring compliance on the Rules Governing the Use of Mechanical Means of Bodily Restraint.	findings will be disseminated to the consultants and the sectors. Any areas of non-compliance will be discussed directly with the team involved for immediate action to ensure compliance with the Rules Governing the use of Mechanical Means of Bodily Restraint.			
Preventative Action	Each episode of mechanical restraint will be audited to ensure compliance with the Rules Governing the use of Mechanical Mean of Bodily Restraint. Each episode of mechanical restraint will be	All relevant staff of the Approved Centre to complete HSELand training on The Rules Governing the use of Mechanical Means of Bodily Restraint. All relevant staff of the Approved Centre will attend training	Achievable	31/05/2024	Registered Proprietor Nominee, Executive Clinical Director, Area Director of Nursing, ADON, CNM3, Heads of Discipline, ACG, Oversight Committee and CMT

	reviewed by the Oversight Committee for the Approved Centre at their monthly meeting to ensure compliance with the Rules Governing the use of Mechanical Mean of Bodily Restrain and the policy of the Approved Centre relating to the use of mechanical means of bodily restraint. The Approved Centre's CNM3 will bring audit findings to the monthly Senior Management Meeting for discussion with corrective actions put in place to address any non-compliances identified.	provided by an identified external expert on restrictive practices which includes information on elimination and reduction of restraint. These sessions have been scheduled on six dates which run up to October 2024. The Approved Centre's Oversight Committee will produce quarterly reports on restrictive practices to include mechanical means of bodily restraint and highlight any non-compliances with the Rules Governing the use of Mechanical Means of Bodily Restraint and corrective actions to ensure compliance with the Rules.			
Reason ID : 10005382		**The multi-disciplinary review and oversight committee did not determine if there was compliance with the rules on the use of mechanical restraint for each episode reviewed, 10.6 (i). The multi-**			

		disciplinary review and oversight committee did not determine if there was compliance with the approved centre's own policies and procedures relating to mechanical restraint, 10.6 (ii). The multi-disciplinary review and oversight committee did not identify and document any areas for improvement, 10.6 (iii). The multi-disciplinary review and oversight committee did not identify the actions, the persons responsible or the timeframes for completion of any actions, 10.6 (iv). The multi-disciplinary review and oversight committee did not provide assurance to the registered proprietor nominee that each use of mechanical restraint was in accordance with the Mental Health Commission's rules, 10.6 (v). The multi-disciplinary review and oversight committee did not produce a report following each meeting of the review and oversight committee, 10.6 (vi).			
	Specific	**Measurable**	**Achievable/Realistic**	**Time-bound**	**Post-Holder(s)**
Corrective Action	The Oversight Committee of the Approved Centre will review each episode of mechanical restraint to ensure compliance with the Rules on Mechanical Means of Bodily Restraint to include 10.6 i., ii., iii., iv., v., vi. and vii, and compliance with the Approved Centre policy on the use of mechanical restraint.	All episodes of mechanical restraint will be audited and the finding will be reviewed at the monthly Oversight Committee meeting where non-compliances will be identified and measured against the Rules Governing the use of Mechanical Restrain and the Approved Centre's Policy on the Use of Mechanical Restraint. The Oversight Committee will produce a quarterly report on restrictive practices in the	Achievable	31/01/2024	Registered Proprietor Nominee, Executive Clinical Director, Area Director of Nursing, ADON, CNM3, Heads of Discipline, ACG, Oversight Committee and CMT

		Approved Centre which will include all episodes of mechanical restraint which occurred during that quarter.			
Preventative Action	Each episode of mechanical restraint will be reviewed by the Oversight Committee for the Approved Centre at their monthly meeting to ensure compliance with the Rules Governing the use of Mechanical Means of Bodily Restraint and the policy of the Approved Centre relating to the Use of Mechanical Means of Bodily Restraint.	Monthly minutes will be available for inspection along with quarterly and annual reports on the use of restrictive practices in the Approved Centre which will include all episodes of mechanical restraint. All staff of the Approved Centre will attend training provided by an identified external expert on restrictive practices which includes information on elimination and reduction of restraint. These sessions have been scheduled on six dates which run up to October 2024.	Achievable	31/01/2024	Registered Proprietor Nominee, Executive Clinical Director, Area Director of Nursing, ADON, CNM3, Heads of Discipline, ACG, Oversight Committee and CMT

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.

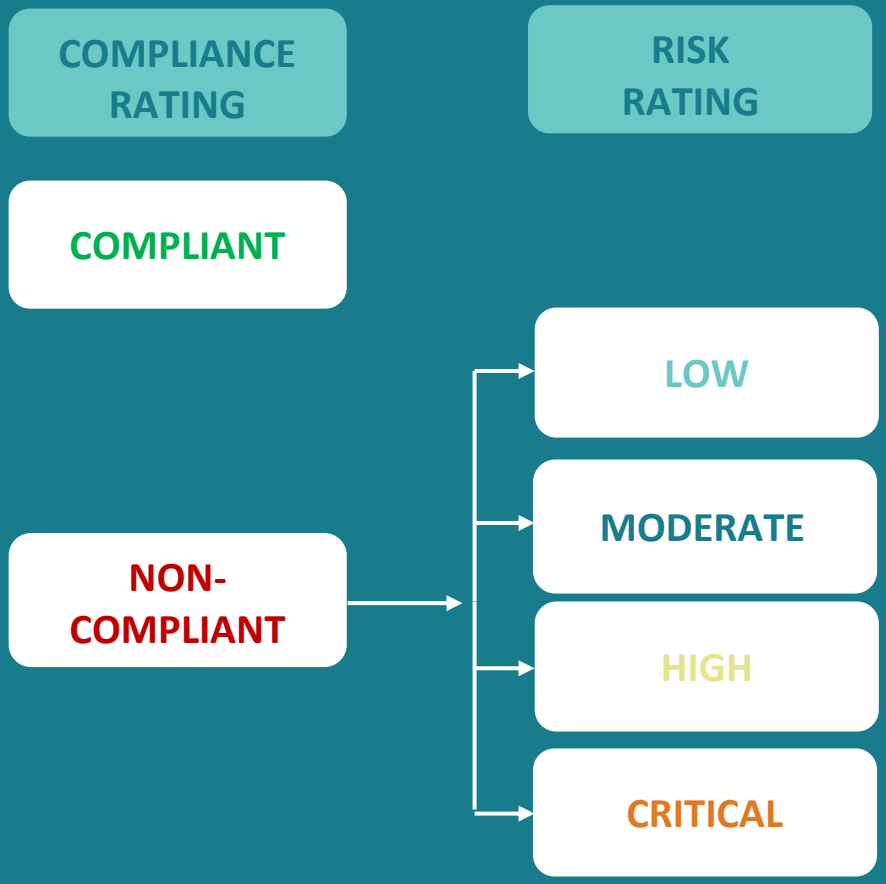
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements.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